Wakefield Safeguarding Children Partnership

A local child safeguarding practice review (LCSPR) commissioned under

The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

'David'

The Overview Report

September 2021

Index

1 Introduction and context

1.1 Purpose and circumstances of the review

1. This review concerns the tragic sudden unexpected death of seven-week-old David in January 2020 the cause of which had yet to be determined when the review started. The death was suspected to be linked to neglect and was reported to the National Panel and this local child safeguarding practice review was commissioned.

2. The review examines the involvement of ten organisations from June 2017 until David's death and listed in paragraph 4. The ambulance service had been summoned to the family home by his mother and transported to the hospital emergency department. David was regrettably dead on arrival. He lived with his mother and three older siblings Child 1 (early secondary school age), Child 2 (pre-school age) and Child 3 (pre-school age). David's mother has an older child who is an adult and lives independently. David's mother was separated from the David's father at the time of the death although he was sleeping at the family home when David died. They are not married. The family are white British. Father was in employment when David died; his mother was not. The family lived in an area of high deprivation[1]. There is no record of religious affiliation. Both parents have extended family living locally.

3. The use of acronyms and other devices are kept to a minimum. Birth family members are referred to by their relationship to David such as mother, father maternal or paternal grandparent. Professionals are referred to by their job titles such as early help practitioner, GP, health visitor, midwife, police officer, social worker or teacher.

1.2 Agencies who provided information to the serious case review

4. The following agencies have provided information and have participated in the learning events conducted remotely for the serious case review:

    a) Bradford District Care Foundation Trust (BDCFT) (community health service); provided health visiting services in Wakefield and District;
    b) Wakefield MDC Children's Services (social work services); historic involvement in 2014 through child protection plans and again from October 2019 through the Early Help Service;
    c) Mid Yorkshire Hospitals NHS Trust; provided midwifery services;
    d) NHS Wakefield Clinical Commissioning Group (CCG); provided primary care services through the GP practices;

[1] 98.7 per cent of English post codes are less deprived than where the family lived. ONS Postcode Database http://geoportal.statistics.gov.uk/

e) Schools (unnamed to preserve the anonymity of the child); there are two Academy Schools who provided information and are referred to as Academy 1 and Academy 2 respectively;
f) Spectrum Community Health and Turning Point; provided the substance misuse services[2] and support to both parents;
g) Wakefield and District Housing Services; provided a housing and tenancy service and made the referral to children's early help services in September 2019 after they found the house in such a poor condition to make it impossible to carry out essential remedial and upgrading work;
h) West Yorkshire Police; responded to the call from the ambulance service in January 2020 when David was found unresponsive in a bedroom and investigation of the circumstances of his death;
i) Yorkshire Ambulance Service who also provide the NHS 111 service as well as emergency services; had one contact with the family in January 2020 when called by the parents.

1.3 Family contribution to the serious case review

5. The parents were informed of the review. David's mother met the report author and the Wakefield Safeguarding Children Partnership Manager. David's mother remains very distressed about his death. At the time of David's death, she was dealing with different stressors; this included family bereavement as well as responding to the needs of young children. When Early Help Services became involved in late 2019 to provide practical support David's mother felt this added to her feelings of stress. She explained that the service helped with acquiring white goods and new beds and bedding although at the same time the family were storing furniture from a relative's home who had recently died. She also explained that receiving food parcels that were intended to help with feeding the children contained items that the family did not like to eat. With hindsight David's mother wishes that she had been able to talk with her drugs worker about what was really happening in her life rather than just attending appointments; she knows that she could have made an appointment to talk with the worker who was someone she felt she could talk to. Since David died children's social care services have become involved; David's mother had established a good relationship with the social worker who she felt took time to understand the family and their history as well as paying attention to understanding her 'emotional world'. David's mother remembered getting information and advice from the health visitor in particular about safe sleeping. She says that on the day that David died he had been poorly and she had been lying on the bed with him.

[2] The services were an opiate substitute prescription service under shared care arrangements that included psychosocial support and recovery reviews. For brevity, the term substance misuse services is used in the report.

6. The parents were advised the review was due to be completed and chose not to see the final report ahead of publishing.

2 Overview of information

7. David's mother had an adverse childhood. Her mother had significant mental health difficulties requiring periods of inpatient treatment culminating in a completed suicide when David's mother was in her twenties. David's mother has no contact with her father. David's mother became pregnant with her first child aged 15 years old soon after meeting David's father (then aged 17 years) and started to use heroin when she was 17 years old. The paternal grandmother lives locally and has provided support such as looking after Child 2 in 2014 when diagnosed with a fractured skull. There have also been periods of estrangement.

8. David's mother told the health visitor in late December 2019 almost four weeks after David's birth that she and David's father had separated although he had daily contact with the children and he was supporting her as were members of the extended family. There had been earlier separations.

9. The family have a long history of contact and support from many different organisations. The two older siblings were made the subject of child protection plans in February 2014 after nine-week-old Child 2 sustained a fractured skull on two occasions within 48 hours one of the injuries occurring when the child was dropped by mother during a feed. The category of risk for the CPP was physical harm. The plan was stepped down to a child in need plan at the first child protection review conference in early May 2014.

10. Neglect of the children and the poor home conditions was a persistent concern. David's parents had chronic substance misuse over many years receiving prescribed opiate substitution medication under shared care arrangements involving the GP and specialist substance misuse services. Father was working at the time of David's death although the family have a low income and significant debt and have relied on receiving help with furnishing and baby equipment from local charities. In addition to their poor financial circumstances, conditions in the family home were cluttered and dirty and the exterior conditions in the garden have been poor and the subject of action by the landlord service over several months. Different professionals visiting the home regularly reported that the house was cold.

11. Although there has been a great deal of contact with different health providers such as GP, health visiting, midwifery and substance abuse services, parental attention to their own health needs and of their children have not been good. For example, the pregnancies were persistently booked long after the recommended time of before ten weeks into a pregnancy; David's pregnancy was 24 weeks into the pregnancy and all of the children were born pre-term and with low birth weight. There was poor engagement with prenatal care and

support. The children also presented with neonatal abstinence syndrome (opiate withdrawal). None of the children was seen very often at the GP practice and appointments with secondary health care providers such as for assessing an eye squint were often missed and thereby increasing the probability of more severe and long term adverse consequences. Another of the children had a growth hormone deficiency which was similarly neglected.

12. David's mother had more consistent contact with substance misuse services than the father and she also had mental health support that included anti-depressant medication some of which have had significant sedative side effects.

13. Child 1 had a poor attendance record at school. Although the parents were called to meetings at the school there was a poor response in attending or improving attendance. Although the school provided some practical help such as providing a coat when asked by the family practitioner at the Early Help Hub on the 18th December 2019, (the child had a coat at home but had refused to wear it). The school did not know of the involvement of any other services until this meeting[3].

14. Child 2 attended a different school to Child 1 where there were persistent concerns about Child 2 looking neglected and unwashed and inadequate clothing. The school provided a food hamper and a winter coat for Child 2. Attendance was poor. The school noticed that a maternal uncle regularly collected Child 2 from school. There is no record of using the neglect toolkit, early help services or making a referral to the MASH.

15. After Child 3's birth at a hospital in March 2018 mother left Child 3 unattended. Hospital staff contacted CSC who processed it as sharing of information rather than as a referral on the basis that a safeguarding concern had not been highlighted. There was no referral to the Early Help Service.

16. In July 2019 Child 1's school referred the poor attendance to the education welfare service for follow up. A home visit found mother in a nervous and anxious state and she talked about a family history of self-harm and concerns that Child 1 was displaying some 'traits'. Mother stated to the school she was taking him to the GP about her concerns and the school do not have access to confirm if this happened or not. It was noted that mother had head lice and

[3] Recent national guidance and arrangements reinforce the importance of school governors and senior leadership teams (SLT) in promoting a culture where safeguarding is taken seriously and that ultimate responsibility for safeguarding rests with them and is part of their duty of care to their students. The designated safeguarding lead is the person appointed to take lead responsibility for child protection issues in school. The person fulfilling this role must now be a senior member of the school's leadership team, and the DSL role must be set out in the post holder's job description.

that the outside of the property was unkempt; there was no reference to conditions inside the house.

17. In December 2019 the Early Help Service became involved with the family following a referral from the housing landlord service in September 2019 who described the very poor conditions in the home that had prevented scheduled repairs and upgrading work to take place. The assessment by the Early Help Service described the need to clear and clean the property and for the children to have their own bedrooms and beds. The focus of the intervention was on improving the physical condition of the home which included the installation of a cooker and white goods as well as acquiring a Moses basket, beds and bedding. The early help practitioners only saw the downstairs of the property because David's mother said she was too embarrassed about the conditions upstairs. There was no recorded consultation with any of the health professionals or the schools as part of the early help assessment.

18. The police response officers called to the family home on the day David died reported the very poor conditions they found throughout the property in clear and unambiguous language. They described very cluttered and dirty conditions with a lot of soiled debris on carpets. The kitchen units were cluttered. Dog biscuits were all over the floor, which was not clean. It was noted that washing powder was out of reach of children and there were no dirty dishes in the sink. The living room area was very cluttered with furniture from the paternal grandmother's home. Lots of piles of clothing. The room could not be accessed, being very untidy but was the cleanest of the house. The house was very cold.

19. The police report described piles of clothes in different places upstairs and the bathroom was very dirty with toothbrushes on the floor which was covered in excrement as was the toilet (although the social worker visited the house the following day and did not see excrement or toothbrushes on the floor). A bedroom at the back of the house had beds that had been donated which were piled on top of one another and still had the plastic packaging on. Another bedroom where Child 1 slept had a mattress (which had been donated) that was still in plastic covering and was placed on the bed. The main bedroom was very dark as it had fleece over the window. The Moses basket was dirty and cluttered and had not been used that night. There was also a cot by the side of the double bed which had not been used; there was a large TV in it and other objects cluttering the cot. There was an ashtray next to the cot which had overflowed and had cigarette butts on the carpet which was dirty and grubby. The bedding was very dirty. The first responding officer's view was that this room was probably the worst in the house. There was a pervading smell of cannabis in the house although drugs were not found.

20. This account remains the most detailed description of conditions in the home and is the only record of any professional seeing every part of the house.

3 Research and national learning relevant to this review

21. The sudden unexpected death in infancy (SUDI), also referred to as sudden infant death syndrome (SIDS)[4], was relatively common in the 1980s, affecting about 1 in 500 live-born infants. Recognition of the importance of the sleeping position subsequently led to a dramatic fall in the rates of SUDI throughout the world. Currently less than one in every 2,000 babies in the UK dies from SUDI.

22. SUDI remains a leading cause for infant mortality in the UK despite the significant reduction in cases since the 1990s. There are ongoing public health campaigns aimed at promoting safer sleep, as the majority of SUDI cases in the UK occur in unsafe sleep environments, predominantly in families from deprived social and economic backgrounds.

23. National Institute for Health and Care Excellence (NICE) Guidelines for postnatal care[5] recommend that parents should be made aware of the associations between co-sleeping and SUDI and be informed that the risks from co-sleeping may be greater when parents smoke or consume alcohol or drugs, or where babies are born with low birth weight or premature. This reflects the practice shown by midwifery and health visiting services in this case.

24. As the incidence of SUDI has declined with concerted campaigns such as *Back to Sleep* at a local and national level, the association with social deprivation has become more marked. For example, in the Avon region of South West England, during 1984-88, 23 per cent of SUDI occurred in the 10 per cent most deprived communities, whereas by 1999-2003 this had risen to 48 per cent of SUDI cases[6].

25. Factors associated with an increased risk of SUDI;

    a) Unsafe sleeping positions (the baby on the back rather than side or front;

---

[4] When a baby dies suddenly and unexpectedly this is referred to as Sudden Unexpected Death in Infancy (SUDI). Around half of the 600 sudden infant deaths in the UK each year can be explained by a post-mortem examination. Deaths that remain unexplained after that are usually registered as Sudden Infant Death Syndrome (SIDS), for which there is no known cause. The acronym SUDI is problematic for unexplained deaths as it is commonly used for 'unexpected' deaths some of which will be explained.

[5] National Institute for Health and Care Excellence. Addendum to clinical guideline 37, Postnatal Care: Routine postnatal care of women and their babies. UK: National Institute for Health and Care Excellence, 2014.

[6] Blair PS, Sidebotham P, Berry PJ, Evans M, Fleming PJ. Major epidemiological changes in sudden infant death syndrome: A 20-year population-based study in the UK. Lancet. 2006; 367(9507):314-19. https://doi.org/10.1016/S0140-6736 (06)67968-3. [PubMed]

b) Unsafe sleeping environment; (co-sleeping, after alcohol or drugs have been consumed, are a significant risk[7]; overwrapping, soft or second-hand mattresses);
c) Smoking; during pregnancy and environmental exposure;
d) An unsafe sleeping environment with particularly high-risk circumstances being co-sleeping, temperature and overwrapping, bedding and mattresses, keeping head uncovered;
e) Use of alcohol or drugs during pregnancy;
f) Poor antenatal care (late booking and poor engagement)
g) Low birth weight (under 2,500kgs) and pre-term (less than 37 weeks).

26. There is an overlap with other sources of risk such as abuse and neglect which is reflected in this case and the findings of the Child Safeguarding Practice Review Panel's report[8] published as the review was being completed.

27. The neglect of children is the most prevalent form of abuse and also presents the greatest challenge for assessment, intervention and presenting evidence to courts. Children are neglected in very different ways and include failure to:

a) Meet basic physical needs (home conditions were often described as unsuitable for young children; dirty and unhygienic and often cold);
b) Access to appropriate health care (poor starting in prenatal care);
c) Meet emotional needs (little comment));
d) Ensure adequate supervision (evidence that it was not consistent);
e) Provide appropriate cognitive stimulation [9](little recorded evidence).

28. The physical home conditions were very poor although it was not until the account given by the responding police officer in January 2020 that spelt out the conditions that the children were being brought up in. The landlord service had been insisting on improvements to be made to the condition of the property over several months and was the trigger for the referral to Early Help Service in September 2019.

29. Factors that contribute to effective work with families experiencing higher levels of difficulty and adversity include;

---

[7] Blair, P. S., Sidebotham, P., Evason-Coombe, C., Edmonds, M., Heckstall-Smith, E. M., and Fleming, P. (2009). 'Hazardous cosleeping environments and risk factors amenable to change: case-control study of SIDS in south west England'. *BMJ, 339, b3666.*

[8] The Child Safeguarding Practice Review Panel (2020) Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm, London, HMSO. Available from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf [Accessed 30th July 2020]

[9] Horwath. J, 2007 Child Neglect: Identification and Assessment Palgrave Macmillan

a) A dedicated worker; provided through the Early Help Service (EHS) from October 2019;
b) Practical hands-on approach; the EHS from October 2019;
c) A persistent, assertive and challenging approach; less evident although encouragement was being given to improving conditions;
d) Considering the family as a whole; the complex and multiple needs and difficulties facing the family were not formally assessed and the intervention of different services reflected a silo approach;
e) Common purpose and agreed action; there was not a common assessment or multi-agency plan apart from the short child protection plan and CIN in 2014.

30. Adverse childhood experience (ACE) describe things that cause harm during childhood and into adulthood. It includes abuse including neglect, domestic abuse in the household, mental illness and problematic substance abuse of a parent or carer. Experiencing ACEs as well as experiencing hate crime, community violence or not having supportive adults exacerbate longer-lasting damage and as is often referred to as toxic stress.

31. Adults who have experienced significant ACEs in their childhoods are more likely to present with a range of needs and difficulty such as poor learning and employment records, illness and substance abuse and have an influence on how they meet the needs of their children which can bring them into conflict with people and services focussed on safeguarding children. Interventions have to develop responses that can help adults address the impact of an adverse childhood experience and prevent children from suffering harm. This has implications for how assessments of parents and children are completed and for encouraging greater curiosity and routine enquiry by people such as primary health care professionals.

32. The findings of the national panel's review of SUDI identifies the need for local services to recognise a continuum of risk with support and interventions that are differentiated according to the needs of all families; families with additional needs and families such as David's who are at risk of significant harm[10].

3.1 Summary of learning from this local child safeguarding practice review

33. Mother's late booking of her pregnancy for David in the first half of September 2019 followed a pattern of behaviour in previous pregnancies although at 24 weeks was far later than previously and increased risk for mother and her

[10] The Child Safeguarding Practice Review Panel (2020) Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm, London, HMSO, p 8.

baby's health. Other risk factors were also identified at the booking session including a history of anxiety and depression, self-harm, and substance misuse; the history included details of being on a regular Methadone prescription as well as anti-depressant medication. There was no referral to the MAPLAG[11] because David's mother was assessed as a historical intravenous drug user rather than a parent on a recovery programme with significant medication to support this as well as antidepressants; the MAPLAG is focused on current substance misuse. David's mother's very late booking left little time to refer, discuss and develop support to change behaviour or lifestyle before birth.

34. The health visiting service in particular regularly discussed and reinforced safe sleeping advice and guidance which was also provided by the midwifery service in line with expected practice. Most of this advice was given to David's mother during visits to the home when his father was more often absent (or at least his presence is not recorded). The health visitor highlighted concerns about loose blankets and propping the baby in a pram. As with the general clutter and dirt in the home mother appeared unable to internalise and implement improved care practices without regular prompting. Routine reviews such as the health visitor's 6-8 week development check of David's immediate sibling in April 2018 included specific discussion about preventing SUDI and safe sleeping. Mother was again encouraged to ensure no loose blankets and to ensure the baby was on flat surfaces and to avoid co-sleeping. The risks of shaking injuries and weaning advice were also discussed and David's mother was described as listening to and responding positively to the advice. It remains a query in this review whether she could understand, process and implement the advice and guidance. In her discussion with the author of this report, she recalled the advice. There is no record of an analytical discussion with a supervisor or with another professional as to whether the advice and guidance were producing sufficient and sustained change in behaviour when for example in May 2018 the health visitor was yet again providing advice to mother after observing David's sibling propped in a crib and the baby being weaned early. This was repeated in August 2018 when David's nearest sibling was being laid on to the top of a pillow in a Moses basket. The midwife and health visiting professionals did not ask to see the bedrooms and never saw where the children slept. One of the more senior midwives described a historical practice that did ask permission to see bedrooms and bathrooms but it was not current practice.

35. The National Panel's SUDI report refers to evidence from the supporting literature review[12] that identified a variety of reasons why parents do not act

[11] Multi-agency pregnancy liaison and assessment group brings together health and social care to identify pregnant women who have histories of substance misuse and to offer enhanced help and support.

[12] A. Pease, J. Garstang, C. Ellis, D. Watson, P. S. Blair, P. J. Fleming (2020). Systematic literature review report for the National Child Safeguarding Practice Review into the sudden unexpected death of infants (SUDI) in families where the children are considered to be at risk of significant harm. https://research-

upon advice and information; this included disrupted routines such as sleeping at a different property or do not consider the advice to be relevant in all circumstances. The research shows that reliance 'solely on giving information is unlikely to produce meaningful change in this group'. They describe parents who treated the advice as 'a list of options from which to choose the ones most appropriate to their circumstances. The research also cites misplaced maternal protective instinct as a factor; examples included parents justifying co-sleeping as the baby was unwell or they were protecting from intruders; in this case, David's mother described how he had been unwell. The research finds that parents give greater credence to advice and information from a trusted source such as a partner or peer or family member rather than a professional. They also identify that parents do not respond to advice that is couched as a list of do's and don'ts or they perceive to be condescending and lecturing in tone.

36. Thirteen-year-old Child 1's school attendance was poor (at times as low as 68 per cent). As with health services, efforts to engage the parents produced little result; planned appointments, for example, to discuss the rate of unauthorised absences were not kept. It was at Child 2's school that teaching and support staff were able to observe evidence of possible neglect; this included at least one of the children regularly being hungry and the children appearing to be small or thin. The schools provided practical assistance such as a coat to Child 1 and Child 2's school donated a food hamper one Christmas. Child 1's school was not aware of the Early Help Service being involved with the family until the 18th December 2019.

37. Schools are an important opportunity for providing support and resilience for children. They can also provide early notice of concerns. For example, in January 2019 five-year-old Child 2 attended school nurse's health screening at primary school. The teaching staff raised concerns about the child's small stature and whether Child 2 was underweight. The school thought there was not a lot of food in Child 2's home. The school nurses confirmed that the child was within range for height and weight although was 'towards the lower end'. The school nurse noted that there was a history of missed health appointments when the child was not brought to appointments. It was one of the few occasions when there was a record of the child's voice being sought by describing Child 2's behaviour and presentation during the appointment (becoming distressed during an eye examination for example).

38. There was a limited discussion between people from the services about the family and their home. Evidence of neglect was noted by various visitors to the home and the respective schools saw evidence sometimes in the appearance of the children. The neglect toolkit was not used to help collate and inform

information.bris.ac.uk/en/publications/systematic-literature-review-report-for-the-national-child-safegu

professionals' judgments. There could have been more curiosity across all services.

39. The two older siblings were asked for their views by people doing assessments such as the Early Help Service. CSC recorded that the children were allowed to express concerns but did not. Their absence of response was not explored at the time. Children who grow up with severe neglect have lower self-esteem, often feel isolated and different from their peers. There is little direct reporting of the children's lived experience including where they slept, were bathed and ate. Visits to the home that records the very poor physical conditions do not make any reference to how the children were affected; the poor hygiene would have been hazardous to their health and relationships with others. There is virtually no reference to how the children presented and for example the condition and suitability of their clothing. The first health visitor home visit in December 2019 following David's birth was when mother disclosed that she and David's father had separated and the house was described as very cold, extremely untidy, dirty, the kitchen full of boxes, pots of food and clothes and a back room had three beds stacked. In all of this chaos safe sleeping practice was discussed but no inquiry about where the three older children were and no attempt to see what the upstairs of the property looked like.

40. The assessment did not have any input from other services which included the substance misuse services and the schools (who had responded to evidence of neglect). None of the people who visited the home saw the home beyond the public space of the cluttered, crowded and often cold front room. This meant that the chaotic sleeping arrangements and insanitary conditions described by the police on the day of David's death could not have been discovered by any other person before that date.

41. The involvement of the Early Help Service which was several weeks after the referral achieved some initial improvement to the physical cleanliness of the ground floor of the home but these improvements were not sustained over Christmas and New Year. There was no discussion or reflection about this with other people and services. The early help workers did not discuss unsafe sleeping unlike the health visitor and midwifery services; it is recognised as an area for development. The circumstances and reasons for the parents struggling with maintaining improvements were not explored. A multi-agency meeting following the completion of the Early Help Service assessment in December 2019 was planned but had not happened before David died a month later.

42. The parents had contact with specialist substance misuse services. David's mother had regular poly-prescriptions for medication to help with her mental health and substance misuse recovery. Regular medication included Amitriptyline, Diazepam and Methadone which could have had a sedative effect on her and which was a symptom observed by some of the people who visited the house and whilst she was at the hospital. There is no evidence that

this was discussed by the GP who would have been aware that there were dependent children or raised by any of the people or organisations working with her and the family particularly within the context of safe sleeping. There is no evidence that the medication was discussed with the health visitor or featured in any assessments by the substance misuse service or the Early Help Service. There was not a routine and regular review of medication and there was no review when specific events or information should have prompted a review; this included the pregnancies and when for example the information was sent through about mother being drowsy whilst feeding Child 3 at the hospital shortly after the birth. The advice from the Faculty of Pain Medicine is to keep all opiate prescriptions to acute rather than repeat prescription[13].

43. The parents' regular drug testing by the substance misuse service did not include checking for cannabis; it is not a routine screening and the use of cannabis was not reported to the service. Father continued to test positive for heroin and opiate use from time to time (August 2017, December 2017 when he was warned about his non-attendance). They both missed appointments and had difficulty engaging with substance misuse practitioners. In April 2018 the substance misuse service suspended prescribing for the father due to his missing appointments. Before his suspension from the service, he had again tested positive for heroin and other drugs. Mother had been discussing her concerns about his mental health in her sessions with her substance misuse practitioners. In February 2019 father attended a prescribing review where he admitted using heroin having fallen out of treatment. He acknowledged he had children but had no social work involvement. There was no safeguarding discussion within the service or contact with any other service. When in April 2019 father admitted to smoking heroin weekly and tested positive for opiates, cocaine, benzodiazepines as well as methadone there was no record of enquiry about the safety of the children or where they were when he was using drugs. He presented with similar information in August 2019 and again there was no safeguarding analysis or referral. In October 2019 father confirmed that he was using heroin and tested positive for opiates. He discussed the pregnancy and although a safeguarding risk assessment was completed it concluded that there were no concerns. There was limited analysis recorded to support the judgment. Less than a month later mother went into labour leaving the children in the father's care.

---

[13] This is in order to encourage the regular review of such drugs. Whilst, in this case, the Practice did prescribe Methadone acutely in each case, the absence of any medication review during the period of this review meant that this medication was effectively on "repeat". https://www.fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/long-term-prescribing". Practitioners working in opiate substitution treatment (OPT) work to guidelines published by the National Institute for Clinical Excellence (NICE) that has an expectation that OPT prescribed for dependence rather than pain control should be on repeat prescription but with regular review. https://www.nice.org.uk/guidance/health-protection/drug-misuse

3.2 Assessment of systemic or underlying reasons for what happened

44. Significant influences include:

a) **Safe sleeping is an issue for services broader than health visiting and midwifery;** the prescribing to new and prospective parents of medication that can have a sedative effect has implications for prescribing and monitoring practice by GP and substance misuse recovery services; the early help assessment did not include any specific sections about sleeping arrangements or general living conditions and is being updated; recognising the danger of co-sleeping has implications for any services visiting homes with infants under six months old; this would include any of the emergency services who may visit in response to calls for service or providing safety inspections such as the Fire and Rescue Service for smoke alarms or landlord services undertaking routine repairs or maintain; the police have committed to circulating guidance to frontline officers in general, to be observant around evidence of co-sleeping when attending any incident within a home setting; the health visiting service has given a similar undertaking that they will encourage health visitors to routinely ask to see where the baby is going to sleep both upstairs and downstairs, and this is to prompt discussion about safer sleep at the antenatal visit and to ensure parents are fully informed as to some of the safety issues of where cots are placed etc; additional recommendations are made to the landlord and ambulance service.

b) **The value of providing timely early intensive help**; mother experienced Early Help as increasing her stress; she felt bombarded by furniture and food parcels that did not help with the stressors in her life; although well-meaning there was little understanding for example about the recent trauma's such as family bereavement; more relationship-based help that took time to understand the family's circumstances would have helped from an earlier stage; uncertainty about when to make a referral to Early Help Services was an influential factor in a referral not being made before September 2019; although two workers were allocated to work with the family the Early Help Service operates with heavy caseloads (25 cases per worker) which prevents intensive levels of contact and help; intervention is likely to be more effective through a service that can allocate a dedicated worker offering consistent relationship-based hands-on and practical help informed by a well-informed assessment and offers a persistent and assertive approach, considers the whole family and brings common purpose and action;

c) **Using chronologies and enquiring into relevant history**; the absence of a good enough chronology of their contact with the family made detecting patterns and cumulative indicators more difficult to identify; the information about three incidents of skull injury was not collated before the review; parents who have experienced trauma or instability or abuse in their childhood are likely to display difficulties in how they respond to and understand the needs of their children; this can manifest itself in many ways including disorganised parenting, putting their own needs before that of their children, emotional unavailability;

d) **Professionals developing and using focussed and respectful curiosity**; except for the police, none of the professionals felt able to ask to see the upstairs of the property and therefore see where the children were bathed and slept; the condition of the exterior areas to the house did not provoke curiosity about the conditions in the 'non-public areas of the house; the early help worker asked to see the upstairs of the property and did not press the issue when mother expressed embarrassment about what would be found; safeguarding concerns that the health visitor identified in the home visit just before Christmas 2019 were discussed with the Early Help Service (EHS); although EHS is part of social care it is not the statutory child care service.

e) **Computer-generated prescriptions for controlled drugs** which have become normal prescribing practice makes the actual process of prescribing opioids much easier and opioids may be entered onto repeat prescribing systems; this practice is discouraged in guidance to GPs prescribing pain relief although for opiate substitution NICE endorse the practice with the caveat of routine review[14]. In general, stronger opioids should not be added to the repeat prescribing system but should be generated as acute prescriptions. These acute prescriptions should be regularly reviewed, the frequency depending upon the medication prescribed and the patient's circumstances;

f) **Using language that reveals vivid pictures of risk and neglect;** the police officer's description of the house on the day of David's death gives the clearest account of what could be seen; it was also the only account of the conditions in the bedroom and bathroom; other professionals used more subjective and jargonistic language such as 'cluttered but hygienic', 'poor decorative order', 'dirty and unkempt', 'suitable for family use'. Even where the more subjective descriptions resulted in a conclusion that the conditions were suitable for a particular

[14] https://www.fpm.ac.uk/opioids-aware-structured-approach-opioid-prescribing/long-term-prescribing

child there was a reference to a carpet being 'very dirty old and worn' and walls that were 'dirty. Describing excrement on a floor with toothbrushes is much more vivid than describing unhygienic conditions; a clear statement is more useful for assessments and if necessary as statements of evidence if, for example, Family Court proceedings become necessary.

g) **Neglect in areas of high deprivation**; several professionals described how none of the children attracted concern within a local context of high levels of economic and social deprivation; for example, the schools are grappling with a local structural problem of poor school attendance and attainment and have leadership teams working to address this; neglect is not the same as poverty although both have a harmful and corrosive effect on children; a limited understanding about what neglect is and how it harms children beyond the physical conditions that they are growing up with; the children were more often than not in clean clothing (and confirmed in the police officer's description of the home on the day of David's death) contributing to optimistic judgments about conditions; the Early Help Service completed a limited assessment as part of their involvement although was focussed on practical issues without enough attention to history and did not use tools and scales to help analyse information that was highly indicative of neglect; this meant that the cumulative patterns of behaviour were not brought out more clearly; the assessment template did not include any information about the presentation of the children when they were in the home or about how the conditions of the home had an impact on their daily lives and longer-term well-being;

h) **Use of tool kits and evidence-based frameworks** to guide and inform the collation and analysis of information about neglect; the neglect tool kit is a relatively recent development; professionals who have used the neglect tool kit are positive and can see the benefit of using a framework and language that education, health and social care professionals can understand; it is not yet in common use; when for example children are presenting with faltering or poor growth or development especially when referrals are made to GPs and paediatric clinics there should be active consideration of potential neglect; this means making sure referral include relevant information and the use of the relevant toolkits are encouraged; the national panel's report describes toolkits developed in areas focussed on safe sleeping[15];

[15] https://www.nottinghamshire.gov.uk/media/1494648/safer-sleeping-risk-assessment-tool.pdf Accessed 31st July 2020

i) **Ensuring primary care services have effective arrangements to identify and respond to neglect**; GPs need to have safeguarding awareness and knowledge and systems in place when reading relevant notifications from services such as the Recovery Team and hospital as well as information about statutory assessments; information about the family was not easy to access; ensuring that safeguarding meetings[16] are meeting in line with professional standards and included health visiting midwifery service; that the meetings are used to identify children or parents who may have higher levels of concern; in this case that includes information about the parents not attending the recovery service; disclosures about low mood; disclosures about ongoing drug misuse at the recovery service; the persistent history of children not being brought to appointments; the delay in seeking assessment and treatment for the eye squint;

j) **The scope of MAPLAG**[17]; recently established in Wakefield the MAPLAG provides an opportunity for early identification of pregnant women who disclose drug or alcohol misuse and to share information about risk and make timely referrals; this mother did not come within the scope of the criteria although was a substance misuser who was in a recovery programme with significant levels of medication and struggling with engagement; the history of late booking of pregnancies, poor engagement with antenatal services during pregnancies, the delivery of pre-term babies coupled with the history of substance misuse and low mood were all factors that could have prompted a multi-agency discussion;

k) **Silo working**; the children were not seen as in need or needing protection; there was no single incident of significant harm; this meant that people and services generally worked in isolation. The Practice safeguarding meeting would have provided an opportunity for a discussion of the concerns about the family, but none of the attendees (GP, health visitor, or midwife) brought this family up at these meetings. This would have helped develop a better understanding of what was happening in the family and perhaps prompted a referral. The suspension

[16] Monthly dedicated GP safeguarding meetings throughout the year should include a GP who is the safeguarding lead for the practice (or their deputy), the link health visitor and midwife. The meeting should not be restricted to children subject of a child protection plan but an opportunity to review patients about whom there are concerns (or family member concerns). This can be further informed by interrogation of the Practice IT system. Good practice would place a record of any discussion on all relevant patient records, especially siblings, with an entry in each one's Safeguarding Node for a health professional to read during a patient consultation.

[17] Multi-Agency Pregnancy Liaison & Assessment Group: all women disclosing drug or alcohol misuse in pregnancy are discussed at the MAPLAG meeting.

from substance misuse service, particularly when the service had evidence that the father was regularly using street drugs and was coping with poor mental health had implications for any dependent children as well as for his health and well-being. There was a lack of curiosity about where the father was getting supplies of drugs from and the implications for finances as well as his health.

l) **Hidden men in the lives of children**; David's father was largely absent from contact with the early help, health visiting and midwifery services; very little information is recorded about him in any agency information for the review and when mother described feeling tired and being up all night with babies there is no record of probing what role the father was playing in the care of the children or sources of support for example from within the extended family. When the parents talked about separation there was no enquiry about the circumstances or the impact on the children. A male who was referred to as 'uncle' collected children from school, answered the door of the family home and was seen in the house by several different people; mother explained to the author of this report that this person was an uncle who had provided important support but this was not known by professionals at the time; the early help service was the only service to seek checks about this man who is a birth relative on the maternal side and has provided care and support for mother over many years; apart from the implications for safeguarding practice, this important source of support for mother deserved better understanding and attention;

m) Several services were experiencing **recruitment and retention difficulties**; the early help and HUB arrangements have been through more than one iteration which caused confusion and uncertain working arrangements for some local services; practitioners reported that arrangements were more secure now with clear information provided to local professionals about how for example to access early help through the local HUBS.

3.3 Recommended improvements to be made to safeguard or promote the welfare of children

I. The Wakefield and District Safeguarding Partnership and the Wakefield Health and Wellbeing Board should develop a public information strategy that promotes safe sleeping for children under six months.

II. The Wakefield and District Safeguarding Children Partnership should publish and promote a safe sleeping guide for professionals and

parents that summarises the factors that can increase the risk of sudden infant death and encourages contact with early help services. The guide should include a checklist for professionals including what to do if they observe evidence of unsafe sleeping arrangements.

III. A copy of the guidance should be sent to the chief officers of statutory services and encourage those services to guide their workforce in particular about paying attention to evidence of unsafe sleeping arrangements for non-mobile infants and the action expected to prevent the risk from persisting. Particular attention should be given to the emergency services, housing or tenancy services and anti-social behaviour services understanding the potentially important contribution they can make in preventing sudden unexpected infant deaths. The Fire and Rescue Service should include a standard check for evidence of unsafe sleeping arrangements when attending domestic properties including fire safety checks.

IV. The Director of Children's Services should review and provide a report to the Wakefield and District Safeguarding Children Partnership about the capacity of Early Help Services to provide the appropriate level of intensive support for children and families with higher levels of complex need and vulnerability.

V. The substance misuse service should provide targeted lessons learnt for substance abuse practitioners; this should incorporate learning from internal reviews including arrangements and outcomes of audit and training, supervision and oversight of case recording and use of adult and child safeguarding protocols.

VI. The CCG should ensure learning is disseminated to all GP practices; this should include the GP practice having robust arrangements in place for reading and making decisions in response to information and notifications coming into the practice; that GP practices regularly and routinely interrogate their IT systems for safeguarding risk factors to identify children or families whose circumstances indicate potential vulnerability or need for discussion at the practice MDT meetings; discourages routine repeat prescriptions of opiate-based medication and promotes active reviewing of medication when women are pregnant and following birth.

VII. Targeted lessons learnt should be provided to schools to include the importance of pupil file transfers when moving schools, the use of the neglect toolkit and oversight by designated safeguarding leads in schools; recording systems that ensure the recording of information, supervisory direction and completion of action; home visits made by school staff and the opportunities to use the neglect toolkit; understanding and use of the early help pathway; understanding and responding to neglect in areas of high deprivation.

VIII. The Early Help Service should ensure that the assessments are robust and timely and include information from all involved services, such as schools, GPs, other health professionals including substance misuse

services. Subsequent interventions with families should be based upon a thorough understanding of the circumstances for the children.

IX. Early Help Assessments and plans should include specific reference to safe sleeping arrangements and incorporate the use of the neglect toolkit.

X. The MASH should ensure that the use of the neglect toolkit is being used within referrals to the service and promote its use in contacts and discussions about referrals.

XI. The criteria for MAPLAG should be reviewed giving consideration to including pregnant women who are in recovery from substance misuse; priority should be given to women who are co-presenting with symptoms of low mood or mental health difficulties and/or are showing evidence of disengagement.

The methodology and terms of reference

Agencies provided a chronology.

A virtual learning event involved people from the services involved although many of the practitioners who directly involved in the events since 2017 were not available. The independent reviewer also had individual discussions and had access to copies of assessments and records of meetings (where they were available) and the child protection conference. The review considered the impact of the following areas of multi-agency practice in the case to inform learning and future practice.

The review considered the impact of the following areas of multi-agency practice in the case to inform learning and future practice:

i. Awareness of reducing SUDIC and overlaying risk.

ii. The scope and organisation of enquiries and assessments, (including pre-birth) and the extent to which they gathered sufficient information from relevant sources and about the risk to the children and provided analysis and how this contributed to an understanding of neglect or other abuse.

iii. Information sharing between agencies and the use of chronologies and awareness of history in decision making about need and risk.

iv. Challenge or escalation when concerns were referred to children's social care resulting in No Further Action.

v. Understanding of the lived experience of all of the children including how the voice of the older child (D) was sought and taken into account.

vi. Recognition of the ongoing domestic abuse and violence within the household and its impact on the children and the evidence of substance abuse.

vii. Different presentations of neglect and emotional abuse.

viii. The impact of adverse childhood experience (ACE) on the adults and the impact on their parenting. Consideration of how this impacted each of the children.

ix. Understanding and responding to the emotional wellbeing of David's mother.

x. The impact of working with hard to engage parents on safeguarding children, including hostility, non-compliance and disguised compliance.

Details of the independent author

Peter Maddocks has worked as a practitioner and senior manager in local authority services and national inspection services in England and Wales and with the non-statutory sectors. He has led or contributed to several service reviews and statutory inspections about safeguarding children. He has not been employed by any of the services contributing to this serious case review.