Blackburn with Darwen, Blackpool and Lancashire
Children's Safeguarding Assurance Partnership

Serious Case Review Child CD

Executive Summary

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SECTION 1: BACKGROUND TO THE SERIOUS CASE REVIEW (SCR)

1. **The Incident:** On the day prior to Child CD's death (early February 2019), the family attended the children's centre communication group, went shopping, celebrated mother's birthday and mother built a wardrobe in Child CD's bedroom. Father was at the family home during the evening and night. Mother described the day as horrendous as Child CD (aged 13 months) was unwell. Mother thought this was due to teething. Child CD was crying excessively, extremely clingy, reluctant to eat or have routine daytime sleeps. She put Child CD down to sleep earlier than usual (1630hrs) and followed medical advice previously given in respect to the management of febrile illness and upper respiratory tract infection. She left Child CD undressed, in a nappy only and medicated her infant with paracetamol at bedtime. Child CD was placed in the usual sleep environment, which was an adapted cot-bed that allowed the infant to get out of bed to play. Child CD was not checked during the evening/overnight as mother did not want to disturb her infant. She felt she would hear her infant shout if support were needed.

2. The following morning (0730hrs) Child CD was found by mother, head down in a fabric toy box. The fabric toy box was next to the wall, at the bottom of the bed and used to store swimwear. Child CD was cold to touch and was moved onto the bed. Mother made a 999 call to the police who contacted the paramedic emergency service. The service immediately dispatched an ambulance and an advanced paramedic. Both parents and a pre-school sibling were present at the scene.

3. On arrival the paramedic crew assessed Child CD did not show signs of life and resuscitation was not attempted. Their assessment was that due to the post-mortem changes observed on the body Child CD had likely died a few hours previously. In line with local policy Child CD was transferred to the nearest hospital's accident and emergency department for assessment by a paediatric consultant. The sudden unexpected death in childhood protocol pathway was initiated. Child CD's parents declined to accompany their infant to hospital, understandably exhibited extreme distress but also displayed aggressive/accusatory behaviours. The ambulance crew expressed concerns regarding the home environment and in the circumstances Child CD was found. It was documented "*Child CD was alone on the bed, wearing a nappy, there was no cot in the room, the room was cold and there appeared to be various bruises to the infant's face and body*". The bruising noted by the ambulance crew was later advised to be as a result of Child CD's death. It was related to the position the infant at the time of death and pooling of blood. The crew submitted a safeguarding alert to the local authority children's services department, due to the circumstances of the infant's death and concerns for the sibling's welfare.

4. The provisional post-mortem findings undertaken by a pathologist concluded:
   - positional asphyxia as the cause of death (pending the outcome of toxicology tests).
   - the presence of a group A streptococcal infection - this was required to be notified to Public Health England, although was not identified as a cause of death.

5. A criminal investigation was initiated and both parents were arrested on suspicion of murder/neglect. They were interviewed and released with no further action planned in respect to the suspicion of murder. Toxicology samples were taken around the time of the police interviews. The review has been informed there was nothing relevant identified in the samples that could have assisted the police investigation. Parents were to remain on police bail until March 2019 in relation to the offence of neglect. In May 2020, the case review panel was informed that there would be no charge levied against either parent.

6. According to national protocol children's services submitted a serious incident notification to the local safeguarding children board (LSCB), which has since been replaced by the children's safeguarding assurance partnership (CSAP). The unexpected death of Child CD was notified to relevant statutory bodies according to national guidance. In late February 2019, the LSCB's case consideration panel completed a rapid review. The recommendation was the criteria for a SCR was met and the decision was ratified by the LSCB chair. In early March 2019, a notification of the decision was made to Ofsted, DfE and the Child Safeguarding Practice Review Panel. The national panel ratified the LSCB decision. A multiagency case review panel was established to work alongside an independent reviewer to support the reviews completion planned for September 2019. The completion of the review was delayed pending the outcome of the criminal investigation and work recommenced in May 2020. The final review was completed for submission to the CSAP in December 2020. The safeguarding partners agreed the report in January 2021 and to its publication as a Serious Case Review, notwithstanding subsequent changes to statutory guidance for reviews. Practitioner participation was secured. It was not possible to secure parental and family participation during the review process, however just prior to publication the review was shared with mother.

7. The case review panel established the following terms of reference.

    1) Was relevant historic information about child and family functioning known and considered in the multiagency risk assessment, planning and decision-making in the period leading up to Child CD's death?
    2) Was the multiagency planning robust, appropriate, effectively implemented, monitored, and adequately reviewed in the period up to Child CD's death to reduce the risk of harm?
    3) To what degree did agencies challenge each other regarding the effectiveness of the risk management, planning and decision making?
    4) Were the respective statutory duties of agencies working with the child, parents and family fulfilled?
    5) Were there organisational, contextual obstacles or difficulties in this case that prevented agencies from fulfilling their duties?
    6) Were the vulnerabilities for the child adequately assessed/managed in the context of planning and intervention to manage the risk for Child CD?

8. Following the collation of a multiagency chronology the following key lines of enquiry were highlighted as the focus for the review.

    1) Information sharing and how did this impact on intervention and outcomes for the child/ren?
    2) Did professionals understand the whole picture of family functioning and safeguarding concerns?
    3) Was there evidence of a longitudinal assessment of this family's safeguarding concerns and recognition of the cumulative risk of harm?
    4) Was there evidence of multiagency working or did agencies revert to silo working?
    5) Was the child's voice heard and their lived experience understood in practice?
    6) Understanding the effectiveness of cross boundary service provision.
    7) Supporting the domestic abuse agenda.
    8) Coordination of care and frequent changes of professionals allocated to the case.
    9) Early Help including step up and step down.
    10) Mother's vulnerabilities to include her, age when homeless, depression and anxiety issues, obsessive compulsive disorder, attachment issues and lack of psychological availability to her children.
    11) The message of '*Walking Alongside'* families rather than leaving vulnerable parents and children to find their own support.

12) Further consideration of the males in mother's life and their impact on the family, including the level of contact that father had with mother and her children.

9. The process has considered parallel enquiries/investigations to avoid any conflicts of interest.
   1) All agencies were asked to disclose investigations or staff interviews undertaken. None were identified.
   2) The coronial inquest had not concluded on completion of the review.
   3) The constabulary commenced a criminal investigation following the death of Child CD. In May 2020, the investigation was concluded and no charges were levied against either parent.
   4) A case review will be undertaken by the child death overview panel (CDOP) according to national and local guidance[1] on completion of this review. The child death review meeting has been completed.
   5) Family Court proceedings have been completed in respect of the older sibling, who has now been placed for adoption.

Section 2: A Summary .

This section provides a brief summary of the main body of the overview report and contains brief detail with some analysis of the key issues raised.

2.1 A Portrait of Child CD.

10. Practitioner conversations and parental police statements helped to build a pen-portrait of Child CD. The agency records did not secure a robust perspective of Child CD's presentation or experience of everyday life. Mother described Child CD as a very agile, vocal, mobile baby who liked to play independently and alongside the sibling. The infant was cruising, not walking independently and would sometimes play with toys without parental supervision. Mother advised Child CD would ask to play with the sibling or might say "*mummy just left* me". Mother attended the children's centre parenting groups regularly to support her children's development.

11. Practitioners observed Child CD to play, socialise normally and was always well presented during contacts. Mother/child interactions were noted to be mostly to be appropriate and positive. The incidents of concern will be highlighted later in this review. Following Child CD's birth, the health visiting service regularly monitored the infant's growth, which was maintained around the 75th centile[2]. Developmental assessments were completed in accordance with expected practice. There were no concerns highlighted until the 12 month health visitor assessment when Child CD's personal and social skills were lower than the expectations. Mother was advised regarding age appropriate play, the use of books and encouraged to attend the children's centre's groups to support the infants development.

2.2 The Family & Social Network.

12. Mother was the children's main parent/caregiver and had lived locally all her life. They lived in private housing and re-located on three occasions during the review's timeframe, the last re-location was prior to Child CD's birth. The reasons for the family moving were unknown but this pattern of re-location is not unusual in the local population. Her contact with local authority housing services was

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[1] See Chapter 5, Child Death Reviews, Working Together to Safeguard Children- a guide to interagency working to safeguard and promote the welfare of children. July 2018. HM Government.

[2] Centiles show the expected growth pattern for infants and children on a growth chart. An infant following the 75th centile means the infant is bigger than 75 out of 100 children of the same age.

minimal. Agency records and practitioner conversations identified the home environment, was consistently good, exceptionally clean, tidy, and ordered. Mother would seek support from a range of practitioners but at times could be challenging, volatile and difficult to engage dependant on her emotional/mental state. It was challenging for her to accept professional advice or support.

13. She struggled historically to maintain her mental and emotional wellbeing and this was well documented. As early as 2013 (aged in her early 20s), mother presented to a variety of NHS services with distressing symptoms related to fluctuating mental ill health (anxiety, depression, intrusive thoughts of self-harm, paranoid thoughts) and disclosed using alcohol and cannabis. There was no further evidence in respect to understanding her substance misuse behaviours.

14. There is evidence she experienced significant adverse childhood trauma both at home and in school. She did not engage with specialist mental health services, was reluctant to talk about her experiences or attend specialist services for therapy. GP services predominately managed her care through medication due to her reluctance to engage in other types of therapy. In 2015/16, during her first pregnancy her struggles with her mental health were again highlighted. She was supported by the GP, the crisis mental health team and perinatal mental health service but again could be non-compliant in respect of medication. In 2018, following the birth of Child CD she discussed with the health visiting service the long term challenges in managing anxiety but was again reluctant to consent to a referral to mental health services, preferring to be supported by the GP through medication. GP services advised they were managing her care in respect of anxiety/depression along with an obsessive compulsive disorder. Her compliance with antidepressant medication was variable and the service had regular contact to encourage her compliance with treatment. The general practitioner triggered numerous telephone contacts with mother to monitor her wellbeing following the birth of Child CD's sibling. **(Good Practice)**

15. Child CD's father did not cohabit with the family, originating from an area in the United Kingdom (over 300 miles away). During Child CD's life father was nomadic, moving back to his home area and returning locally to enable contact with his infant. He was registered as homeless and actively supported by local housing and third sector homeless services on three occasions during the review's timeline. **(Good Practice)** The review has identified he was in contact with and assumed childcare responsibilities for the children and supported mother following the birth of Child CD. The consistency or frequency of this contact was unclear to agencies involved. The parental relationship was unstable, sometimes appearing supportive yet other times volatile. There were frequent incidents of concern documented. Mother made a series of complaints in the antenatal period regarding harassment, and then again during Child CD's life. These incidents are discussed in the comprehensive overview report. Locally, father had no known support networks, his sister lived in his originating area. He described mother as a friend to housing professionals. Professionals in contact with father advised he was easy to work with and complied to their requests for action.

16. There has been limited information provided to gain a longitudinal perspective of father's health. In the months following Child CD's birth he smashed up allocated accommodation on two occasions, whilst expressing suicidal ideation on one of these occasions. He registered with a local GP practice (September 2018) whilst supported by a homeless service worker. Father had a diagnosis of anxiety and depression. Following communication with a previous GP in a cross boundary area, the local GP practice prescribed antidepressant therapy. Father disclosed his compliance with antidepressant medication was not always consistent. He requested sleeping tablets which were not prescribed, with the GP offering alternative options e.g., not drinking energy drinks and creating independent sleep patterns. On an occasion father disclosed to his homeless worker challenges with alcohol misuse. Mother stated during the police interview he had previously smoked cannabis and used cocaine. He had no arrests or convictions for drugs/alcohol related offences. The information provided does not confirm he had significant challenges with substances.

17. Child CD's pre-school sibling regularly attended a local children's centre. Whilst in nursery, the child was noted to be friendly and exhibited age appropriate interactions with peers and other adults. There were no concerns about the child's developmental progress. The child was noted to be clean, dressed appropriately, with adequate spare clothing and was equally happy to be dropped off and picked up from nursery by mother. The child's relationship with the nursey worker was described as positive. When attending the centre's messy play group following the birth of Child CD there were occasional concerns with regards to mother's interactions resulting in the child being extremely upset. These incidents are described in the comprehensive overview report. Positive interactions were also observed and mother sought appropriate advice from health services for a range of minor ailments and issues.

18. Child CD's maternal grandparents lived nearby. Grandma was documented to be in regular contact and often present when mother had health appointments for herself and her children. A number of practitioners identified mother's relationship with her own mother could be fragile, volatile, and unstable. Their relationship had broken down nine days prior to Child CD's death and the children's centre was advised by mother that maternal grandma should not be allowed to pick up her elder child. Mother was supported by an auntie and three close friends. The review identified these relationships appeared to be constructive and offered positive support to the family.

2.3 An Analysis of the Historical Information up to 1st April 2017.

19. Mother's adolescence was a challenging time experiencing significant adverse childhood experiences. She had multiple vulnerabilities including substance misuse, emotional/mental health instability, family stress/ violence/ breakdown, was disengaged from education, homelessness, behavioural challenges and social isolation. It is unclear whether there was a comprehensive multiagency early help response to assessment, planning and intervention to support a whole-person approach in the management of her complex and interlinked vulnerabilities. Education were not always aware of her vulnerabilities. There was evidence the GP practice and social worker worked together under a child in need plan, were successful in securing her trust and made significant attempts to link her into the support services to help her manage her challenges (emotional, mental distress, homelessness). Unfortunately, mother would not engage in talking therapy and treatment which may have helped to address the root cause of her challenges.

20. A key question the review was asked to consider is how adolescents with such complex and interlinked vulnerabilities would be currently supported in practice. Practitioner conversations identified demographically there remains large numbers of adolescents locally with the same challenges as Child CD's mother. The numbers were likened to those of an inner city area. Additionally, the area attracts many transient adolescents from cross boundary local authority areas. These adolescents often remain difficult to reach out to, with agencies facing significant challenges in effectively engaging them in interventions to support their development into adulthood. Whilst some may meet the threshold for statutory intervention and will be well supported through multiagency assessment, planning and intervention others remain partially or fully hidden. They may dip in and out of services with no comprehensive, whole person approach to assessment, planning, intervention, and risk management. Practitioner conversations have highlighted more recently the local area has developed a range of multiagency and coordinated services to work with this group of young people. The focus being the young person remains at the centre of the assessment, planning and intervention. This is a positive development and the issue should remain a focus of commissioning and provider activity to monitor continued improvement.

21. The review has not been asked to look in depth at this period however the chronology provides evidence of coordinated interagency working (GP, midwife, perinatal mental health team, health

visitor, the children centre) to support mother's mental and emotional wellbeing during the pregnancy and following the birth of her first child. There appeared to be an accurate assessment of her family needs with appropriate levels of intervention based on the health visiting offer of universal plus. It is notable that during this period mother appeared to develop positive relationship with key professionals offering support and this also coincided with a short period of stability in her mental/emotional wellbeing. **(Good Practice)**

22. Learning Points suggested during this period.

LP 1: *Is the safeguarding partnership assured multiagency arrangements effectively support all adolescents with complex and diverse needs through a single pathway and team around the child that remains focussed on the needs of the child as opposed to the needs of the system?*

2.4 An Analysis of the Period May 2017 to January 2018: Child CD's Antenatal Period.

23. During this period, the parental relationship developed from a friendship into a relationship during which time Child CD was conceived. There is evidence father spent time and lived in the family home but was also in contact with homeless/housing services. Their relationship was unstable at times and parents separated prior to the birth of Child CD. There were a number of incidents highlighted, linked to domestic abuse due to perceived harassment by father through text messages. Additionally, father expressed concerns through an alert in respect of mother's emotional wellbeing. There was some evidence of positive information sharing between multiagency partners, however the information gathered did not trigger professional inquisitiveness or additional support for the family. The assessment of family needs was often made without access to the full range of multiagency information available. It was based on a single incident rather than a holistic picture. At that time, the step down processes to support families through early help was emerging as an adhoc system. Recent conversations have highlighted the system has been strengthened however there remains significant challenges embedding early help processes into multiagency practice consistently. This needs ongoing multiagency agency commitment from both a provision and commissioning perspective to ensure the system becomes embedded into frontline multiagency practice. Mother was compliant with her antenatal care and responsive to service requests.

24. Learning Points suggested during this period.

LP 2: *Maternity Services had robust systems in place to support domestic abuse enquiry however an omission still occurred. Therefore, maternity services should provide assurance to the safeguarding partnership that routine domestic abuse enquiry is effective, and this is not a widespread issue.*

LP 3: *The safeguarding partnership should be assured that the process to assess alerts that are considered to be malicious is sufficiently robust and is always inclusive of multiagency information.*

LP 4: *PVPs in respect of adults are now recorded on both the adult and child health visiting records. The safeguarding partnership should be assured of the effectiveness of the system.*

LP 5: *The safeguarding partnership should through quality effectiveness processes receive assurance that the step up and down processes are effectively supporting families.*

LP 6: *The adherence to the expectations of multiagency early help guidance is inconsistent in practice and the pace of change is sluggish with practitioners who work with families making decisions whether to opt in or out of the process. All relevant agencies should ensure their workforce engages with the expectations of the multiagency early help guidance and provide assurance of effectiveness to the safeguarding partnership and commissioners of the services.*

LP 7: *Early Help may be indicated when families move frequently. Multiagency practitioners should investigate and ascertain whether the family has challenges i.e., victims of antisocial behaviour, debt etc.*

LP 8: *There should be a robust assessment of family needs when women with a significant history of mental/emotional instability are pregnant and in the post-natal period to support them in caring for infant and their other children. The universal plus health visiting offer should always be a consideration to enable this support.*

2.5 An Analysis of the Period January to April 2018: Child CD birth - 3 months.

25. During the first 3 months of Child CD's life there were a number of incidents indicative this could be a family under stress. In isolation each of the incidents would not have met the threshold for statutory safeguarding intervention however had the potential to impact negatively on the everyday life of the children. There was some evidence of positive information sharing between the health visiting and general practitioner services. However, the support offered to support mother in the management of infant feeding challenges was not robustly coordinated between universal services. An anonymous referral to children's social care was closed down without the children being seen and not all the universal services were contacted for information. Communications were not sufficiently robust with email used to ascertain key information regarding the risk to the children and universal services did not always share relevant information. There was no evidence of a longitudinal assessment of the family needs and parenting capacity. Information sharing was not as effective as it should have been with key services in contact with the family not always being aware of each incident. There was missed opportunities for services to work together to assess and support this family. Mother began to demonstrate a reluctance to consent to information sharing or accept support as her mental health challenges escalated.

26. Learning Points suggested during this period.

    LP 9: *Infant feeding support should be effectively coordinated between all services to ensure families receive timely and consistent feeding advice for their infants.*

    LP 10: *The safeguarding partnership should be assured through commissioning and quality effectiveness processes that mothers with a history of are exhibiting unstable emotional and mental well-being will be assessed accurately and prioritised for an enhanced health visiting service.*

    LP 11: *Children's Centres have internal systems to log safeguarding concerns, these concerns do not always meet the threshold for a multiagency safeguarding referral to assess the need for statutory intervention. It is crucial the centres are inquisitive and with parental consent, share relevant information with partner agencies to ensure the opportunity to provide a structured early help approach.*

    LP 12: *All anonymous contacts that raise significant concerns for the welfare of babies and young children should be robustly assessed. This can be achieved through communication with all agencies involved with the family. A current picture of their presentation, the risks they face and everyday experience of life should always be established and the children should be seen.*

2.6 An Analysis of the period April to July 2018: Child CD 3 - 6 Months.

27. In this period the homeless and housing services worked effectively with Child CD's father to support his re-location. The information highlights father had significant contact with the family

during this period, sometimes taking a sole caring responsibility. However, there was no focus on developing father's role as a caregiver or assessing his role and presence in family life. The homeless service provides emergency accommodation, drop in sessions and food. It also works intensively with homeless young adults during life skills sessions. These sessions do not currently include developing childcare or caregiving skills which could be an opportunity for these young adults who become parents or assume childcare responsibilities. The services that respond to the needs of vulnerable adults should remain alert to the safeguarding children issues when it is known the young person is in contact with children.

28. The focus of intervention remained on mother who was understood to be the children's sole carer. During practitioner conversations it was highlighted key services (midwifery, health visiting, children's centre, general practitioner) in regular contact with the family, would not have re-visited their understanding of father's involvement in family life or his role in childcare provision unless there had been an indication to do so. Practitioners should always remain inquisitive in relation to adults providing childcare and this should remain a line of questioning during contacts with families. It is positive that currently engaging fathers is a current focus through the Better Start offer through the health visiting service. However, at the time there was limited focus on father who was in effect a hidden male.

29. There were continued incidents. Mother made a number of police reports due to feeling harassed by text messages and a perceived burglary. She thought these were linked to father's actions. Information sharing systems were more robust resulting in children social care stepping her case down to the early help hub as the threshold for statutory intervention was not assessed to be met. At this point there had been a number of recorded incidents so it could be argued that the threshold was met for a child and family assessment. The early help hub stepped the case down to the health visiting and children's centre services, however there is no evidence of further activity.

30. Mother's expressed concerns regarding a change of health visitor. The system encourages health visitors to formally handover cases when a family moves home or changes GP and is assessed to have additional needs. Building and maintaining trusting partnerships with families when the main carer has unstable emotional health is crucial, therefore frequent changes in key workers should be minimised and the views of parents should be considered to support ongoing work with families. The service increased their offer to universal plus.

31. Learning Points suggested during this period.

    LP 13: *Building and maintaining trusting partnerships with families when the main carer has unstable emotional health is crucial, therefore frequent worker changes should be minimised, the views of the family taken into consideration and a transition handover period considered. The system should be adaptable to be able to accommodate, the family taken into consideration and a transition handover period considered.*

    LP 14: *All services engaging in intervention with young adults, (who have or assume childcare responsibilities as parents or through their contact with children) should ensure their intervention includes the development of childcare responsibilities, be alert to potential child safeguarding issues, along with other strands of intervention supporting development of their life skills.*

    LP 15: *All practitioners should remain inquisitive and alert to adults involved in providing care to children. This should always remain a line of enquiry and not a one off enquiry.*

2.7 Relevant Events and Episodes of Care: Child CD 6 Months to the Final Incident.

32. During this period mother consulted her general practitioner. Her mental/emotional wellbeing fluctuated. She declined the support of the health visiting service, even though they remained in contact with mother. The general practitioner actively followed mother's care through telephone contacts when she did not attend for planned consultations. **(Good Practice)** Mother's adherence to her medication regime could be chaotic. For reasons unknown she changed her general practitioner practice and the system changed her allocated health visitor. The final health visitor being the fourth change since Child CD's birth.

33. Father re-engaged with homeless services having returned from his originating area where he had been evicted from homeless property after smashing up his room. He remained keen to remain near Child CD. The information reviewed does not provide clarity of his contact with Child CD during this time, although the police statements identify mother would contact father if she needed support.

34. There was no direct communication between the health visiting service or the general practitioner. Mother sought support from the health visitor at the general practitioners request, which generated a contact and development assessment for Child CD. Safer sleep advice was provided; it is not known whether the health visitor was aware Child CD was sleeping in an adapted cot bed meaning the infant was not being placed in a safe sleeping environment. The service reduced the health visiting offer to universal provision. The SUDC Prevention Group has recently reviewed the strategies and initiatives around safer sleeping advice, support, and promotional materials. Changes to promote knowledge and understanding were launched in July 2020. This is positive intervention and should become embedded into practice. The health visiting service was not fully aware of the incidents in the children's centre or contained within the police reports. This information may have strengthened the service's assessment of family needs. Given mother's continued unstable emotional/mental health, the previous known concerns, and Child CD's low level development it may have benefitted the family to remain on the universal plus offer of health visiting intervention.

35. There continued to be incidents logged by the children centre, the general practitioner and incident reports to the police. The children centre logged five incidents during this period. These issues/events were not shared with other services in contact with the family, nor was the centre aware of other agency information relating to the issues of harassment or maternal mental health. It has not been established why information was not shared but the centre advised that whilst these incidents were of concern the children were frequent attenders and were generally happy, well presented children who related positively towards their mother and vice-versa.

36. There were two further police reports made by members of the public. The first being Child CD left in a car unsupervised and the second a child being seen being dragged down the street by mother. The police responded to both these incidents, saw the children, and had no concerns for their welfare. PVP's were not generated which was a missed opportunity to share information with multiagency partners and to generate a child protection alert especially in respect of the second incident. The agency review of this incident is the behaviour of mother was clearly aggressive and concerning enough to warrant a member of the public to contact police. It suggests a vulnerable child PVP should have been submitted to share these concerns. This would have ensured all agencies were aware of mother's aggressive behaviour towards her children. Mother's explanations were accepted without further investigation and information was not shared with multi-agency partners, meaning that there was no opportunity to review the bigger picture. These events occurred in the weeks prior to Child CD's death.

37. ***Early February 2019: The Final Event***. During the day prior to Child CD's death, the family attended a children's centre communication group, went shopping, celebrated mother's birthday and mother

built a wardrobe in Child CD's bedroom. Father was at the home during the evening and night. Mother described the day as horrendous. Child CD was unwell which was thought to be due to teething, was crying excessively, extremely clingy, reluctant to eat or have the routine day time sleeps. Mother decided to put Child CD down to sleep a couple of hours earlier than usual (16 30hrs). Mother followed medical advice given 10 days related to the management of febrile illness and upper respiratory tract infection, through temperature control and additional fluids. She left Child CD undressed, in a nappy and medicated her infant with paracetamol at bedtime. Child CD was placed in the usual sleep environment, which was a cot-bed bed adapted to allow Child CD to get out of bed to play. Child CD was not checked during the evening or night as mother did not want to disturb her infant and would normally hear if her infant needed support. The following morning (0730hrs) Child CD was found by mother, head down in a fabric toy box at the bottom of the bed which was next to the wall. The box was normally used to store swimwear. Child CD was cold to touch and was moved onto the bed. Mother made a 999 call to the police. The police contacted the paramedic emergency service who immediately dispatched an emergency ambulance and an advanced paramedic. Both parents and an older pre-school sibling were present at the scene.

31. Learning Points suggested during this period.

LP 16: *A lack of consent should not deter a professional from sharing information if it is assessed this is justified and necessary to safeguard the vulnerable child/adult. This is a development issue for the multiagency workforce.*

LP 17: *The Safer Sleeping Guidance for Children now includes a sleep assessment tool for professionals to complete with parents and also a parental awareness review tool. Both the booklet and the guidance includes sleep advice for toddlers. This was launched in July 2020. This is positive intervention and should become embedded into practice for all agencies. Its implementation should be subject to scrutiny.*

SECTION 3: OVERARCHING CONCLUSION.

38. The review has identified areas of good practice and learning where multiagency partnership working could be strengthened. During the period following Child CD's birth key services were experiencing significant transition and there were capacity issues in the workforce, this has since improved. The review acknowledges that multiagency safeguarding practice has been strengthened in the period since Child CD's death through improvements made by multiagency partnerships. Examples of the improvements include the development of new multiagency guidance and policies to improve multiagency responses to cases at the differing thresholds of concern. Improvements have been made in the MASH to ensure information is collated and assessed by a multiagency team. An early help hub has been established by children's services to provide leadership and support to multiagency professionals when working with families requiring support through early help.

39. Ultimately, Child CD was placed in an unsafe sleeping environment, enabling the infant to move into an unsafe position thereby causing positional asphyxia. Locally the issue of inappropriate sleeping positions has been considered by the CDOP, following the sudden and unexpected deaths of a number of children under the age of 2 years who were placed in inappropriate sleeping environments. Improvements have been planned and the project launched (July 2020). However, it is important this becomes embedded into frontline practice for all multiagency partners in the way safer sleep messages for infants has been implemented. The effectiveness of the campaign should be monitored and remain a focus of health promotion for all multiagency services. The review process has identified safer sleep advice nationally is focused on babies and does not address

adequately unsafe sleep environments when mobility increases in infants. The learning from this review should be shared nationally.

40. Information sharing was most effective between closely aligned services but not all services held the total information about the fourteen documented significant incidents and the range of other issues that have been raised within the review. Information about key incidents was not always alerted to relevant multiagency professionals having regular contact with the family. Each agency held some information but there was no evidence that professionals were inquisitive or searched for missing information. This meant there was a less than robust assessment of the cumulative risks for these children living in an environment where the main caregiver had fluctuating mental/emotional health and unstable support relationships.

41. The review has considered how the principles of early help were applied at the time. Maternal refusal to consent was a significant feature. However, the principles of early help were seldom considered in practice and the system not well understood. In addition, the step down process to early help when the threshold for statutory intervention was not met was unclear. It is positive the review has identified the system has been strengthened with the development of early help hub however there remains challenges in the system when securing practitioner and agency involvement in early help cases. Some practitioners advised they were not involved in the early help process. All agencies need to understand their role in respect to facilitating multiagency early help. There is no multiagency data available to monitor the current effectiveness of this system and the review has been informed that no performance monitoring occurs within agencies excepting children's services. It is a contractual expectation for some agencies to monitor early help provision but no evidence was provided to assure this occurs in practice.

42. Mother's history highlights the need for agencies to work effectively with adolescents who are on the edge of statutory intervention. Mother's case is not isolated case as the review was informed her presentation as an adolescent remains a significant problem for many adolescents locally who have complex health and social needs. It is recognised that there are now in place many services/systems locally that offer support and work together in planning support for adolescents. This is a significant improvement.

43. Father was involved intermittently in family life and at times provided sole care to the children. His involvement was hidden to many services who were unaware of his function within family life. Professionals acknowledged the challenges in working with absent fathers. Working with non-cohabiting fathers/partners to assess and build their parenting capacity is essential and there is evidence that this is considered more often in practice now. The homeless services undertook significant interventions with father which were supportive. However, this intervention does not consider their role in childcare which is a potential opportunity for improvement.

44. There were challenges in partnership working with mother. Mother actively sought the support of universal services (health visiting, general practitioner, and children's centre) and there was evidence she had previously sustained positive professional relationships. However, a deterioration in her mental/emotional wellbeing often coincided with a change in key professionals during child CD's life. The allocation systems (health visiting) are complex and struggle to consider the individual's needs so was not able to respond to mother's concern about another change of health visitor during Child CD's life. When working with families and building trust time is needed to build relationships and if possible frequent changes of professionals should be minimised.

45. The motivation of front line practitioners to support this family was evident and the review has not identified any omissions in practice that directly contributed to Child CD's death.

SECTION 6: OVERARCHING RECOMMENDATIONS

1. Agencies should assure the safeguarding partnership in respect of the learning points.

2. Safer sleep and the risks to mobile infants/toddlers should remain a focus of local multiagency activity with consideration of highlighting the potential of this issue nationally.

3. The quality effectiveness of early help as a multiagency response should to subject to performance monitoring.

4. There should be a focussed response and co-ordinated multiagency working with adolescents with complex health and social needs on the edge of statutory intervention.

5. Assessing and working with young fathers (the hidden male) who have or assume childcare responsibilities is crucial. This should be a focus of multiagency partnership working.