Cheshire East Safeguarding Children Partnership (CESCP)

Local Child Safeguarding Practice Review (LCSPR)

Child J

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Learning identified from considering Child J[1]

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[1] The child is to be referred to as Child J initially; this may be subject to change following consultation with the safeguarding partnership and the family.

1. Introduction

1.1 This review is considering the very sad death of a 26-day old baby who died in November 2021. On behalf of Cheshire East Safeguarding partnership, I would like to express our sincere condolences to the family and all who knew him.

1.2 The Cheshire East Safeguarding Children's Partnership agreed to undertake a Local Child Safeguarding Practice Review by considering a case to be referred to as Child J. They recognised that lessons could be learned from reviewing the practice in the case, with the aim of better safeguarding the children of Cheshire East.

1.3 Child J was 26 days old when he tragically died as a result of unsafe, co- sleeping. At the time of his death, he was being cared for by his father in the home of his mother. On the night of Child J's death, father had last fed him at 1:00am and placed him in a right-angled pillow on a settee, when father awoke at 5:20am, Child J was not breathing. The friend woke to father screaming and called an ambulance. Father and his friend had been drinking alcohol and had a takeaway. When police attended the scene there was evidence of cannabis and alcohol use. Father had not had many drinks and subsequent toxicology confirmed that there was no evidence of alcohol though evidence of some cannabis use. There was no suggestion of neglect as a result of substance / alcohol use and subsequently the police took the decision that no further action would be taken. Mother was not at home at the time of the incident.

1.4 The review considered the professional involvement with this family in order to identify learning for the wider systems and practice in cases where safe sleep messages have not been effective, and there are risk indicators in relation to high-risk domestic abuse, alcohol use and mental health.

1.5 Learning has been identified in the following areas:

- The effectiveness of safe sleep messages, particularly with fathers and where there are known parental risk factors.
- How well agencies worked together to share information, assess risk factors and safety plan for child J.
- The impact of working in difficult and exceptional circumstances, particularly when families are not fully engaged.
- The effectiveness of professional curiosity in triangulating information from different sources to gain a better understanding of individuals, family functioning and parenting capacity.
- Understanding of impact of domestic abuse, including pathways and support.
- The importance of professional challenge.
- Meaningfully considering fathers.

2. The Process

2.1 An independent lead reviewer was commissioned to work alongside local professionals to undertake the review. Information provided to the rapid review meeting was considered and individual agency chronologies including analysis were requested from all involved. These identified important single agency learning. Professionals involved at the time were involved in discussions about the case and the wider systems, a practitioner event was held virtually in May 2022 using video technology.

2.2 In addition the Cheshire East Safeguarding Children's Partnership undertook a multi – agency audit of the effectiveness of safe sleep messaging that was attended by the Independent Reviewer and findings from that audit are incorporated into this review where relevant, particularly in relation to the wider system.

2.3 Children's Social Care and the Domestic Abuse Hub reviewed pathways into the hub and undertook a dip sample audit of cases to inform the review, findings and subsequent actions were shared with the independent reviewer and will be incorporated into the review where relevant to support wider system learning.

2.4 A team manager from children's social care met with mother to inform her of the review and to offer her an opportunity to meet with the independent reviewer and to contribute to the review which she declined. Attempts to engage with father were not successful. Further attempts were made by Children's Social Care to offer parents the opportunity to see the report and meet with the independent reviewer prior to publication, however, they were unable to make contact with either parent.

3. The Learning

3.1 The Learning identified for the system and partnership is as follows:

<u>Learning Point 1:</u> Safe sleep guidance needs to be seen as the business of all professionals and should be covered as part of multi - agency planning. The guidance and advice needs to be shared more widely than the mother and particularly around "out of routine" situations.

3.2 Cheshire East Safeguarding Children's Partnership promotes safe sleep training to professionals through its ICON training and a comprehensive 7-minute briefing[2] which guides professionals about the questions they need to consider with parents and other carers and particularly when baby is "out of routine". Out of Routine : A review of Sudden Unexpected Death in Infancy (SUDI) in Families With Children At Risk[3] emphasises the importance of this work being embedded in multi – agency working and not just seen as the responsibility of health.

3.3 Child J was born by emergency caesarean due to a pathological CTG score (cardiotocography used to monitor a baby's heart rate and a mother's contractions

[2] pan-cdop-infant-safe-sleep-brief-2019.pdf (cescp.org.uk)
[3] Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (publishing.service.gov.uk)

during labour). Father wasn't at the birth as mother had asked that he be removed from the labour ward. Child J was kept in hospital for seven days as mother had sepsis during pregnancy. During this period both parents visited Child J in the Special Care Baby Unit. There is no evidence that safe sleep was discussed with father during those visits. This has now been addressed and safe sleep will be discussed during these visits and recorded.

3.4 Prior to and following his birth there is evidence that mother was spoken to by either midwifery or health visitor on at least six occasions about safe sleep, sudden unexplained death in infancy and ICON messages. There is no evidence that this advice and guidance was shared directly with father by any professional.

3.5 A visit was undertaken by duty social workers as the allocated social worker was off sick, the day after Child J's discharge from hospital, both parents were seen but there was no evidence that safe sleep was discussed which is a missed opportunity to engage father in discussions. Social workers should see a child's bedroom / sleeping arrangements as part of any visits, and this is clearly an opportunity to promote safe sleeping. The newly allocated social worker visited the family again 11 days later, on this visit mother did not allow social workers to see upstairs where says Child J usually slept, which would be good practice. There was a Moses basket in the lounge which was described as clean and appropriate. Mother clearly spoke about her understanding of safe sleeping and said she would take the advice of her health visitor.

3.6 During the review it was apparent that safe sleep messaging is still seen very much as a health domain and there was limited evidence during the multi - agency audit of safe sleep, of other professionals engaging in these discussions. It was also acknowledged that there tends to be an emphasis on sharing these messages with mothers as there can be challenges in engaging fathers either because parents are not co-habiting or fathers are not present during visits. Additionally in the safe sleep audit there was evidence of extended friends and family being named in safety plans for young babies but no evidence that safe sleep guidance had been shared with them. The Out of Routine review identified that 'safer sleep conversations and risk assessments tended not to be sufficiently joined up with wider plans to work with the family in addressing safeguarding concerns and changing circumstances' and the review found this to be true in Cheshire East. This will be addressed in recommendations for the Cheshire East Safeguarding Children's Partnership.

3.7 The review found that there can be an over - reliance on mothers passing on and sharing guidance, this was exacerbated during Covid 19 Pandemic when printed material was not readily available and much of the material was on-line. The health visitor did advise mother to share information with father, however, the appropriateness of this in situations where there is a significant history of domestic abuse in relationships needs to be considered. It is unclear how able the mother of Child J was to do this, given her own difficulties with her mental health and concerns around the history of domestic abuse in the relationship.

<u>Learning Point 2:</u> Pre – birth assessments should be completed in a timely way, clearly address risk factors and safety plan to mitigate risks, have multi – agency involvement and be shared with relevant agencies.

3.8 Child J was referred to children's social care prior to his birth and was deemed to be a Child in Need which appears to be appropriate. There is evidence of good safeguarding practice by the enhanced midwifery team, a home visit in April 21 identified a range of issues including the relationship with Child J's father where alcohol and domestic abuse was a factor. They had been discussed at a Multi – Agency Risk Assessment Conference (MARAC) and father was subject to a Domestic Violence Prevention Order, though mother had also said domestic abuse was no longer a factor and there hadn't been any police attendance for 12 months. Mother had experienced bereavement of close family members including a previous partner. Father had an older child who he had no contact with, and mother was known to mental health services and diagnosed with emotional, unstable personality disorder. Mother also expressed her worries about having a baby and how she would manage. Mother hadn't disclosed these issues at time of ante -natal booking.

3.9 The midwife had a consultation with Cheshire East Consultation Service (ChECS, front door to services), this was followed up with a referral which was appropriately progressed for assessment. A referral was also made by the midwife to the perinatal mental health team. At this stage Cheshire East Consultation Service should have followed the domestic abuse pathway and consulted with the Domestic Abuse Hub who had significant history of involvement with parents, it was identified in the rapid review that this did not happen.

3.10 This was a missed opportunity for the known domestic abuse history to be fully considered in the subsequent assessment. As a result of this Cheshire East Consultation Service and Domestic Abuse services took immediate action to review the pathway to mitigate the risk of this happening again. Additional checks have been incorporated into processes including; Cheshire East Consultation Service will always consult the Domestic Abuse Hub as a matter of course, even if there is no suggestion of domestic abuse in the contact, as they do with other agencies, additionally all contacts will be signed off by a manager who will ensure that relevant agencies have been consulted. The Domestic Abuse Hub also receives self – referrals and they will now ensure that all cases where there are children will be discussed at the Cheshire East Consultation Service daily meeting. There will continue to be regular dip-sample audits to ensure these processes are embedded. This review was assured by practitioners that they know how to access the hub and that they value the input from the hub.

3.11 Children's social care undertook an unplanned visit to mother on the day the referral was received as they had been unable to make contact by phone. Mother did not allow access as the visit was unplanned and social worker noted a strong smell of cannabis but there was no evidence this was discussed with mother. Mother attended the perinatal mental health clinic sixteen days later and informs that she had met a social worker but was rude to her, and practitioner suggests a joint visit with midwife and social worker which she agreed to. This is an example of good

practice with professionals recognising who mother has a relationship with to support her during the visit and subsequently a joint visit was undertaken 15 days after the initial referral.

3.12 The social worker made contact with father by telephone to inform the assessment, however, no arrangements were made for a face-to-face discussion and no clarity was sought as to where he was actually living.

3.13 A children and family assessment was completed within 47 days of referrals (statutory guidance is a maximum of 45days)[4]. The risk factors were identified but there is a lack of clarity around the safety plan and how these risks would be mitigated to ensure the safety of the then unborn baby. Issues detailed in multi – agency risk assessment conference minutes (MARAC) are not sufficiently addressed, and it was still unclear where father actually lives. The assessment had minimal information about father's older child and the reasons he does not have contact, though it is known that domestic abuse was a feature of the relationship with his older child's mother. There had been no reported incidents of domestic abuse in the prior 12 months, however there was little understanding of what had changed to achieve this other than parents self-reporting a reduction in alcohol use. Mother was inconsistent in what she told professionals about alcohol use. As previously indicated above, closer working with the domestic abuse hub may have led to a greater understanding of the impact of domestic abuse, particularly in relation to safety planning during pregnancy and with a new-born baby.

3.14 A pre-birth assessment was recommended as an outcome of the assessment which would be expected to cover much more detail about the parents' relationship, functioning and capacity to care for Child J. The pre- birth assessment was never opened or completed. This was potentially exacerbated by the allocated social worker being off sick and the fact that it was not opened on the system meant it would not have been flagged as incomplete. It is understood that the manager signing off the Children and Family assessment should open the pre-birth assessment on the system if one is indicated. The multi–agency audit of safe sleep looked at several cases where a pre–birth assessment had been indicated and in all cases where a pre-birth had been indicated they had been completed, in a timely manner and were of good quality, however, agencies did report that they weren't always shared with professionals involved which is in the agreed Cheshire East Safeguarding Children's Partnership procedure on pre–birth assessments[5].

3.15 The lack of a good quality assessment and absence of the social worker is likely to have impacted on future decision making in this case which appears to have been influenced by the rule of optimism and a lack of multi–agency planning.

<u>Learning Point 3:</u> Multi–agency planning meetings should provide an opportunity for information sharing, development of safety plans and appropriate professional challenge as well as an opportunity for respectful curiosity.

[4] Working Together to Safeguard Children 2018 (publishing.service.gov.uk)
[5] prebirth_assess_pg.docx (live.com)

3.16 Cheshire East Safeguarding Partnership procedures state that Child in Need meetings should be held at 6 weekly intervals. The Pre-birth Assessment procedure states,

"The pre-birth assessment will be managed by multi-agency meetings, that includes parents and family members (see Appendices) led by Children's Social Care".

3.17 There is limited evidence of robust multi – agency planning in this case. Child J was open to children's social care for approximately five months prior to his birth. There is no evidence that a Child in Need meeting was convened to gather multi -agency information to inform completion of assessment during this time and to share information from a multi–agency perspective. There is evidence of health visitor chasing up a Child in Need meeting 5 months after children's social care had opened the case and one was then arranged to be held virtually due to the ongoing restrictions related to the Covid 19 pandemic.

3.18 At this meeting there was a unanimous decision by professionals that a discharge planning meeting would not be needed, this is despite the fact that parents did not attend the meeting, father due to work and mother because she overslept. The social worker did discuss the safety plan subsequently with mother, but there was no evidence that it was discussed with father. Whilst there are a number of positives detailed in the plan there are also a number of outstanding risks identified which include; mother not engaging with identified therapeutic support around her mental health, neither parent had accessed domestic abuse support, mother had not engaged consistently with midwifery appointments, mother had disclosed to health visitor she had been having small amounts of alcohol, (alcohol screening indicated that this was not excessive). Professionals recognised that it was likely parents would reach a point of crisis due to non-engagement with services and recognition that mother uses alcohol as a coping mechanism. As parents did not attend there was a lack of respectful curiosity from professionals and a missed opportunity to engage with parents to share concerns and address risk in a meaningful way. This appears to be the only Child in Need meeting during the period of intervention as a subsequent arranged meeting was cancelled due to the absence of the social worker.

3.19 There is no evidence that any professional raised concerns about the lack of pre-birth assessment, lack of multi–agency planning (prior to health visitor instigating the one meeting that did take place) or the decision not to have a discharge planning meeting.

3.20 Approximately two weeks after this meeting the social worker was off sick and it was 24 days before the case was reallocated and 11 days after the birth of Child J. It would appear that this decision was influenced by a number of factors including a lack of clarity about when the allocated worker would return, a number of absences in the team due to the pandemic, a lack of challenge by other professionals, as well as a lack of understanding of the risk factors involved leading to a rule of optimism. This decision does not appear to have changed following the birth of child J and the incident on the labour ward.

3.21 Prior to Child J's birth, mother asked that father was removed from the labour ward as she did not want him there. Mother said he had been drinking and was abusive to

her, he did leave the suite, the midwife did not observe that he was under the influence of alcohol, and it was noted that he became frustrated that he couldn't get out of the doors and needed staff to assist him. There is no evidence that this information was shared with any other agency, which is a potential missed opportunity to reconsider a discharge planning meeting or to convene an early Child in Need meeting on discharge to review safety planning considering this information. Immediate action was taken as a result of this review to ensure all ante-natal plans are updated by the labour ward even if there is no new information and a full and comprehensive discharge plan to be shared with all relevant agencies.

The multi -agency audit also identified that Child in Need planning needs to be strengthened, plans tended to be far more robust when children were subject to child protection plans.

Learning Point 4: All professionals must consider and engage fully with both parents to inform assessment and develop safety plans.

3.22 It is documented throughout this review that engagement with father during this period of intervention was at best sporadic. It does not appear that father's role in the care of Child J is fully understood nor the relationship between the parents and impact of significant domestic abuse.

3.23 Children's social care appear to have made one phone call to father during the assessment period and prior to Child J's birth. There is no evidence that safe–sleep guidance had been shared with him directly. It is known that mother did not want him on the labour ward, but this information does not appear to have been shared. Father also has an older child who agencies know about, but no-one has explored further the circumstances that have led to father having no contact with them. The basic question of where father lived was never addressed and it was accepted that he visited mother and lived with a friend. There was an evident lack of professional curiosity about father.

3.24 Services are often 'mother focussed' rather than seeing both parents as equally responsible for care of the child. The review was told that there was a need for professionals to consider fathers more rigorously. In the 2015 NSPCC report, 'Hidden Men – Learning form Serious Case reviews'[6] it is pointed out that men can be 'ignored by professionals who sometimes focus almost extensively on the quality-of-care children receive from their mothers'.

3.25 The Myth of Invisible Men[7] stresses the importance of ensuring 'that working with men is not somehow 'extra' or desirable work – it is essential. An assessment is not an assessment if it does not include (or at least made every effort to include) the father and any intervention must address both the support needs of, and the risks presented by, male carers.'

[6] Learning from case reviews briefing: hidden men (nspcc.org.uk)
[7] The Myth of Invisible Men (publishing.service.gov.uk)

4. Conclusions and Recommendations

4.1 This Local Child Safeguarding Practice Review has considered the learning from Child J's case and identified learning that will be helpful for the wider system. Whilst there has been good practice identified, vulnerabilities have been exposed in practice, particularly a focus on mothers in promoting safer sleep messages and this being seen as health role as well as the impact of a lack of rigour in multi -agency planning.

4.2 Single agency actions have been identified during the review and recommendations agreed to address these, including the importance of reallocation processes when a worker is off sick. There has been excellent cooperation with this review from partner agencies, which was essential in establishing the learning from this case.

4.3 Having considered the learning from this review that has not been addressed by single agency actions, the following additional recommendations are made to ensure improvement actions are taken.

Recommendation 1:

The Cheshire East Safeguarding Children's Partnership should seek assurance that safer sleep messaging is embedded into multi-agency safeguarding practice, includes fathers and where they provide significant care or are named in safety plans, wider friends and family.

Recommendation 2:

The Cheshire East Safeguarding Children's Partnership should seek assurance that fathers are fully involved and engaged in assessment and planning processes.

Recommendation 3:

Cheshire East Safeguarding Children's Partnership should seek assurance that there is a robust approach to Child in Need planning and where this is not the case, professionals challenge and hold each to account.

Recommendation 4:

Cheshire East Safeguarding Children's Partnership undertake a multi – agency audit focussed on the impact of domestic abuse on parenting, particularly in relation to unborn and young babies and where parents are not believed to be co-habiting. The audit should also ensure that changes to the pathway to the Domestic Abuse Hub are embedded and effective.