Dorset Safeguarding Children Board

Serious Case Review

SCR S26: Child S

Review report

Independent Reviewer: Kevin Ball

Date: 26th June 2018

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1. Introduction to the case

1.1. Based on statutory guidance[1] Dorset Safeguarding Children Board determined that a Serious Case Review should be conducted following the death of a child in August 2017, who for the purpose of this report, will be known as Child S. Child S died as a result of injuries suffered following a road traffic accident in which the Mother was driving and was found to be three times over the permitted alcohol driving limit, but also to have been using cocaine. Child S's Mother had a known history of alcohol dependency and had, over a number of years, been in contact with a range of agencies. The Mother is now serving a custodial sentence having been found guilty of death by dangerous driving, causing serious injury by dangerous driving and causing death by careless driving whilst under the influence of drink.

2. Process for conducting the review

2.1. Dorset Safeguarding Children Board recognised the potential to learn lessons from undertaking a review into the agency involvement with Child S and family; particularly in the manner in which agencies worked together to safeguard children.

2.2. The Board commissioned Kevin Ball as the Independent Reviewer[2]. The approach taken has complied with the principles as set out in statutory guidance[3]. Additionally, a learning model using systems ideas based on a Soft Systems Methodology[4] has been adopted allowing *'… an action orientated process for inquiry into problematical situations in which users learn their way from finding out about the situation, to taking action to improving it …'*. As such, the process been able to capture and identify opportunities for professionals and organisations to learn and improve safeguarding practices from a whole safeguarding system perspective.

2.3. Following the decision in September 2017 by the Independent Chair of the Board to commission this review the following steps were taken;

- Terms of reference for conducting the review were set by the Case Review & Audit Group[5],
- Briefing session of single agency authors for those organisations that had contact with Child S and family,
- Single agency reports and chronology were requested and submitted[6], which in turn generated a combined chronology of agency involvement. This process provided each agency with the opportunity to reflect on their

[1] Working Together to Safeguard Children, HM Government, 2015 (Amended 2017).

[2] Kevin Ball is an independent and experienced safeguarding consultant, with specific experience of chairing and authoring case reviews.

[3] Working Together to Safeguard Children expects SCRs to be conducted in a way that; recognises the complex circumstances in which professionals work together; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did; seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight; is transparent about the way data is collected and analysed; and makes use of relevant research and case evidence to inform finding. This review has adhered to these principles.

[4] Soft Systems Methodology by Checkland, P., & Poulter, J., in Systems Approaches to Managing Change: A Practical Guide, Reynolds, M., & Holwell, S., Open University, 2010.

[5] The Case Review & Audit Group is a sub group of the Dorset Safeguarding Children Board.

[6] Single agency reports were submitted from the following agencies;
- Dorset Police
- Dorset HealthCare NHS Trust
- Dorset Clinical Commissioning Group (CCG) General Practitioners
- Maternity Services of Salisbury NHS Foundation Trust
- Pre-school 1

involvement with Child S and family – from both a single agency viewpoint but also from a wider, and more interactive systemic perspective. As a result, agencies have been able to consider actions required of themselves in order to make improvements to practice,

- A facilitated multi-agency workshop which involved practitioners who had come into contact with Child S and parents. This initial workshop had three main features; firstly, to examine what happened in this case, as well as understanding the underlying reasons why events occurred as they did, secondly, to explore agency interactions and emerging themes and thirdly, to consider changes and improvements needed,
- A further facilitated multi-agency workshop with the same group of professionals to consider the findings of the review and further develop improvements,
- Throughout the above steps, the Case Review & Audit Group has maintained oversight of progress and activity, offering support and assistance when necessary.

2.4. It was agreed that the timeframe for the review would be from the point that Child S's Mother first became known by agencies to be pregnant with Child S in October 2013, through to the road traffic accident in August 2017 when Child S died. Relevant information prior to this timeframe is also included as necessary.

3. Family structure & contribution to the review

3.1. For the purpose of conducting this review the following individuals are relevant;

Individual:	**Identified as:**
Subject child	Child S
Mother to Child S	Mother
Father to Child S	Father
Maternal Grandmother to Child S	Maternal Grandmother
Maternal Grandfather to Child S	Maternal Grandfather

3.2. Seeking the contribution of family members has been an important consideration. The Independent Reviewer, via the LSCB, made attempts to speak with both the Mother and Father to Child S. Whilst the Mother did respond to the request, she declined the opportunity to meet. The Father did not respond to the request.

4. Summary of relevant case history prior to the timeframe under review

4.1. In 2012, two years prior to the Mother giving birth to Child S, she had engaged with the local Community Alcohol & Drugs Advisory Service for an assessment, having been referred by her GP. This assessment revealed that the Mother had experienced a long history of using, and misusing alcohol from a young age, with an estimated start period around 14 years of age. The assessment also highlighted other significant and highly relevant history about the Mother's background which, due to sensitivities, do not require disclosure for the purposes of this report. The outcome of the assessment by the Service was a judgement about Mother being moderately to severely dependent on alcohol with a suggested treatment route offered. Mother however declined this treatment offer wishing to prioritise her work commitment above her recovery; she was discharged from the Service.

4.2. In addition to the above history, seven months before Mother attended the first pregnancy booking appointment, she attended A&E with a paracetamol overdose. As a result of this, and the alcohol dependency, there were concerns

- Pre-school 2
- Dorset Children's Services

about Mother's mental health. Shortly after this A&E attendance there was also Police involvement due to a domestic incident between Mother and Father.

5. Summary of relevant case history during the timeframe under review

5.1. This section provides a summary of agency contact and involvement with Child S and family during the timeframe under review.

5.2. Mother attended her initial booking appointment in 2013 with the Midwifery Service for the pregnancy, and further ante-natal checks as a matter of expected routine. At the initial booking appointment the Mother disclosed that she drank high amounts of alcohol before the pregnancy but was not drinking now; however this was not explored any further at that time. During routine follow-on checks Mother advised that she had significantly lowered her consumption during the pregnancy.

5.3. Six months prior to Child S's birth in 2014, Dorset Police stopped Mother whilst driving; finding Mother four times over the legal drink-drive limit. As a result of this she was prosecuted and banned from driving for 30 months, which was subsequently reduced as a result of her completing a rehabilitation course. At the time of Mother being stopped by Police, she did disclose she was 13 weeks pregnant.

5.4. Following Child S's birth, which was without complication, the Midwifery Service transferred care to the Health Visiting Service. The Health Visitor conducted a routine primary home visit where no concerns were recorded about either the Mother, Father or Child S.

5.5. Shortly after this home visit, records indicate an anonymous referral was made to the local authority Children's Services about possible alcohol and cocaine use in the family home. Records further indicate that the Social Worker made contact with both the Midwifery and Health Visiting Services enquiring about any concerns. No substantive concerns were expressed by either Midwifery or Health Visiting. Only two incidents of note were reported; firstly, the Midwife commenting that she had smelt alcohol on Mother once during pregnancy and when questioned the Mother described being nervous and having one drink as a way of managing her anxiety, and secondly; the Health Visitor had heard, what were suspected to be bottles of alcohol, clanking together on one occasion when the Maternal Grandmother had arrived during a home appointment. The referral to Children's Services was treated as a desk based assessment and the matter was closed.

5.6. Following this, the Health Visiting Service had seven routine contacts with the Mother and Child S at clinics and a group for new mothers and babies. No concerns were raised or recorded and the service provided to the Mother and Child S was based on the Universal[7] level of engagement with mothers and children.

5.7. During the timeframe under review Children's Services received a total of six contacts/referrals. During the same period, two separate Pre-School Provisions had contact and involvement with Child S and the Mother. No substantiated concerns were observed or assessed despite information indicating a worrying, and emerging pattern, of alcohol misuse.

6. Significant episodes

6.1. In reviewing the multi-agency contact and involvement with Child S and family, and now with the benefit of hindsight, it has become apparent that there are two significant episodes that warrant closer examination in order to

[7] The Healthy Child Programme: Pregnancy and the first 5 years of life, Department for Health, focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. Different tiers of service are available dependent on need. The universal level of service is the lowest level of intervention and support offered.

further understand what happened, and why events occurred as they did. These two episodes are relevant from a multi-agency safeguarding system and practice perspective because a number of agencies and professionals were involved. As such, they provide us with the greatest insight into the quality and effectiveness of the response to Child S and family.

- Significant episode 1 – April 2016 to May 2016
- Significant episode 2 – March 2017 to July 2017

6.2. Significant episode 1 – April 2016 to May 2016

6.3. In April 2016 Hampshire Police were called to a supermarket late afternoon on a Friday where Mother was seen to be heavily intoxicated, and had dropped a child whilst being carried. Mother had been driven to the supermarket by her own parents. Child S was just under two years of age at the time. On the same day as this incident the matter was referred to Children's Services where it was noted *'an urgent assessment is required to decide on the level of risk and if the threshold of significant harm is met'*. Contact by the Social Worker was made with the Mother the same day where initial information was gathered. The Mother is reported to have described herself as *'…only having a couple of drinks by herself that day but normally is only a social drinker …'.*

6.4. Four days later there was further telephone follow up on this incident between Children's Services and the Health Visitor, as well as between Children's Services and the Mother. Some information was shared between professionals, specifically; there being questions about Mother's drinking during pregnancy due to a report from the Midwifery Service about Mother smelling of alcohol on one occasion as a way of coping with anxiety. However, no current concerns were shared by the Health Visiting Service.

6.5. Children's Services also made contact with Pre-School 1 where Child S attended, 18 working days after the incident. No concerns were expressed about Child S's welfare.

6.6. Records indicate that 19 working days after the incident in the supermarket the case was closed by Children's Services as there had been no corroborating evidence to support any ongoing risk to Child S. From the assessment exercise there were no concerns expressed by either the Health Visiting Service or Pre-School 2.

6.7. Period in-between significant episodes

6.8. In June 2016 Dorset Police received an anonymous call regarding the Mother driving a vehicle whilst suspected being intoxicated. The matter was not investigated until August 2016.

6.9. In October 2016 Dorset Police received information linking the Mother with other third parties who were misusing alcohol and drugs.

6.10. In December 2016 Dorset Police were called twice; once in relation to a report of drink-driving and secondly, to a domestic incident between the Mother and her new partner. On attending the address for the domestic incident, no one was home however two hours later Mother and partner returned. Police completed a SCARF[8] however Child S was not present due to staying at the Father's house.

6.11. Significant episode 2 – March 2017 to July 2017

6.12. In early March 2017 Pre-School 2 contacted a local area office of Children's Services seeking advice due to the Mother arriving with Child S and appearing to slur her words and displaying exaggerated behaviour. Advice was given should the Mother be in a similar state when she arrived to collect Child S. However, the Pre-School 2 were not content

[8] Single Combined Assessment of Risk Form used by the Police to share information.

with the advice given and formulated their own contingency plans. When Mother did arrive, there were no signs of any concerning behaviour and no further action was necessary.

6.13. Later in March 2017 Dorset Police were informed of the Father being involved in a road traffic accident where he failed to stop at the scene. The following day he made contact with the Police and admitted responsibility. He was found guilty and fined.

6.14. A few days later, Mother was also reported by a member of public as failing to stop at the scene of an accident, having hit a cyclist whilst driving. Review of this incident results in the matter not being taken any further due to lack of evidence.

6.15. Towards the end of March 2017 Children's Services received an anonymous call to their Out of Hours Service stating that the Mother was driving whilst under the influence of alcohol; although the referrer did not have any immediate concerns for Child S. Records indicate that Children's Services recognised that this information evidenced a trail of similar historical concerns. Records state '*threshold met and CIN assessment is needed*'. A Social Worker spoke with both the Health Visitor and Pre-School 2; however, no concerns were expressed by either about Child S's current welfare or development.

6.16. Over the following days the Social Worker made numerous unannounced attempts to visit the family home. Eight days after the initial referral a Social Worker was able to gain access to the family home and met the Mother having pre-arranged an appointment due to the earlier unsuccessful attempts. The family home was found to be well maintained and Child S was observed to be playing, healthy and chatty. No evidence of alcohol was seen in the house, despite very good efforts by the Social Worker looking for it. The decision was taken to close the case given no substantiating evidence had been found to support any ongoing concern or risk to Child S.

6.17. Alongside the above incidents and contact, an additional public protection forum became involved (to be known as Forum A). Due to sensitivities, it is not possible to report on this episode in detail however there was a request by this forum to Children's Services to reassess the decision to close the case in respect of the concerns for Child S. There is no information to evidence follow up, or the outcome, of this forum's contribution to the situation.

6.18. Almost in parallel to this, information from another Social Worker who, in the course of duties had seen Mother seemingly intoxicated whilst caring for Child S. This intelligence was passed to Children's Services. Again, Children's Services were able to recognise the pattern of referrals and trail of similar concerns. Records state a *'… full assessment is needed with a view to starting a s47 investigation …'*. Further unannounced visits were attempted all of which were unsuccessful, although the Mother did make phone contact with the Social Worker.

6.19. At the end of June, a successful announced home visit was completed, where it appears the history of concerns was discussed. Mother denied drinking alcohol whilst caring for Child S, commented that she had her drinking under control and was only drinking socially. Child S was observed to be happy, talkative and having a good bond with the Mother – responding appropriately when asked questions. No signs of alcohol were seen in the home and there were no concerns about the manner in which Mother presented.

6.20. The Social Worker made contact with the Health Visiting Service and Pre-School 2; again, no concerns were expressed by either about Child S's care or welfare, or about the Mother's parenting capacity. At the end of July, Children's Services closed the case. Child S died the following month.

7. Analysis of professional practice & the multi-agency safeguarding system

7.1. This section provides a thematic commentary and analysis of professional practice from the multi-agency safeguarding system. These themes have been captured following documentary review of all agency submissions as well as discussions with agency authors, managers and practitioners. Where possible, an explanation of why events,

or actions occurred as they did, has been provided. Also, practice notes for learning have been emphasised. The following themes are explored;

- Seeking, sharing and using information to support assessment & intervention
- Thresholds & the professional response to discrepant information
- Knowledge and understanding by the professional network of functioning alcoholism
- Involving, and assessing, the child's father

7.2. Seeking, sharing and using information to support assessment & intervention

7.3. This Review has highlighted where information about the Mother, and Father, might have been used to aid the assessments undertaken by those professionals involved. It has revealed opportunities where information remained unseen within single agency records, but where it could have been knowable by other agencies if searched for. From a thematic perspective, the findings and learning arising from the seeking, sharing and use of information, carry the greatest weight in understanding what happened, and why, in this case.

7.4. The local Community Alcohol & Drugs Advisory Service assessed Mother in 2012 as being moderately to severely dependent on alcohol. In the context of child protection work, this is significant and valuable information based on extensive research about the known impact of substance misuse on children's safety and development[9]. It is also a widely known risk factor which is seen frequently in other case reviews[10]. The assessment also referred to other factors, again of interest from a child protection perspective, such as domestic abuse, illicit drug use, relationship difficulties and motivation to change. However the Mother was not pregnant at the time of being assessed by this Service – so there were no reasons for this Service to actively share their assessment – other than with the referring GP Practice. The information therefore remained only known about by the Service itself and the GP Practice.

7.5. At the initial booking appointment, and subsequent follow up appointments during pregnancy in 2013/2014, the Midwifery Service were informed by the Mother that she had used alcohol excessively, however there was no exploration about the frequency or amounts used. Records reveal that there was also no follow up about this issue, nor any social history taken despite there being further opportunities to enquire about this during the pregnancy. Given the self-reporting by the Mother about this potentially worrying habit (or dependency), the failure to be sufficiently curious and seek information shows a series of missed opportunities. With the benefit of outcome bias[11] it is possible to now see a good reason for hoping that some curiosity had been exercised at this moment in time by the Midwifery Service, as it may have revealed significant and valuable information relating to the Community Alcohol & Drug Advisory Service's assessment. Due to the passage of time and workers who were involved at the time no longer working for the service, it has not been possible to ascertain the reasons why this did not happen. However professionals who had more recent involvement reflected on this practice being four years ago, and that practice standards and expectations had considerably improved – providing reassurance that there was less likelihood of these omissions happening again. Examples of this include; the provision of regular group safeguarding supervision for Community Midwives to increase confidence, professional curiosity and having difficult conversations with parents. There has been a continued increase in attendance at these groups since 2014 with evidence highlighting attendance

[9] Children's Needs – Parenting Capacity: Child abuse – parental mental illness, learning disability, substance misuse and domestic violence, 2nd Edition, Cleaver, H., Unell, I., & Aldgate, J., 2011, The Stationary Office.

[10] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., Harrison, E., Retzer, A., Sorensen, P., HM Government 2016.

[11] Outcome bias – a way of thinking that over-emphasises the outcome (in this case the fatality from the road traffic crash) rather than being based on an analysis of the factors that led to the outcome.

from 68% at four quarterly sessions yearly in 2015/16 to 93% in 2016/17. Attendance at specialist training has also increased in this timeframe from 39% in 2015 to 93% in 2017.

7.6. This Review has also revealed that, whilst there are pockets of good information exchange between many Midwives and GPs at the point of a woman booking in her pregnancy, practice across Dorset is inconsistent. Some GP Practices allow Midwives access to certain information on computers however this will only happen if they provide clinics at the GP Practice. Some GP Practices also hold regular multi-professional safeguarding meetings to share information and discuss vulnerable families; however this is also inconsistent across the County. Having access to only certain information will limit the Midwife's ability to make an informed judgement about actual, or potential risk. Additionally, Midwives request a summary from the GP Practice, however it has been reported that the quality of the summary varies at times.

Practice note: *When engaged with pregnant mothers and new mothers and fathers, how do Midwives and Health Visitors weigh and assess information about alcohol consumption against presenting behaviour and appearance? Is less weight attached to such disclosures if attendance is good, appearance is clean and tidy and there are no signs of neglectful conditions?*

7.7. Research[12] helps us understand the importance of learning about social history especially when there are multiple risk factors*' … although not all children living with a parent with alcohol problems will suffer significant harm, a retrospective study of adults who were the children of problem drinkers found that, as children, they experienced significantly more negative experiences, were less happy and had a less cohesive childhood than … the comparison group … it is the link with family disharmony and violence that increases the risk of harm to children of problem-drinking parents …' (p.37).*

Practice note: *Social history should always be gathered, as far as is possible, during the early stages of pregnancy by those professionals who have most contact with the expectant Mother and partner (where applicable).*

7.8. Despite the Mother admitting to drinking alcohol to excess, and notwithstanding the failure to exercise any curiosity, no information was passed to either the GP or the Health Visiting Service by the Midwifery Service as a potential mechanism to follow up any outstanding queries. Again, this was a lost opportunity. At the time the GP records on SystmOne[13] were not accessible to the Health Visiting Service so they would not have been able to access the assessment completed by the Alcohol & Drugs Advisory Service. Further to this, the Review has revealed learning for GPs in that the coding used on the Mother's electronic records, whilst coded correctly, did not reflect the severity of her alcohol dependency and mental health issues nor were they as visible to other's who may wish to search for this information.

Practice note: *Electronic GP records, such as SystmOne, allows for codes to be used to flag certain information, which in turn highlights to the professional viewing the record, the need to be alert to specific issues. The opportunity to code and flag in all health records – as a quick reference mechanism - should always be taken when risk factors relating to children are found. This may involve a review and re-evaluation of historical records, especially following a change in circumstances for the patient.*

7.9. In early 2014 the Mother was prosecuted for drink-driving offences. Information from Dorset Police, as a result of this episode was not shared with other relevant agencies via either SCARF or PPN[14]. As the Mother declared she was

[12] Children's Needs – Parenting Capacity: Child abuse – parental mental illness, learning disability, substance misuse and domestic violence, 2nd Edition, Cleaver, H., Unell, I., & Aldgate, J., 2011, The Stationary Office.

[13] SystmOne is a recording database used extensively across health services.

[14] PPN – Police Protection Notice, similar to a SCARF.

13 weeks pregnant at the time of being stopped, recording and sharing this would be within standard and expected procedure. This was a further missed opportunity. A pregnancy that has reached 13 weeks is more likely to proceed to full term than not – therefore even in early pregnancy safeguarding considerations are relevant to consider. There is no explanation as to why standard procedure was not followed in 2014, however current practice does expect such notifications to take place; and additionally, where there is a child involved or the adult is judged as vulnerable, they are sent to the GP as a matter of routine practice. This then allows the opportunity for SystmOne flags to be created and made visible to other health professionals such as Midwifery and Health Visiting. Dorset Safeguarding Children Board may wish to seek reassurance about the quality, effectiveness and consistency of this mechanism to share information between professionals. This is especially so given that this Review has revealed inconsistency in terms of whether all Health Visiting teams can access GP data-bases in the Dorset area.

7.10. Further to this, the Police became involved with the Mother again in 2016 when Hampshire Police were called to a supermarket due to her being drunk and appearing to be in charge of a child late afternoon. During the course of dealing with this incident, having returned to the Maternal Grandparents home, the Mother disclosed to the Police historical domestic abuse between herself and Child S's Father. This was followed up further the next day by another Officer over the phone, but this time from Dorset Police. Whilst it is accepted practice to follow up such matters, it is not expected that this should happen over the phone. Despite the original presenting episode relating to intoxication and in charge of a child, the entire matter appears to have been logged as a domestic incident; essentially missing the child safeguarding aspects completely and being adult centred. This response by the Police reflects similar findings from other case reviews[15] with the focus often being on the adults and the child becoming lost in the interaction. Information relating to previous contacts by the Police were not pieced together and an assessment of risk was incomplete. A significant contributing factor for this not happening was the Hampshire Police logs did not link to the Dorset Police log system – meaning information did not match up. Crucially, the information generated from this episode was not added to the Mother's records on the Police system. Discovering this has prompted Dorset Police to complete a deep dive audit of similar possible scenarios and has revealed further cases where this may have been an issue; these system errors are often referred to as latent errors which are dormant features but which are only triggered by specific circumstances[16]. Since the introduction of the Dorset MASH[17] in January 2017, practice has been considerably more joined up and this system error should be less likely to occur again.

Practice note: *Having effective protocols and mechanisms in place for when information needs to be exchanged across geographical boundaries, but also when services span different local authority areas, is fundamental to safeguarding children and vulnerable adults. Given the fragmentation of some services having systems and processes in place to reduce human error is also important. Checking their effectiveness should be a regular activity.*

7.11. The Mother came to the attention of Dorset Police yet again in 2016. In June, on one occasion, matching information to the Mother was not possible because insufficient information was available; however the concern related to drink-driving. It is only now, with the benefit of hindsight, that links in the database about this information have been made. However, a second incident in June – again relating to drink-driving – did result in the matter being correctly logged and followed up. The matter was followed up via Operation Dragoon[18] - providing an opportunity to

[15] NSPCC Learning from case reviews: Summary of risk factors and learning for improved police practice.

[16] Dekker, S., The Field Guide to understanding human error, 2006, Ashgate

[17] MASH – Multi-agency safeguarding hub.

[18] Operation Dragoon – Dorset Police initiative launched in September 2016 as a road safety partnership aimed at reducing casualties on the roads of Dorset specifically aimed at those driving with little or no regard for the risk that their behaviour presented to themselves or others. Although launched in 2016 it was linked to another initiative 'No Excuses', launched in 2010.

collate intelligence reported to the Police from various reporting strands and assess them for risk and determine an appropriate response. This resulted in positive action being taken, a home visit being conducted by the Police and a Notice being served. However, and critically, previous information relating to Mother (previous conviction and the logs created by Hampshire Police) was not linked to this most recent incident; the history was not considered and the focus of the evaluation of risk was not based on any consideration of there being a child potentially at risk of being driven by the Mother whilst intoxicated – the matter was dealt with in isolation to knowing the history. An additional factor in the Police responding to the above incident was the delay in them meeting, and assessing, the Mother. Almost eight weeks passed before an Officer was able to make a home visit. The reason for this delay was due to the volume of incidents referred to the No Excuses/Operation Dragoon initiatives. To set this in context, in the first 12 months the Police had received 15,000 pieces of information – all of which needed some level of assessment. This volume severely impacted on the capacity of the Police to respond in a timely manner. Nevertheless, despite this pressure, the attending Officer was able to report – with the benefit of hindsight – no observable concerns about the home conditions or the Mother's manner or behaviour. Being alert to the wider picture of what the presenting concerns might mean for a family, and children, is however a learning point to come out of this review for the Police, and those Officers involved. Information from this significant episode at the time was not shared with any other agency as, for them, there was no obvious concern to share.

7.12. In December 2016, an initial Police contact related to a report of the Mother drink-driving did not result in any substantiating evidence being found to corroborate the alleged offence; again, the information from this episode was not joined up with the previous incidents. A second Police contact in December, relating to a domestic incident did appropriately result in information being shared, via a SCARF, with Children's Services. Although Child S was not present at this incident, as she was with the Father, records indicate that there was a greater consideration of alcohol fuelling the incident but also that there was a possibility that a child could have been involved. This is clearly a recognition of the potential safeguarding aspects and is expected practice.

Practice note: *For all professionals, when predominantly working with adults, it is important to assess not only the presenting concern but also think wider and remain alert to how the adults behaviour might impact on children and family life.*

7.13. The Health Visiting Service was not aware of Mother's history of drug and alcohol dependency. As there was no worrying information passed over to them from the Midwifery Service, they had no reason to be concerned or to consider any further assessment. As the family were being seen under the Universal offer, opportunities were infrequent to assess the quality of parenting offered to Child S. When a natural opportunity did present itself, for example via the two year developmental review, this was completed by a Nursery Nurse instead of a Health Visitor. As the Mother and Child S were on the Universal level of service provision this was routine practice, however it did follow the incident at the supermarket when Child S was dropped by the Mother due to her being intoxicated; this incident in itself, justified a more thorough assessment by a Health Visitor rather than expecting a Nursery Nurse to be taking on this task. This was a missed opportunity to be curious with the Mother about her circumstances.

Practice note: *When an incident occurs that involves Children's Services and there are concerns about a child's welfare, and where the Health Visiting Service has current involvement with the family the information should always be reviewed by a qualified Health Visitor.*

7.14. Children's Services were presented with a number of opportunities to seek information and undertake an assessment. These are explored more fully in the following sections.

7.15. The contribution of the additional public protection forum (Forum A) highlights joined-up multi-agency working, recognising the potential risk to Child S. The request by Forum A to Children's Services to re-assess their decision making to close the case in respect of the referrals about the Mother shows insight however records indicate that

there was no follow-up, or further challenge, to this request by Forum A. Having a mechanism to monitor actions is fundamental to it demonstrating impact.

7.16. In summary, information was not sought or shared when it could have been; this appears to be due to human error[19] and as a consequence it was not available to be used to inform the professional response by the wider professional network when needed. There were also information system processing errors which meant that information was not appropriately routed to the best source. Professional judgements were made in isolation of thinking more widely about potential safeguarding issues.

Practice note: *Effective information sharing between professionals and local agencies is essential for effective identification, assessment and service provision; early sharing of information is the key to providing effective early help where there can be emerging problems[20].*

7.17. Thresholds & the professional response to discrepant information

7.18. This review has highlighted that two agencies/organisations, at different times, received information which indicated a potential concern for Child S's welfare; this included,

- Children's Services between 2014 and 2017 when formal Child in Need[21] assessments were conducted.
- Pre-School 2 in 2017 when Mother presented with slurred speech and exaggerated behaviour

7.19. Children's Services, had a total of nine contacts and referrals between 2014 and 2017; and on at least four occasions, formally conducted a Child in Need assessment (July 2014, April 2016, March 2017, and May 2017). On each of these four occasions, when information was sought from other professionals, evidence failed to support the referring concerns for Child S. Whilst Children's Services did recognise the developing pattern, information from other agencies continued to conflict, and could not be substantiated.

7.20. As the Health Visiting Service were not aware of the Mother's history of drug and alcohol dependency they had no cause to question the parenting or care offered to Child S, other than when contacted by Children's Services. Information provided to the Health Visitors about the Mother misusing alcohol therefore had to be reconciled with what Health Visitors knew at the time about the Mother and Child S. No concerns were observed during routine appointments; which made the notion of the Mother misusing alcohol discrepant with the Health Visitor assessment of the situation.

Practice note: *When conducting assessments and gathering information there is a need to think wider than Health Visitors for younger children; avoid making assumptions that Health Visitors have access, or information, to all health-related records.*

7.21. Appropriately, Pre-School 2 sought advice having witnessed potentially concerning behaviour by the Mother. Pre-School 2 did not formally escalate their dissatisfaction with the advice given by Children's Services. Use of the escalation procedure is always an option where there is either professional disagreement or a lack/loss of confidence in the interaction between professionals. However, when the Mother returned to collect Child S later in the day there

[19] A view point that human error is an effect, or symptom of, other issues which are systemically connected to features of the tools, tasks and environment in which people operate – as described in Dekker, S., The Field Guide to understanding human error, 2006, Ashgate & Munro, E., Common errors of reasoning in child protection work, 1999, LSE Research Articles Online.

[20] Working Together to Safeguard Children, HM Government, 2015 (Amended 2017).

[21] Child in Need – section 17 of the Children Act 1989 which provides for a general duty to safeguard and promote the welfare of children within a local authority area, who are in need, and to promote the upbringing of such children by their families.

were no signs of further worrying behaviour – this therefore conflicted with what had been observed earlier in the day making any contingency planning impossible to follow through. This appears to have been the only episode where such behaviour was noted, again having the effect of placing one episode in isolation against an otherwise relatively positive picture of parenting ability. Child S's attendance at the Pre-School 2 was regular and good, and there was no other concern noted about Child S's appearance, behaviour or welfare.

7.22. In situations where information is referred by an agency and which might indicate a risk of harm to a child, it is often necessary to triangulate known information as a way to verify and test the validity of the concern; this is the cornerstone of contemporary child protection practice in a multi-agency environment[22].

7.23. With the benefit of hindsight, this review is now able to piece together several strands of information, which had they been known and triangulated at the time (certainly during the six months prior to the fatal car crash) would have likely resulted in a different approach to any formal assessments undertaken. Some attempts were made by Children's Services to triangulate the referring concerns and test the hypothesis that the Mother was misusing alcohol to the extent that it was likely, or actually, causing harm to Child S. Triangulating information is standard practice and for all intent and purposes, the response by Children's Services at the time was within these expectations; there is however learning that can be taken from this series of episodes.

7.24. Whilst the obvious professionals to contact were the Health Visitor, Pre-School 1 and/or Pre-School 2, there was no attempt to contact the GP. Had this been done it could have provided a different, and valuable, professional perspective. The role and contribution of GPs in identifying actual, or potential, child maltreatment is an essential feature of a healthy and effective safeguarding system for three reasons; firstly, due to GPs being a universal and family centred service, secondly; them having (potentially) a longitudinal view of care and health needs, and thirdly; them holding the primary care record as an information repository[23]. This again, highlights the importance of having good flagging alerts on SystmOne and other electronic GP records.

Practice note: *When concerns about a child's welfare become apparent, approaching GPs to seek information about parental capacity, risks and vulnerabilities, should always be considered. An active decision not to seek such information should be documented with a clear rationale about the reasons.*

7.25. Given the route to assessing the information was via a Child in Need process, consent to seek information should be sought from the individuals involved. Consent was sought, and provided, by the Mother however the Social Worker made contact with only a selection of other professionals; this did not include the GP.

7.26. Consent to share information about the individual to which the information relates is not needed if there are concerns about safeguarding and promoting the welfare of children at risk of abuse or neglect[24]. In this case, it seems that the level of professional concern had not reached a threshold in order to dispense with consent[25]; the weight of information did not appear to support greater intervention. Practitioners from all agencies involved with Child S have

[22] Children Act 2004 and Children Act 1989.

[23] NSPCC, Royal College of General Practitioners, UCL Institute of Child Health & University of Surrey, The GP's role in responding to child maltreatment: time for a rethink?, July 2014.

[24] HM Government, Information sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers, March 2015.

[25] Consent to seek and share information between statutory agencies is not required from the individuals involved if there are concerns about likely, or actual, significant harm.

reflected on the value attached to the information known at the time; which in turn has provoked mixed views about whether a more interventionist approach was justified.

7.27. Records do indicate thresholds for intervention were considered but on balance a judgement about assessing the situation via a Child in Need route was taken. This Review has highlighted how information was either not obtained, or not linked together and it is only with the benefit of hindsight that it is possible to form a view that it would have been better to have followed a more robust route of conducting a child protection enquiry, via section 47 of the Children Act 1989[26]. This would have generated a broader information gathering and assessment process, demonstrating a more complex and multi-dimensional decision-making process.

7.28. A significant challenge for any operational gatekeeping service is to ensure people achieve effective decisions, in terms of both speed of the decision making and of the quality of the decisions made. Based on the presenting evidence and attempts to respond to Mother a rational linear course of intervention[27] was taken by Children's Services – by looking at the presenting information and only taking into account the information that was available from a set number of other agencies. Had contact with the GP been made it would have revealed new information.

7.29. Whilst highlighting a relatively linear course of action these episodes also reveal elements of confirmation bias[28]; information gathered from the same sources as before reinforced the belief held that there was little foundation in a hypothesis that the Mother was significantly misusing alcohol or drugs and was of no threat or risk to Child S.

7.30. Judgements and decisions were made based on presenting evidence. In exploring these judgement and decisions this Review has found that they were reasonable given the circumstances, however this Review also finds the style of thinking by Children's Services to be formulaic; in that the approach to triangulating information to assess the level of risk to Child S appeared not to deviate despite an increase in referral rate and an escalation in the level of potential risk. Such an approach might be viewed as a 'thinking trap'; being trapped in a particular way of thinking, feeling or acting when faced with a particular situation. Such a trap is not unexpected in a busy, demanding and complex environment like a multi-agency gatekeeping service where proportionate assessments might be needed, but does reflect a degree of over-optimism. Seeking information from new sources to either confirm or disprove any hypothesis formed is not unreasonable given the escalating number of episodes where the Mother was reported to be using alcohol.

7.31. Additionally, in April 2016 (significant episode 1) Children's Services considered *'an urgent assessment is required to decide on the level of risk and if the threshold of significant harm is met'*. Although contact by Children's Services was made the same day, this was via the telephone. Four days then elapsed before contact with other agencies was made and in respect of contacting Pre-School 1 this took place 18 days after the incident. The case was then closed.

[26] Section 47 of the Children Act 1989 provides the local authority with a duty to make enquiries as considered necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare, where there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm.

[27] Rational linear model of thinking - when faced with a decision people first identify some problem which will need a decision to be taken; second, they gather information which will help them solve the problem, third they generate some potential solutions to the problem, and fourth they make a rational choice and select the best solution, which is then implemented; From - Brooks, I., Organisational behaviour: individuals, groups and organisations, Pearson Education Limited, 2009.

[28] Confirmation bias – informed by beliefs and when people would like a certain idea/concept to be true, they end up believing it to be true. This error leads the individual to stop gathering information when the evidence gathered so far confirms the views (prejudices) one would like to be true.

Based on statutory guidance[29] this assessment exercise was completed well within the permitted 45 day period. There are however two points to draw out of this episode.

7.32. Firstly, whilst it is good practice to inform the subject of the referral about the matter being referred to Children's Services, the use of a telephone call to the Mother to initiate this – in this instance - is problematic. Given the concern was almost a repeat of similar concerns, a more cautious and open minded approach could have been considered. Assumptions about the Maternal Grandmother and Maternal Grandfather being a protective feature in Child S's life also appear to have been made by Children's Services, when contact was made with them as part of the assessment. Secondly, the attribution given to *'… an urgent assessment … to decide on the level of risk …'* is subjective and reflects the uncertainty of the situation. To conclude an assessment of risk after 18 days does not reflect a level of urgency, especially with the known history which, albeit limited, should have aroused a level of professional curiosity and healthy scepticism.

7.33. In summary, the professional network was faced with pockets of information which was never determined to be at a level to warrant a more interventionist approach. These episodes reflect the uncertainty of risk management in child protection and the fine judgements which often need to be made when presented with information that is discrepant, cannot be substantiated or is unreliable. Whilst the response of those agencies involved can be judged as reasonable, there is an opportunity to learn from this in order to strengthen future practice.

Research[30] highlights a number of valid learning points from the above findings;

Practice note: *'… Judgements and decisions must be taken, and working hypotheses reached, but nonetheless professionals need to constantly guard against the tendency to cling to their original beliefs and overlook, devalue or re-frame any new information that challenges beliefs …'.*

Practice note: *Playing 'devil's advocate' with your own views, values and decisions can often support exploring new angles. Asking yourself '… would I react differently if these reports had come from a different source? ', and '… what were my assumptions about this family and what, if any, is the hard evidence supporting them …?'*

Practice note: *The actions and decisions of individual practitioners and managers must be examined and understood in the wider context. When this context is placed alongside an appreciation of our relationship with alcohol as a society it is reasonable to seek a fresh perspective and re-evaluate our initial decisions.*

7.34. Knowledge and understanding by the professional network of functioning alcoholism

7.35. Whilst the focus of the review has examined the quality and effectiveness of the safeguarding partnership in Dorset for this case, it has highlighted the inherent challenges for professionals when working with parents who use, and misuse, alcohol. In this case, clearly the Mother had a long standing and deeply ingrained dependency on alcohol. For the professional network, assessing and making decisions about parental capacity *can* become a subjective, and value laden, exercise which *may* be informed by our own bias and usage of alcohol. Where explicit alcohol use is apparent, it may be easier to assess and make meaningful and timely decisions. Where usage is more covert – as was the situation in this case - it is much harder.

7.36. The British Medical Association recently raised concerns about our relationship, tolerance and acceptance, as a society, with alcohol stating *'…our relationship with alcohol has been normalised in modern society. In 2016, 7% of*

[29] Working together to safeguard children, HM Government, 2015.

[30] Burton, S., The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information? C4EO, Safeguarding briefing 3, November 2009.

adults regularly drank over the chief medical officers low risk guidelines (14 units for men and women), and 2.5 million reported drinking over 14 units on their heaviest drinking day …'[31]. Further to this, Alcohol Concern noted that *'…in England, there are estimated to be 595,131 dependent drinkers, with only 108,696 currently accessing treatment …'*[32]. A recent study by an All-Party Parliamentary Group on Children of Alcoholics, and which was widely publicised through national media found that one in three child deaths or serious injuries from neglect or abuse are linked to alcohol misuse; *'… millions of parents drink too much and their misuse of alcohol causes horrific problems for their children …'*[33]. Provisional data for 2016[34] estimates that there were 230 fatalities in the UK due to drink-drive accidents. Data produced about child deaths[35] in 2017 shows that of all child deaths in the 2016 – 2017 period 3% were due to road traffic collisions, and of that 3%, 69% had modifiable factors – preventable or potentially preventable factors.

7.37. In this case, the Mother was assessed as being moderately to severely dependent on alcohol some five years prior to the road traffic accident, with no evidence of any treatment in the intervening period. No single professional who had recent contact with the Mother realised this. By allowing practitioners to see, albeit with the benefit of hindsight, the greater picture of what was happening for the Mother, and Child S, it has encouraged individuals to reflect on their perception and tolerance of parental alcohol use, challenging assumptions and values. This has been especially so given the Mother functioned as an alcoholic which possibly challenges any stereotypical image of how an alcoholic might look or behave. Practitioners involved expressed a consistent desire for further, more specialised training, around these issues to help them in their daily work with children and families. Practitioners also reflected on the challenges associated with having difficult conversations with parents. Factors such as individual confidence, appropriate use of professional authority, risk management, and experiences of working openly and transparently whilst keeping a clear focus on the welfare of the child, all come into play.

7.38. As a result of this Review, the Dorset Safeguarding Children Board training offer on safeguarding children has been examined and shows that there is little emphasis on parental alcohol use and the risks it presents to keeping children safe.

Practice note: *Training for professionals about their duties and responsibilities for recognising and responding to concerns about children's welfare must include explicit mention of how alcohol use, misuse and dependency can impact on a child's day to day safety & welfare. It must also include ways to encourage an open and transparent dialogue between professionals and parents/carers. This training should also examine related aspects such as neglectful parenting, ability to effectively supervise children, drink-driving, and links to domestic abuse and mental health.*

7.39. Dorset Safeguarding Children Board have conducted four Serious Case Audits over recent years (Case 17 – Family C13 and other Multi Agency Case Audits in March 2014, and Case 13 and Case 14 - Family C9 and Family C10). A common factor in those cases was the use of alcohol. Whilst this Review does not need to repeat the learning from those audits, there is a clear need for the Board to consider the effectiveness of the multi-agency response when alcohol (and substances) are a dominant feature in a case. During the course of conducting this review it has become

[31] British Medical Association, accessed 06/02/18, https://www.bma.org.uk/collective-voice/policy-and-research/public-and-population-health/alcohol

[32] Alcohol Concern, accessed 06/02/18, https://www.alcoholconcern.org.uk/alcohol-statistics

[33] As reported in The Guardian, accessed 11/02/18, https://www.theguardian.com/society/2018/feb/11/parental-alcohol-abuse-linked-to-child-deaths-and-injuries

[34] HM Government, accessed 11/02/18, https://www.gov.uk/government/statistics/reported-road-casualties-in-great-britain-estimates-involving-illegal-alcohol-levels-2016

[35] Child death reviews: year ending 31 March 2017, HM Government,

apparent that the local Drug & Alcohol Advisory Service is not represented on the LSCB. Given the weight of local evidence alongside national research about the prevalence of alcohol use in critical incidents involving children, representation at Board level is essential for an effective whole system response. The following quote from one of these local audits/reviews speaks to a number of issues which have been highlighted as a result of this Review and can be seen as a further learning point;

Practice note**:** *'… working with parents who abuse alcohol is particularly challenging. Many workers having different views about what is sensible and acceptable alcohol use. The message from previous Serious Case Audits is that supervisors should challenge pre-conceived notions. Additional learning emphasised the need for family members who are deemed to be protective to also truly understand issues related with alcohol addiction and to be challenged to understand their own reactions within this* context …' (Case 17 – Family C13 and other Multi Agency Case Audits).

7.40. Review of the Board action tracker following the above audits and case reviews reveals a number of actions which are highly relevant to the findings of this Review. In particular, actions relating to parental alcohol use and the quality of assessments undertaken, confirmation bias within the professional network, increased risk of harm to children when there are multiple parental factors, and alcohol not being taken seriously as a child protection issue. Whilst the tracking document does reflect progress against actions identified, the Board will wish to seek further reassurance about current practice and impact of actions taken in 2014 around these highly relevant features.

7.41. In 2013/2014 the Board was responsible for initiating a local publicity campaign – Drinking Heads - advising adults not to drink alcohol whilst caring for children. The Board may wish to consider further publicity campaigns.

7.42. Review of the Dorset Safeguarding Children Board procedures, offers good guidance on children of parents who misuse substances, however there is a greater emphasis on those parents who are dysfunctional and chaotic rather than those who function. Providing specific guidance to professionals around this issue, with an explicit mention of needing to ensure working hypotheses are tested through making contact with the GP and Police will be a valuable addition to these procedures.

7.43. Involving, and assessing, the child's father

7.44. Information submitted, as well as discussion with those practitioners closely involved with Child S, clearly reveals a noticeable absence of information, or recognition of, Child S's Father.

7.45. Review of the Child in Need assessments conducted by Children's Services reveal very limited information about Child S's Father. One record states *'… no concerns about dad – only met him once but he was pleasant …'*. Child S's Father had a sufficiently regular level of contact, involvement and responsibility for Child S to justify including him in an assessment exercise – assessing both protective and risk related areas. There are no meaningful records of contact with the Father by either the Midwifery or Health Visiting Services. The failure to recognise, and assess, fathers' is an issue that is frequently seen as a finding in other case reviews[36], and indeed was noted in a recent Serious Case Review conducted by the Board[37].

7.46. In this case, the involvement of the Father seems to be critical given that he would have been involved in the hand-over of care of Child S to the Mother and be in an ideal position to comment on whether the Mother had been drinking or not. It is also noteworthy that the Father was responsible for making at least two referrals to the Police expressing concerns about the Mother driving whilst intoxicated.

[36] NSPCC Learning from case reviews – Hidden Men.

[37] Serious Case Review Child M, S25, Dorset LSCB, November 2017.

Research by the NSPCC captures the learning;

Practice note: *Professionals sometimes rely too much on mothers to tell them about men involved in their children's lives. If mothers are putting their own needs first, they may not be honest about the risk these men pose to their children.*

Practice note: *Professionals do not always talk enough to other people involved in a child's life, such as the mother's estranged partner(s), siblings, extended family and friends. This can result in them missing crucial information and failing to spot inconsistencies in the mother's account.*

8. Identified good practice

8.1. This Review has identified a number of areas which can be highlighted as good practice. These include;

- Pre-school 2 demonstrated clear thinking and sound contingency planning when faced with the Mother who appeared to be slurring her words when dropping Child S off in the morning. They formulated a sound contingency plan should the Mother return in the same state, and also went further in their planning than advised by Children's Services.
- The Social Worker involved in significant episode two demonstrated tenacity and curiosity when making attempts to visit the Mother and looking for evidence of alcohol use. This included looking around the house and in cupboards, in the waste bins outside.
- Operation Dragoon, instigated by Dorset Police, provides an initiative that is well placed to try to reduce road deaths
- Forum A's request to Children's Services demonstrates a willingness to challenge decisions made by agencies.

9. Conclusions

9.1. This Serious Case Review has examined the circumstances of professional contact and involvement with a three year old child who died as a result of a road traffic collision, caused by the Mother who was intoxicated with alcohol and drugs. It has revealed that, despite the Mother being assessed as moderately to severely dependent on alcohol some five years prior to the fatal car collision, no professional was actively working with her on this issue. Information about it was held in the GP Practice notes, however it was never accessed. The Mother functioned as an alcoholic, challenging many people's assumptions about how alcoholics look and behave, made doubly difficult by the fact that Child S appeared to be a happy and well-adjusted child. Dorset Police had considerable contact with the Mother however the focus of the Police involvement was predominantly on the Mother, and not the safeguarding of a child. Information from Police involvement was never requested with any other assessment work being undertaken by other professionals. Opportunities were available to Children's Services to join this information together however the presenting concerns were never judged as being at a sufficient level to warrant a more joined up and holistic approach.

- Opportunities were missed to seek, and use, information more effectively,
- Both human and system errors contributed to information not always being sought and links not being made,
- Decision making and thresholds for intervention were clouded by information which was discrepant, or was unreliable or unsubstantiated,
- The Mother disguised her alcohol dependency, concealing the impact on her lifestyle and any influence it might have had on her parenting ability,
- The Father was not included in any assessment work by agencies, and assumptions were made about him being a protective influence,
- It was assumed that the Maternal Grandparents were a protective factor in Child S's life however this was not explored appropriately.

- Some of the systems, processes and practice issues highlighted as deficits during the timeframe under review have improved i.e. the introduction of the MASH, expectations of Midwifery about gathering history.

9.2. Given the apparent escalation of worrying behaviour by the Mother in the months preceding the car collision, it might be argued that there was a degree of inevitability that she would be involved in a serious incident involving driving a car.

9.3. Whilst the Review has exposed a series of missed opportunities, it has also highlighted a number of areas for learning and improvement. Some of these areas will be familiar to Dorset Safeguarding Children Board as they have been expressed in previous case reviews and audits conducted.

10. Recommendations

10.1. As a result of this Review agencies that have contributed have been able to identify learning that can be taken forward internally. As such, it is the role and responsibility of the LSCB to monitor, scrutinise and challenge progress against single agency action plans. The following recommendations are for the Dorset Safeguarding Children Board:

1. To ensure the learning from the review is disseminated across the multi-agency safeguarding partnership to practitioners and managers.

2. To seek reassurance that the actions identified by each partner agency, as a result of this review, have been managed, implemented and embedded in a timely manner.

3. To ensure the Drug & Alcohol Advisory Services are invited to attend all relevant working groups of the Dorset Safeguarding Children Board.

4. To review the action tracker relating to (Case 17 – Family C13 and other Multi Agency Case Audits in March 2014, and Case 13 and Case 14 - Family C9 and Family C10), consider the findings of this review against those actions identified in 2014, and formulate a position statement about progress.

5. Review the training offer to ensure there is a sufficient focus on a) parental alcohol use, misuse, and functioning alcoholics b) how this can impact on parenting capacity and children's welfare and development and c) how to manage difficult conversations.

6. Review the training offer to ensure there is a focus on the need to involve, and assess, fathers and adult men who are connected to children.

7. Seek reassurance about the quality and effectiveness of the information sharing mechanisms for all child safeguarding relevant PPNs being sent to GPs and other primary care health professionals.

8. To seek assurance that Forum A has a mechanism to check the progress of single agency actions.

9. To promote the use of the Pan Dorset escalation policy when there is either professional difference or a lack/loss of confidence in the professional interaction.

10. To seek reassurance that information sharing protocols between Midwifery services and primary care are robust and that information of relevance to safeguarding is shared.