Wakefield Safeguarding Children Partnership

A local child safeguarding practice review (LCSPR) commissioned under

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

‘Jason’

The Overview Report

May 2021

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1 Introduction and context

1.1 Purpose and circumstances of the review

1. This review was commissioned following the tragic death of three-month-old Jason in August 2019. It examines the involvement of ten organisations from 1st February 2017 until Jason's death. Jason had already died when his 29-year-old mother contacted the emergency services and he was taken by ambulance to the hospital. A subsequent skeletal survey found no injuries over and above the evidence of attempted resuscitation. Jason had been co-sleeping with a sibling (Child 2) and his mother. The eldest sibling (Child 1) was not with the mother or the two younger children and has lived with the paternal grandparents since May 2019. Jason's 37-year-old father was already remanded to prison at the time of Jason's death for an offence of grievous bodily harm (GBH) with intent. The family live in an area of high deprivation[1]. Jason's parents are white British and English is their language of communication. Father was employed before going to prison. His job involved working away from home for most weekdays and nights. There is no record of any faith-based affiliation for either parent.

2. For clarity, the use of acronyms is kept to a minimum. Jason is the name used for the child whose tragic death is the subject of the review. Child 2 is a 19-month-old full sibling and 10-year-old Child 1 is a half-sibling with a different father. Any birth family members are referred to by their relationship to Jason as mother, father or grandparent for example. Professionals are referred to by their job titles or role such as GP, health visitor, police officer, probation officer, social worker or teacher.

1.2 Agencies who provided information to the review

3. The following agencies have provided information including agency learning and contributed to a virtual learning event for the LCSPR:

   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); statutory children's assessments
   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] 94.4 per cent of post codes in England are less deprived. ONS Postcode Database http://geoportal.statistics.gov.uk/

e) Primary school (unnamed to preserve the anonymity of Jason and his family);
f) South West Yorkshire Partnership Foundation Trust; offered access to mental health services;
g) West Yorkshire Police; involvement over several years about allegations of anti-social and violent behaviour, repeat offending, substance misuse, sexual abuse,
h) West Yorkshire Community Rehabilitation Company Ltd; supervised father following his conviction for a drink driving offence in 2018 and was imprisoned in summer 2019 following a violent assault
i) Yorkshire Ambulance Service who also provide the NHS 111 service as well as emergency services; had contact in February 2018 about mental health concerns when the response crew made a safeguarding referral about the children; attended a road traffic accident in 2018 when father was convicted of drunk driving and in January 2019 were called when the mother was assaulted by a member of the extended family.

1.3 Family contribution to the review

4. The parents were advised about the review and invited to provide information. The mother made no response. Father asked for a meeting with the report author at the prison but declined to have a discussion when the author visited him.

5. The parents were advised the review was due to be completed and have received copies of the final report ahead of publishing. Both parents chose not to provide any comment.

2 Overview of information

6. The family had contact with universal and specialist services over several years dating back to the childhood of both parents when both had been looked after in local authority care at different times. Both parents had adverse childhoods although much less information is recorded about the father. Jason's mother has presented with evidence of self-harm (cutting and overdoses), low mood and domestic abuse. She experienced traumatic experiences in her childhood and was the subject of a child protection plan as well as being looked after for several years. She experienced several disrupted placements in residential and foster care. Mother has difficulty in regulating her emotions and can be very aggressive and volatile; this occurred for example at GP surgeries, with housing officers and social workers as well as in the general community. She struggled at times with understanding and responding to the needs of Child 1 her eldest child. An example is the mother's insistence that Child 1 had ADHC (attention deficit hyperactivity disorder) and poor behaviour despite the school not observing any evidence of ADHC or particularly problematic behaviour compared to peers. Both parents used alcohol and drugs which aggravated and

contributed to incidents of significant antisocial and violent behaviour. Child 1 was subject to a child protection plan (CPP) between December 2008 and February 2010 due to concerns about emotional abuse. The case was closed to social work involvement when the CPP ended although very soon afterwards Child 1 was injured and there had been verbal and physical confrontations between mother and Child 1's father. There was a social worker assessment and the case was closed. In the summer of 2013 Child 1's school attendance was poor; this has remained a factor up to 2019 when Child 1 moved to the grandparents. There was the third assessment in 2015 and the Early Help Service were involved for a short time. In June 2015 mother received hospital treatment following an overdose. Following a short Child in Need (CIN) plan social work involvement was closed in 2015.

7. Child 1 became the subject of a further CIN (child in need) plan in March 2017 following a referral from the police in respect of domestic abuse and an assessment was completed by Children's Social Care (CSC) who closed their involvement when the assessment was finished and the CIN plan was stepped down to the Early Help Service through the HUB. The closure and stepping down was not discussed with other services.

8. In early February 2018, the school made a home visit; this was not the first and the school was regularly in contact with the mother and visiting the home in an effort for example to improve Child 1's attendance at school. The mother reported difficulties with managing Child 1's behaviour and persisted in her assertion that Child 1 had ADHD despite the school not seeing evidence of this in behaviour at school. From their contact with Child 1 and mother, the school had a range of information about the family's circumstances; mother was receiving anti-depressant medication through the GP and she acknowledged low mood; she also disclosed information that Child 1 was being used as a carer in the family for Child 2 and which was probably a contributory factor in Child 1's poor level of school attendance.

9. Less than a week after the home visit Child 1 told the school that she was worried that her mother might have self-harmed. The school visited the home and spoke with the mother who acknowledged having thoughts of self-harm but had no plans to do so. The mother described Child 1's behaviour at home as being a significant stressor. When Child 1 did not come to school the following day the school visited the home but could get no answer and therefore involved the police who gained entry to the property. They found drugs during their search for the mother and the children who were not in the house. Subsequent contact by phone established that the mother and the children were at the maternal grandmother's home. The only service to make a referral relating to the incident was the ambulance service who had been called to attend in anticipation of the police entry into the family home. None of the services requested a strategy meeting although CSC completed an assessment. The assessment was an opportunity to make enquiries with other services and to collate relevant history as well as the more recent concerns.

This did not occur and is discussed later in the report. A combination of physical standards not causing concern, mother's lack of engagement and insufficient attention to the lived experiences of the respective children were significant factors in professionals not recognising the level of neglect. The assessment recorded Child 1's school attendance as good when it was a persistent concern.

10. The YAS made a second referral in April 2018 when they attended a road traffic accident (RTA) after the father had collided with another vehicle and tested positive when breathalysed. Mother and the children were in the vehicle with him. They had not been in any approved child restraint seating. The police did not make a referral. There were other incidents when for example father had assaulted a taxi driver in February 2018 and reports of drug dealing from the house were not reported.

11. In May 2018 the police received the first of what would be several further contacts from the local community reporting concerns about drug use and supply from the house. There were also complaints of intimidating text messages with a threat to harm from mother against people making complaints. Those contacts which did not result in any police checks as to where children were in the household did not result in any discussion in or referral to the MASH.

12. In May 2018 father began his 12-month community supervision order. There was contact from the probation officer to the social worker at the outset of the supervision; this included advising the social worker about planned work on binge drinking which was seen as a factor in his offending behaviour (having been convicted of drink-related motoring offence) and 1.1 work on the impact of domestic abuse on partner and children. The supervising officer identified from the first session that the father's relationship with Jason's mother and with previous partners had been characterised by domestic abuse. Father claimed he did not use drugs and that he had managed to move from being alcohol dependant to controlled drinking. Information was exchanged with CSC after the first session which ensured that CSC was aware of the court directed work and for CSC to inform the supervising officer that the children were known to CSC but were not subject to a child protection plan. There is no recorded evidence that the safeguarding concerns identified as part of the offender assessment were discussed with CSC and considered alongside their long history of contact with both parents and the children.

13. The police sent a copy of a DASH[2] risk screening to the MASH[3] in June 2018 after they responded to a report of the parents being intoxicated and fighting at the family home. This was triggered by an argument about how to handle the baby (Child 2). The DASH provided little detail about the incident.

[2] Domestic abuse, stalking and harassment (DASH) risk identification and assessment tool
[3] Multi-agency safeguarding hub (MASH)

Significantly, within the context of a review following the sudden death of an infant, the mother was asleep when the police arrived and could not be roused and the baby Child 2 was asleep on the bed beside her. Child 1 was worried that her parents would not wake during the night when the baby needed feeding. As discussed later in the report the use of substances and co-sleeping presented a very significant risk of harm to infants under six months; there was also evidence of potential emotional and physical harm to all the children as well as neglect. There was no strategy discussion requested by any of the services. There was a CIN meeting although the records do not confirm who participated. The police would not have been in attendance nor the GP; both of these services had significant and relevant information that should have informed a discussion about need and risk. The meeting resulted in a written agreement with the parents that they would not drink when the children were present and there would be no domestic abuse. The reliance on such a written agreement without any substantial exploration and understanding about what was driving the behaviours and concerns was ill-advised.

14. The police were still responding to incidents of aggression in the community. For example, in August 2018 there were reports from members of the public observing the parents having a violent confrontation outside a supermarket and a relative also raised concerns about another incident. Some of this information was treated as intelligence rather than being recognised as potential safeguarding concerns that should have been processed through the police safeguarding team and the MASH. The school also saw the father collect Child 1 from school when smelling of drink and the mother was also observed to be intoxicated when she was pregnant. This did not result in any follow-up action at the time.

15. Although a follow-up CIN meeting was told that Child 1's attendance at school was 89 per cent, was working below expected age and ability levels and was displaying difficulties in concentrating and seeking attention, CSC planned to appropriately step down to universal services.

16. The mother continued consulting the GP about her low mood and was regularly seeking to have her medication of Tramadol increased. The GP made a referral to the IHBTT[4] in late summer 2018; the referral was declined by the service because the mother's symptoms did not meet the levels of concern and need for a service intended to respond to patients with evidence of developing more severe mental illness.

[4] The intensive home based treatment team (IHBTT) provides assessment and treatment to adults who are experiencing the onset of, or relapse of severe mental distress. The service provides a gatekeeping role to inpatient services, signposting people to appropriate services, facilitating and coordinating admission to hospital where necessary.

17. In late September 2018 mother was admitted to the hospital via the ambulance service with severe abdominal pain. She admitted drinking heavily and had been looking after the children on her own. The ambulance service described the house as smelling of cannabis. No referral was raised by the ambulance service or by the hospital. The information was sent to the GP but there was no discussion at a GP practice safeguarding meeting[5]. The use of alcohol and cannabis with the prescribed medication including Tramadol and sole care of the children had safeguarding implications including safe sleeping. It is a significant point of learning given that at about the same time CSC believed that the mother was complying with her agreement to not be drinking while the children were with her.

18. In the first half of October 2018, there were two incidents when the parents displayed very extreme levels of verbal aggression to housing staff who were showing a property for the family to rent (the family were living in temporary accommodation). Mother, in particular, showed very little self-restraint and they continued arguing with each other outside the property. Although the incidents were reported as abuse of housing staff there was no discussion within the housing service or with the MASH about the potential safeguarding issues given the uncontrolled behaviour being witnessed by a child. Around the same time, the police had been called to deal with an argument at the family home and although a DASH was completed it provided little detail and there was no discussion in MASH to consider the pattern of call outs and other concerns about the family.

19. The health visitor also reported that the mother was very frantic and aggressive in her speech during a home visit in late October 2018. There was no discussion with the GP practice about whether for example the behaviour was a symptom of psychological or psychiatric distress or related to the use of substances; the health visitor along with other health professionals did not have anything like a complete picture of the substance misuse. The health visitor contacted CSC to speak with the social worker although it was not for another two weeks in mid-November 2018 that the social worker and health visitor were able to speak by phone. The case was closed to CSC in October 2018.

20. The midwife booking in early November 2018 with Jason's pregnancy included a discussion about the maternal family's history of mental health and anxiety. None of that history was disclosed or explored in assessments by CSC and was

[5] 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 patient IT system. Good practice would place a record of any discussion on the patient record for a health professional to read during a patient consultation.

not referred to in the referral to CSC that was made for a pre-birth assessment for example.

21. In November 2018 there were several anonymous referrals to CSC from people in the community who knew the family. The referrals described concerns about physical assaults on Child 1, use and supply of drugs from the family home and anti-social behaviour. There was not a strategy discussion to discuss any of the referrals which represented allegations of criminal and safeguarding concerns. A social worker discussed concerns with the mother who interpreted them as the malicious gossip of an ex-friend who would subsequently report being the target of the mother's concerted and abusive texting. The mother, in turn, made a complaint to the police that the person was harassing her. Case recording by the social worker in December 2018 described the allegations made against the mother as malicious and the Early Help Service was asked to provide support.

22. An assessment, the third since 2017 and the sixth since CSC had first become involved with any of the children in 2009, again relied on the parents agreeing not to use alcohol when with the children and that there would be no domestic abuse. There was little evidence of direct or indirect input of information or analysis by any other professional outside of CSC.

23. The closing summary included significant inaccuracies; it asserted that there were no health concerns although there was a recent history of Child 2 needing hospital assessment and treatment and the mother had enduring mental health needs of low mood and were prone to thoughts of self-harm. There was no mention of Child 1's school attendance or attainment and interaction at school. Child 2 was described as 'not presenting with any emotional or behavioural issues because of their young age'. The parents were described as accessing community resources. It was an optimistic description that was not based on accurate and verified information but reflected what the mother was describing.

24. In February 2019 the midwifery service requested a pre-birth assessment which was declined by CSC at the beginning of March 2019. The referral was a one-sentence request for the pre-birth assessment.

25. In late March 2019, the midwifery and GP services were told in a letter about the outcome of a single point of access (SPA) referral to the mental health service. The letter described the mother's disclosures about trauma in her childhood that included physical and emotional abuse by her parents and been removed from their care at the age of ten. She reported having multiple placements including residential homes. With the benefit of hindsight offered by this review, some discrepancies are highlighted about the mother's ability to respond to the needs of her children. During this SPA assessment, she cited her children as protective factors yet one of her increasing stressors had been identified as her daughter Child 1 and her reported ability to 'press mother's

buttons to initiate a reaction. The information was not discussed at a GP safeguarding meeting and CSC was not aware of the consultation or the disclosures until much later. A follow-up session with the psychologist identified increasing stressors in the mother's life and that she wished to have support. This was not followed up in letters to the GP or the MASH.

26. It was not until an initial child protection conference in June 2019 discussed information from the services participating in this review that the full picture of what life was like for any of the children began to be understood more completely. The quoting of an individual professional or from recorded minutes is not a practice encouraged in a review such as this. However, in this case, the words of the chair of the conference in the record of the ICPC that summarised what had happened at that meeting deserve including:

"*It has become clear at the meeting today based on all information shared that there are multiple issues which may be impacting on mother (sic) and father's (sic) ability to parent their children safely and meet their needs appropriately long term. We have heard extensive evidence of substance and alcohol misuse, domestic violence, parental mental health issues, criminal and anti-social behaviours and chaotic family functioning. It is extremely worrying that despite the level of social work involvement over the years that all of this information was only learned by professionals involved today at the conference. Although it was a single incident criminal allegation that led to the conference today, professionals must not be side-tracked and realise that there a multitude of issues which expose all three children to a combination of risks. Alongside police history about both parents, Child 1's (sic) presentation, poor school attendance and the missed health appointments have been discussed as well as the history of disguised compliance from mother who has historically used lots of different ways to detract professionals involved from the issues that are impacting on parenting capacity and causing a risk of harm to her children. Such tactics include numerous complaints about professionals and requests for changes of professionals being upheld. It is extremely important that this is considered in future assessment and planning and the children's needs always remain the priority and the focus of assessment and intervention".*

27. Even at this initial child protection conference and for several weeks after there were people who still did not share the level of concern expressed in the summary of the conference chair. Jason and Child 2 were made the subject of a child protection plan because of neglect in the face of opposition from some professionals who later challenged it without success.

Research and national learning relevant to the review

28. The sudden unexpected death of an infant (SUDI) which is also referred to as sudden infant death syndrome (SIDS) was relatively common in the 1980s, affecting about 1 in 500 live-born infants. Recognition of the importance of the infant's safe sleeping position led to a dramatic fall in the rates of SUDI

throughout the world. Presently, less than one in every 2,000 babies in the UK dies from SUDI. Almost nine out of ten (88 per cent) SUDI deaths happen when the baby is six months or less[6]. Of the babies who die whilst sharing a bed with an adult, 90 per cent died in hazardous sleeping conditions. There is an adult who has recently consumed alcohol, they or a partner smoke, have taken drugs that cause drowsiness and/or the baby was a premature birth or weighed less than 2.5kgs at birth[7]. These are factors present in this case. SUDI is still a leading cause for infant mortality in the UK despite the significant reduction in cases since the 1990s.

29. The National Institute for Health and Care Excellence (NICE) Guidelines for postnatal care[8] 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.

30. As the incidence of SUDI has declined the association with social deprivation has become more marked. For example, in Avon in 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[9].

31. Factors associated with an increased risk of SUDI;

    a) Co-sleeping after alcohol or drugs have been consumed are a significant risk[10]; was observed and recorded by the police although sleeping arrangements were not seen by most services;
    b) Unsafe sleeping positions (prone or side);
    c) Smoking; both parents smoked;

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[6] https://www.lullabytrust.org.uk/safer-sleep-advice/what-is-sids

[7] Safer Sleep: saving babies lives a guide for professionals https://www.lullabytrust.org.uk/wp-content/uploads/Safer-sleep-saving-lives-a-guide-for-professionals-web.pdf

[8] 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.

[9] 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]

[10] 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.*

d) An unsafe sleeping environment with particularly high-risk circumstances being co-sleeping, temperature and overwrapping, loose bedding and mattresses, keeping head covered; not commented upon;
e) Use of alcohol or drugs during pregnancy; mother denied but was using alcohol and drugs;
f) Poor ante-natal care.

32. 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[11] published as the review was being completed.

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

a) A dedicated worker who can build a relationship; this was not achieved in this case;
b) Practical hands-on approach; offered through the Early Help Service as a step down from social work involvement that did not recognise the level of neglect;
c) A persistent, assertive and challenging approach; was not achieved and when there were some attempts mother was able to block it;
d) Considering the family's circumstances as a whole; not achieved in this case;
e) Common purpose and agreed action; was not achieved in this case; the ICPC in June 2019 was the first occasion when a multi-agency discussion of all services took place but still did not reflect a common purpose until some weeks later.

34. Adverse childhood experiences (ACE) describe things that cause harm during childhood and into adulthood. It encompasses abuse including neglect, domestic abuse in the household, mental illness and problematic substance misuse 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 is sometimes referred to as 'toxic stress'.

35. Adults who have experienced significant ACEs in their childhoods are more likely to present with a range of needs and difficulties 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

[11] 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]

conflict with people and services focussed on safeguarding children. There is no recorded evidence that the evidence of significant ACEs in the history of both parents was considered and explored in education, health and social care assessments with the family.

36. Resistance to professionals demonstrated by parents is a common theme in reviews over many years. It is behaviour manifested in different ways including open hostility, 'disguised compliance' and sabotage[12], and is a significant obstacle to establishing more open and effective relationships. Although there can be particular reasons such as a fear of losing children to care that can drive the behaviour it is often a manifestation of parents who have had poor cumulative experiences as children and adults. The co-existence of poor physical and mental health, substance misuse that can be denied or disguised as seems to have happened in this case, poverty, learning difficulties and domestic abuse are factors that contribute to inconsistent parenting and disorganised lifestyles that are harmful to children. It leaves parents with difficulty in controlling their emotions and problems for the parent in providing adequate emotional care for their children. It is why good taking a good history is important when completing an assessment, something which is not evident in this case.

37. Interventions by health and social care services, in particular, 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 and for providing access to appropriate help which can include trauma-informed care.

3 Summary of learning from this local child safeguarding practice review

38. There was poor sleeping practice at the time of Jason's death despite the repeated advice provided by the health visiting and midwifery services. There was a high reliance on the parents implementing the advice and guidance being given including when subsequent examples of unsafe practices showed this was not being followed. This case shows that some parents have difficulty assimilating and consistently following the advice and are the circumstances under which children's needs are neglected. The way that parents respond to the needs of their children is influenced by many factors including their childhoods. Parents who have experienced unstable or adverse childhoods can mean that they have learnt to just focus on their own needs because they have learnt not to depend on others. They can exhibit the disorganised neglect

[12] Reder, P. Duncan, S. and Gray, M. (1993) Beyond blame: child abuse tragedies revisited. London: Routledge.

described by Horwath and others[13] that is driven predominantly by emotion which as in this case can be exacerbated by the influence of alcohol or drugs. Their needs take precedence over anybody else including their children. Although there may be occasions when the needs of the parent and the child converge there will be other times when that is not the case. It is behaviour that can be perplexing and provide false positives and assurances when for example discussing safe sleeping or an agreement to stop drinking. If the parent is more focused on their own emotions and needs their attitude for example to where their children sleep will be inconsistent and lack routine.

39. The neglect and risk of emotional and physical harm, in this case, were not sufficiently recognised by any service largely because the information was processed as single separate events or incidents. The issue of cumulative risk of harm when different parental and environmental risk factors are present in combination and over extended periods is an issue identified in serious case reviews for several years. It applies particularly to domestic abuse, parental mental ill-health, and alcohol or substance misuse as well as adverse childhood experiences. Most of the services worked without enough knowledge of the family's history. For example, the child protection conferences relating to Child 1 in 2009 described the care history of the mother as a child, the difficulties she had with substance abuse and anger. It was a behaviour that continued during events up to 2019. CSC and the 0-19 service (as well as the other services such as school) did not use a chronology. The extent of involvement by services such as CSC over many years beginning with both parents in their childhoods was largely hidden. The absence of multi-agency discussion and decision making at the point of referral or before case closure is significant. The development of a multi-agency pregnancy liaison and assessment group (MAPLAG) postdates the events examined in this case; it provides a multi-agency forum and opportunity for coordination although its current remit would not include a mother who is not declaring current substance misuse.

40. Safeguarding work represents a challenge and can present issues and difficulties that contribute to less effective practice. These can range from professionals becoming overwhelmed by the intractability of difficulties that a particular family presents; becoming intimidated by the aggression or behaviour of an adult or be misled by the apparent cooperation and compliance. None of the services has described their various staff as ever being overwhelmed although it is self-evident that the scope of difficulties that the family faced extend beyond the capacity of any single person or agency to address. The level of need and risk presented by the family needed a well-informed multi-agency response that was led effectively and could provide intensive involvement and work. Mother made complaints against

[13] http://www.safeguardingshropshireschildren.org.uk/media/1250/j-horwath-working-with-child-neglect-during-the-covid-19-pandemic.pdf Accessed on 20th July 2020

professionals when she felt they were beginning to challenge and show curiosity about what was happening.

41. Despite the level of difficulty and long-term indicators about neglect, this was a family where help and support were largely episodic and focused on responding to specific incidents, not all of which got the level of response that would be expected and was hampered for example by not using strategy discussions between services. There was insufficient coordination or a sense of common purpose. When a statutory assessment was completed it was largely conducted as a single agency activity by CSC. Decisions by CSC to step down their involvement for example in January 2019 from CIN to involvement by the Early Help Hub was accompanied by the 0-19 service stepping down their level of contact to a universal service offering on the basis that the services did not have safeguarding concerns. The school nursing service likewise stepped down to a universal service level for the eldest child.

4 Assessment of systemic or underlying reasons for what happened

42. These include:

a) **Seeing the world of the child through their eyes** and giving them **a voice of influence** in enquiries, assessment and decision-making; reflecting upon and asking about the impact the behaviour of the parent has on the child is important for a child of any age; silence or the absence of any disclosure is not evidencing that all is well; children who are too young to have language can still provide important information to people with an understanding of age-related child development who spend enough time with parents and child can observe the interaction of parents with their children and show curiosity; for example about Child 1 being used as a carer for younger siblings and a potential factor in the poor school attendance; Child 1's need for adult attention; children witnessing extreme levels of abusive behaviour;

b) **Chronology and history** that gives context to single incidents; seeing and understanding the complexity and significance of history and cumulative harm eluded professionals until the child protection conference in the summer of 2019; even at that stage some people could not see the significant harm being done to the children through the emotional abuse and neglect and risk of physical harm; a student social worker had collated a chronology in March 2017 but the significance of the history was not sufficiently understood at the time and it did not draw information from other services; this is not a criticism of the individual student social worker and it was the only time a chronology was collated;

c) Using **multi-agency systems for processing and discussing safeguarding concerns** about children including MASH that include the police and GP in multi-agency discussion of risk such as occurred at the child protection conference in June 2019; the systems would have been relevant such as the incident of domestic abuse in June 2018 that resulted in the oldest child being injured was not discussed in a strategy discussion or subject of specific child safeguarding enquiries and assessment; although the police requested a strategy discussion there was no escalation or referral when there was no response from CSC; this was in part reflected by the organisational stress that was having an impact in CSC but it also indicates organisational passivity on the part of other services who did not escalate concerns to more senior managers or within the MASH; there were occasions at school, at the GP, within the police and social care as well as in MASH to recognise and respond appropriately to evidence of concerns; some important safeguarding information was not reported to the police and social care;

d) **Developing relationships of support for families**; high levels of complex need and vulnerability are less likely to be understood enough through single or time-limited home visits; people who have the time to develop an understanding of underlying history and issues and to build a relationship of trust are more likely to provide effective help; underestimating the level of need contributed to the family not being encouraged to use a children's centre for example; relationship-based and practical work with families dealing with multiple challenges needs to be well-grounded in systems of professional support and safeguarding practice; the early help service was the only service attempting to provide practical hands-on assistance but did not recognise important indicators of risk; some of this was missed by other people as well;

e) **Being curious** enough about finding out the underlying drivers for concerns and risk[14]; the verbal and physical violence, emotional and psychological difficulties and the use of substances were not just markers of an anti-social lifestyle that represented a risk for children; the deep-rooted implications of the parents' adverse childhoods; these are not easily addressed or amenable to exhortations to behave better and to keep to agreements; not understanding the significance and implications of history undermines developing more effective help;

[14] It is acknowledged that the CRC offender risk assessment did explore and record drivers but it was not used in any multi-agency or other services assessment.

f) **Barriers and control of narrative and professional reaction**; professionals are less able to help families effectively when important interaction is controlled by parents who are unable or not motivated to make necessary changes; many of the problems that were described when Jason was born and was described when he died were longstanding concerns; avoidant strategies that block communication or minimise concerns are manifested in different ways; professionals can be closed down by outright confrontation and hostility or be manipulated into false states of reassurance; mother had a 'toolbox of behaviours' to manage her interaction with various professionals; she was described by one as being able to display outright hostility and rejection through to presenting as being compliant and needy; it was a behaviour that reflected her history of abuse and trauma and behaviour learnt and unchallenged over many years; when mother sensed a professional was more assertive and curious about what was happening with the children she would make complaints; this happened in CSC on more than one occasion as well as at the school; one of the social workers had the case taken off them against their professional judgment following a complaint by mother; the mother showed the same behaviour to people in the community whom she suspected of trying to raise concerns with CSC or the police;

g) **Community and neighbourhood networks** are often aware of what is happening in a complex household; this case shows the importance of giving attention to information coming from people who may see far more of the family and what is happening with children than any of the services; ignoring or dismissing as malicious the concerns of people who are not part of a recognised profession or service; taking concerns seriously and making robust enquiries that involve all relevant people;

h) Recognising the **impact of domestic abuse** on children and exploring it as part of assessments; Child 1's disclosures of drinking and fighting between the parents did not result in concerted follow-up; there were other occasions such as reports from the community to police and social care; there is no evidence of the GP considering domestic abuse as part of mother's presentation for low mood; the probation risk assessment was not factored into any other assessments of risk and was the only one to highlight coercion and control as a particular risk;

i) **Assessments being rigorou**s enough in terms of the investigatory process and age-related child development; on more than one occasion a social worker wrote that a preverbal child 'does not present with any emotional or behavioural difficulties given their (sic) age'; the processing of referral and

conduct of assessments were not curious and aware of why parental history was critical and included all relevant people to give information and contribute to analysis; none of the assessments that were complete resulted in the level of social work involvement that was required along with other services; not using tool kits and frameworks designed to help inform professional judgment about issues such as neglect or a child's attachment; the neglect toolkit in the 0-19 service was not used in 2018 when evidence of potential neglect began to emerge; this was despite specific advice given by a safeguarding nurse practitioner. The service also found that when completing reports for the initial child protection conference in 2019 the scaling of risk was not completed by health visiting or school nursing services and at the time danger statements were not being used; mother's low mood and self – harming behaviour was not meaningfully explored in assessments; the GP was peripheral to the work being done through other health and social care services.

j) **Pre-birth assessments**; requests being accompanied by a summary of concerns highlighted for example during a booking appointment with midwifery services; a good pre-birth assessment could have taken into account the factors that had a negative impact or implication for Jason and set that against any protective factors which in this case were very limited;

k) **Written information and advice about safe sleeping is not equally effective for all parents**; the high reliance by health professionals providing SUDI advice to parents to act appropriately even when there were repeated occasions when unsafe practices were observed; more attention to how parents understand, retain and can act on the information is important and seeing where children are sleeping;

l) Preventing **SUDI as a public health and child safeguarding issue**; early years and social care practitioners need to demonstrate a good understanding of the risk of SUDI and their role in assessing and reinforcing safe practice advice; this includes seeing where children are sleeping; police officers who visit households where there is evidence of substance misuse and co-sleeping have a role in giving immediate advice and reporting information through the MASH;

m) **Poverty and social deprivation** are overrepresented in the profile of children dying from SUDI; this does not mean those factors cause SUDI but do need to be factored into risk assessment and are relevant to a wider consideration of children's welfare and resilience; there was no recorded evidence of this being considered and explored in assessments with the family;

n) **SUDI and neglect as co-existent risks**; neglect is not a one-off incident or event; it is cumulative and has a corrosive impact on the health and wellbeing of children; tool kits help collate, analyse and understand underlying patterns of neglect; adversity in parents childhood and the co-existence of issues such as substance misuse, mental ill-health contribute to inconsistent and ineffective parenting and a chaotic and disorganised lifestyle; they will struggle to implement advice such as safe sleeping; it has an impact on how they control emotions and an inability to provide emotional warmth for their children;

o) **Separate help for adults** who have been significantly damaged by their childhood and life experiences.

5 Summary of recommended improvements to be made to safeguard or promote the welfare of children

I. The WDSCP should ensure that all multi-agency training includes the need to be curious about and to understand where children are sleeping as part of assessments and intervention.

II. The learning from the review should be referred to the local multi-agency task and finish group for the prevention of overlay that is developing a risk assessment.

III. The WDSCP should develop a safe sleeping procedure that emphasises the importance of ongoing risk assessment about safer sleeping for all services. This should include a specific risk of overlay assessment tool identifying that modifiable factors exist which are known to contribute to SUDI due to overlay[15]. The procedure should direct that routine safe sleeping risk advice is always joined up with an overlay risk assessment. This should be part of the core ongoing contact delivered by midwives at booking and ante-natal checks; health visiting mandatory contacts and visits; six-week checks by the GP; early help workers, social workers and police enquiries; chairs of child protection conferences or CIN meetings.

IV. The WDSCP should consider how the use of the neglect tool kit is promoted and used routinely by services. The WDSCP should review whether the strategy and provision of training in respect of neglect is giving sufficient understanding to professionals about the different types of neglect which include disorganised neglect, emotional neglect and, passive and physical neglect. The current neglect toolkit should be amended to include intentional unsafe sleeping practices

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

and /or no provision of safe sleep space for infants as indicators of neglect.

V. The CCG should continue encouraging every GP practice to have a written protocol for discussing safeguarding concerns and follow up. This should include routinely referring notifications and requests for information from the MASH in respect of statutory CIN or child safeguarding assessments and recording in relevant patient records.

VI. The CCG should encourage GP practices to develop and use assessment templates that routinely explore domestic abuse with patients presenting with symptoms of low mood or other mental health needs.

VII. The Director of Children's Services should ensure that within MASH all information or reports about safeguarding concerns are processed under the safeguarding partnership's protocols for strategy discussions, enquiries and investigation.

VIII. The Director of Children's Services should remind social workers when completing enquiries or assessments to verify where children are bathing and sleeping as a matter of routine and are using appropriate age-related frameworks to inform assessments about children's development.

IX. The Education Safeguarding Advisor should ensure that a summary of learning outcomes is provided to the chair of governors, head teachers and designated safeguarding leads. This should include promoting the use of the neglect tool kit, systems for recording safeguarding concerns, supervision of staff who conduct home visits, the use of referral pathways to Early Help and MASH.

X. The Health and Wellbeing Board should consider the learning from this review in respect of how local services respond effectively to the needs of parents with a history of adverse childhood experiences and the need for strategies to reduce poverty and health inequalities that support systemic arrangements for prevention and early intervention to support more vulnerable families.

The methodology and terms of reference

Agencies were requested to produce summaries of learning drawing on agency records and the direct involvement of practitioners who worked with the child and family to reflect on practice issues and demands. In this way, the reports reflected learning for the system in which the professionals were working.

A virtual learning event involved people from the services involved although many of the practitioners who had direct involvement in the events since 2017 were not available. Peter Maddocks, 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:

i. Awareness of reducing SUDI 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 the mother.

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