Report of the Learning Lessons Review respect of Child C December 2017

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1.0 Context for the Learning Lessons Review (LLR)

This review has been initiated as a result of multi-agency discussion within the North Yorkshire Safeguarding Children Board (NYSCB) Safeguarding Practice Review group on the 2nd October 2017 which agreed that consideration of multi-agency responses to Child C, her mother and extended family could identify substantial learning opportunities for safeguarding partners in North Yorkshire.

1.1 Child C was born on the 6th May 2017 and died on the 8th July 2017, Child C was 63 days old. There were no concerns in regard to the circumstances of Child C's death; as a result, the death was not notified to Ofsted as having been the result of a serious incident and was not therefore considered for a Serious Case Review (SCR).

1.1.2 On the 20th July 2017 the North Yorkshire Child Death Overview Process (CDOP) considered the circumstances of Child C's death and identified if potential multi-agency learning including possible elements of chronic neglect in respect of Child C's mother who had previously been in receipt of services. North Yorkshire Police (NYP) colleagues shared growing concerns with regard to the apparent time lapse between Child C's mother discovering her death and calling an ambulance. Child C's mother was herself known to services and the Prevention service were providing support to her immediate family at the time of her pregnancy and of Child C's death. The Police had significant concerns regarding the home conditions they had encountered during a visit to the home of Child C following the death. CDOP recommended that the case be presented for discussion in the NYSCB Safeguarding Practice Review group on the 2nd October 2017 and it was agreed that a Learning Lessons Review (LLR) should be independently facilitated which would affect further consideration of the multi-agency support offered to Child C and immediate family prior to the death of Child C.

1.2 Working Together 2015[1] is clear that professionals and organisations protecting children need to reflect on the quality of their services and learn from their own practice and that of others. Good practice should be shared so that there is a growing understanding of what works well. Conversely, when things go wrong there needs to be a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.

1.2.1 SCR's and other case reviews should be conducted in a way which:

[1] HM Government (2015) Working together to safeguard children 'A guide to inter-agency working to safeguard and promote the welfare of children'

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed and
- Makes use of relevant research and case evidence to inform the findings.

1.2.2 This LLR is based on the principles of the Significant Incident Learning Process[2] (SILP) in which frontline practitioners and first line managers participate; this gives a much greater degree of ownership and commitment to learning and dissemination of lessons. SILP uses systems methodology and appreciative enquiry, looking at how the actions of professionals are influenced by the organisations and systems in which they are working. The focus of this review was in regard to the effectiveness of professional systems in North Yorkshire at the time to safeguard and provide support to Child C and immediate family.

1.2.3 It was agreed that the scope period of the LLR will be the period from June 2016 up until the events on the day of Child C's death (which have already been considered by CDOP). However, any significant events which occurred before the scoped period in relation to the case, which were deemed to be relevant to the learning have also been included.

1.2.4 It was agreed that Child C's mother will be informed of this LLR by the lead reviewer in writing and via the current key worker. A home visit will be offered to encourage and facilitate participation.

1.2.5 The LLR was chaired and the report prepared on behalf of NYSCB by Dallas Frank an experienced strategic and Safeguarding Children Board Manager who holds a Post Graduate certificate in investigating serious incidents and is an accredited SILP lead reviewer. Dallas has no previous knowledge or involvement in this case.

1.3 Introduction to the case and family background

Child C was the first child born to the mother who is the eldest of three siblings and was aged 19 at the time of Child C's birth. Child C was born at 12.03pm as a result of a normal delivery and weighed 3030g. Child C's maternal grandmother had died some nineteen months prior to the birth of Child C. Child

[2] SILP is a tried and tested approach to reviewing cases, whether in the context of a serious case review or other form of learning activity.

C's mother lived in the family home with her father (Child C's maternal grandfather) and two siblings (Child C's aunt and uncle). The family are of White British heritage although the ethnic details of Child C's father are not known. Child C's mother declined to give information to health professionals regarding the identity of C's putative father and as a result it has not been possible to include his views in this report.

1.4 Scope of LLR and terms of reference.

The scope period of the practitioner review will be from June 2016 up until the events on the day of Child C's death (which have already been considered by CDOP).

1.4.1 The *Practitioner Learning* Review will consider (terms of reference as ratified by the NYSCB Executive in October 2017):

- What stood out about the child and the family – how was she viewed by professionals/organisations and how did this impact on intervention?
- What were the key issues in the work with the child and her family?
- Were there opportunities to respond to the child and the family which were missed by services?
- How were the home conditions noted and included in any risk assessment or intervention plan, prior to and following the birth of C?
- Which professionals were involved with the family and what intervention/ support was being provided?
- What information regarding the parent's history, including information regarding the putative father, was known and considered in relation to the potential / actual impact on parenting of C?
- What was the quality and timeliness of any referrals, responses and interventions and what was the impact of this on the child and the wider family?
- What was the interface between the support provided for C's aunt and any specific support considered in respect of C or her mother?
- Was there appropriate information sharing and analysis between agencies?
- Were there any examples of good practice in working with this family?

1.5 The Process and Contextual information;

Decision to undertake LLR: 2nd October 2017
Agency reports completed: 14th December 2017
Learning Event: 10th January 2018

Recall event: 22nd January 2018 Electronic quality assurance to all participants
Presentation NYSCB: NYSCB Executive October 2018
Dissemination of learning event: Learning points from the review will be disseminated to managers at the managers master class events in December 2018, and a review of training to include salient learning will also be undertaken. The final report will be published anonymously on the NYSCB website to augment wider learning from practice.

1.5.1 Individual agency reports were received from the following sources:

- York Hospital NHS Foundation Trust
- Harrogate District NHS Foundation Trust
- General Practitioner
- North Yorkshire Prevention Service
- Yorkshire Coast Homes
- North Yorkshire Police
- North Yorkshire Children and Families Service
- Local Authority Primary School

2.0 Background prior to scoped period

Child C's mother became known to North Yorkshire Police (NYP) and to North Yorkshire Children and Families Service in October 2013 when she was reported to NYP as missing by her mother; Child C's mother was fifteen years old at the time. Similar referrals to the Children and Families Service were made on the 30th June 2014 and 1st July 2014. On the 5th July 2014 following information from the Police the Youth Support Service attempted, but failed to make contact with Child C's mother and the case was closed.

2.1 On the 3rd February 2015, the District Nurse made a referral to the Children and Families Service regarding concerns for the family following a home visit to support Child C's maternal grandmother to change her dressings. The District Nurse found *Child C's maternal aunt aged ten, to be unsupervised, the house 'unkempt' and cat faeces on the floor, there was also a locked cage containing a number of kittens*. The child was described as not attending school and it was agreed that an Initial Assessment would be undertaken by the Children and Families Service. The Initial Assessment was completed on the 13th February 2015 following a home visit to the family which, in line with best practice included the views of all of the three children. The Social Worker found the home conditions had improved and also made contact with the School of Child C's maternal aunt where it was identified that there was a good level of support

for her regarding attendance. All three children identified that they did not want support and the outcome of the Initial Assessment was that there was no role identified for the Children and Families Service at that time.

2.1.1 On the 21st October 2015 a further referral was received from the Pupil Safeguarding and Inclusion Officer at the school of Child C's maternal aunt indicating concerns regarding Child C's aunt and siblings residing with a family *'whom there were significant concerns with'* whilst their mother was in hospital. The children's home conditions were described as *'dire'* with the bedrooms described as *'extremely dirty'* with numerous piles of unwashed clothing covering the bedrooms and hall floors as well as an unchanged cat litter tray on the landing. An Initial Assessment was undertaken by the Children and Families Service and the case was transferred to the North Yorkshire Prevention Service.

2.1.2 Child C's mother booked in for antenatal appointment at Scarborough Hospital[3] on the 28th September 2016. At the time of booking no information was shared by Child C's mother regarding the Prevention Service being involved with the family. Child C's mother denied any substance, alcohol or tobacco use despite a raised carbon monoxide level. Staff responded appropriately by requesting a gas safety test within the family home to rule out increased carbon monoxide from household appliances. Child C's mother had told the midwives that Child C's father was *'in the army'* but did not disclose his identity. Child C's mother also shared information that she had a repair to a hole in her heart and that her mother and a sibling had died as a result of cardiac related problems. This information was later triangulated by the Community Midwife who discussed with Child C's mother and was made aware that this information was not substantiated within her health records.

2.1.3 During the practitioner event which discussed the multi-agency context in this case, the GP indicated that there were some concerns regarding Child C's mother's description of her medical history, Child C's mother indicated and appeared to believe that she had significant health concerns relating to her heart which were not established medically and that it is possible that some medical interventions during pregnancy *may* have been unnecessary.

2.1.4 Maternity records have been reviewed for the purpose of this LLR where it has been identified that Child C's mother failed to attend three Antenatal appointments and one Physiotherapy appointment. It is of note that the Midwife Hospital did refer to York Hospital's guidance regarding non-attendance, in which it identifies what actions should be taken when a pregnant woman fails to attend. This appropriately triggered a series of checks including safeguarding concerns and a list of professionals to be consulted with including the GP, Community Midwife, and the hospital's Safeguarding Team. The Community

[3] York Teaching Hospital NHS Foundation Trust provide antenatal services at Scarborough Hospital

Midwife also made contact with Children and Families Service on the 13th October 2016 and was informed that there was no case open for Child C's mother and that the last intervention was as a result of Child C's mother and siblings living with a family where there had been safeguarding concerns.

2.1.5 Between the periods of the 9th September 2016 and the birth of Child C on the 6th May 2017 Child C's mother was seen by her GP on twelve occasions.

2.1.6 On the 14th November 2016 Child C's mother was seen by the GP reporting that she was '*kicked in the abdomen the other night'*. This incident was described by Child C's mother as having taken place accidentally during play fighting. There is no information recorded to identify any further context for this incident or who kicked her. Child C's mother was offered a Doppler[4] scan in a few weeks *'if she was interested'*.

2.1.7 On 19th December 2016 Child C's mother was admitted to Scarborough hospital Gynaecology department complaining of lower right abdominal pain radiating to her back[5]. Child C's mother was diagnosed with mild hydronephrosis (the swelling of a kidney due to a build-up of urine) at the right kidney. Subsequent investigations were normal and she was discharged with a diagnosis of non-specific pain on the 22nd December 2016. Later on the same day, she was readmitted after being seen by another GP in the practice with the same complaint of lower abdominal pain, she was assessed in the Accident and Emergency department (A&E) at Scarborough Hospital where the pain was seen to have subsided. Test results were normal and Child C's mother was discharged from A&E on the same day.

2.1.8 On the 28th December 2016 Child C's mother presented at the delivery suite accompanied by two friends. Child C's mother was described as displaying '*unusual behaviour and making random comments'* raising concerns of a possible learning difficulty or drug use, the record also indicates that Child C's mother '*smelt strongly of cigarette smoke*'. These concerns were appropriately documented and effectively shared with the Community Midwife. This information was not shared with the Children and Families Service at this time and this is likely to be as a result of previous checks undertaken where it had been established that there was no current involvement of the service in respect of Child C's mother.

2.2 The North Yorkshire Prevention Service became involved with the family in February 2017 when a contact/referral was received in respect of Child C's maternal aunt indicating concerns with regard to her emotional responses to

[4] A Doppler is a form of ultrasound scan undertaken to assess a baby's health. The scan measures the blood flow in the umbilical cord, brain and heart to assess whether the efficiency of the placenta to ensure all necessary oxygen and nutrients reach the child.
[5] Pain in the right iliac fossa can raise suspicion of appendicitis although abdominal pain in pregnancy also causes problems because of distortion of the normal anatomy and stretching of structures.

the death of her mother. The contact/referral indicates that the '*whole family need support to address their relationship issues and learn not to resort to physical violence as a solution'*.

2.2.1 In February 2017 a referral to the North Yorkshire Young Parenting Programme was made by Hospital Midwives in respect of Child C's mother. However, there remains some discrepancy regarding the timing of this referral as the Midwifery Team have information suggesting that this referral was made at the time of booking some three months earlier; although this does not appear to have been received by the programme until February 2017. The programme's top age limit is 19 years old and Child C's mother was 19 at the time of the referral. Unfortunately, at the time the programme was oversubscribed resulting in no placement being available. However, this was appropriately passed to universal services on the 14th February 2017 and Child C's mother was allocated a worker on the 5th March 2017.

2.2.2 The health visitor was asked to undertake additional visits to the family as part of the North Yorkshire Young Parenting Pathway and Child C's mother was offered four additional home visits from the Health Visitor. However, of these four visits two were unsuccessful as Child C's mother was either not in or appeared to have forgotten the meeting and a further one was not undertaken as a result of Child C's birth. It has been established that there existed *'a plan'* for the Community Midwife to make a referral to the Children and Families Service at the time, although this appears not to have taken place and information was not available to the review to further understand the reasoning for this. However, at this time, a referral had already been submitted by North Yorkshire Police on the 26th February 2017 in respect of the children and the unborn infant: the Midwifery Services were aware of this referral.

2.2.3 The referral made by North Yorkshire Police on the 26th February 2017 to the Children and Families Service was made following a visit to the family home. The Police identified a lack of preparation for the new baby, concerns regarding the home conditions and issues relating to Child C's maternal uncle having perpetrated criminal damage in the home. Child C's mother was spoken to and identified '*a need for support'*. This information was appropriately passed to the Family Outreach Worker within the Prevention Service working with the family.

2.2.4 On Wednesday the 8th March 2017 a joint visit was planned to the family by the Family Outreach Worker and the Health Visitor (HV) and subsequently it was suggested that the Midwife should be linked in. This visit took place to address the above concerns and for an assessment to be undertaken of the potential risk to Child C (unborn) and to identify additional support needs. Although only the Family Outreach Worker attended due to unavailability of both the Health Visitor and Midwife. The Family Outreach Worker found the home conditions to be adequate and Child C's mother to have made appropriate preparations for the impending birth of Child C. It was at this meeting that Child C's mother

shared information pertaining to the putative father of Child C indicating that *'he keeps changing his mind about if he wants to be involved when the baby is born'*. This information could have contributed to concerns regarding support available to Child C's mother following the birth given that her own mother had recently died, her father was experiencing difficulty in managing the behaviour of her siblings and there appeared to be no extended family support. Further information pertaining to Child C's father should have formed an important element of any assessment which took place regarding her welfare. Information regarding the potential involvement of paternal grandparents or extended family was not pursued.

2.2.5 The Community Midwife visited Child C's mother and Child C on the 29th April 2017, on this occasion the midwife had noted the *smoky home environment* and also observed areas of the home including the kitchen and bathroom. The Community Midwife had spoken with Child C's mother regarding the smoky environment within the home and discussed health implications for Child C. A further discussion was had with Child C's mother following the midwife's observation of the presentation of both the kitchen and bathroom. The Community Midwife advised Child C's mother the importance of keeping the home tidy and the floor uncluttered.

2.2.6 On the 4th May 2017, further information was received in the form of an anonymous contact/referral to the Children and Families Service the referrer reported that Child C's mother *'had been seen drinking alcohol, smoking and sniffing something' at a party'*. This information was passed to the Family Outreach Worker who proposed to visit the family and discuss the concerns. A decision by the Prevention Service was made at this time to discuss the potential for a 'step up[6]' meeting. However, due to the birth of Child C on the 6th May 2017 this meeting did not take place. This information was shared with the Midwife who disclosed that as a result of this information and concerns regarding Child C's mother's presentation at a previous visit to Scarborough Hospital a plan had been developed to support Child C and mother in Hospital for seven days, to monitor them.

2.2.7 On arrival at the delivery suite on the 5th May 2017, the midwife has recorded Child C's mother as having presented in a *'very dirty condition*' with her clothes being '*grime filled and smelling of smoke'*. Also at the time of delivery observations were made regarding Child C's mother pertaining to her personal presentation and concerns regarding potential self-neglect. These concerns were shared with the North Yorkshire's Children and Families Emergency Duty Team (EDT) prior to Child C's discharge from Hospital.

[6] A meeting between the Prevention Service and Children's Social Care to discuss escalation or escalation of a cases, to or from S17.

2.3 Following a discussion between the hospital and community midwifery staff, a joint home visit was arranged and undertaken by the Emergency Duty Team and the Community Midwife on the 8th May 2017 in order to ensure that the home conditions were appropriate. A holistic assessment was repeated and recorded observations noted that condition of kitchen was improved. This visit had proved upsetting for Child C's mother who had informed her father that she was not able to return home as '*social services are getting involved'*. The Hospital were aware that there was a Family Outreach Worker involved with the family and contacted the Children and Families Service to identify any contraindications to their discharge. The Hospital were informed that there had been no involvement with Child C's mother since she had been reported as missing/homeless in 2015. During the LLR it was established that the hospital records contained no additional information regarding discharge arrangements for both the mother and the child – this is not unexpected since a joint home environment assessment had already been undertaken and hospital staff had been informed that no pre-discharge planning meeting was required.

2.3.1 Whist in the care of Scarborough Hospital some concerns were raised regarding Child C's mother's understanding of the need to ensure the baby's temperature was regulated, this resulted in Child C being placed in a *'hot cot'.* Staff recorded concerns that Child C's mother did not appear to understand the importance of Child C remaining there and subsequently removed Child C from the *'hot cot against medical advice'*. Child C's mother was also seen to be bed sharing with the child on the ward and was strongly advised against this practice. Records also show that Child C's mother required prompting in order to change and feed the child, although this could be as a result of her inexperience as a new parent.

2.3.2 On the 10th May 2017 the first post natal visit took place at the home of Child C and although concerns regarding the home environment had been previously raised, there is no documented evidence that this was considered at this visit. At the second post natal visit concerns were raised regarding a 2.4% weight loss and Child C's umbilicus was noted to be '*red moist and inflamed'*, this resulted in a swab being taken. It is of note that a 10% loss of weight following birth is expected and Child C's mother was offered advice regarding the correct techniques for mixing formula, sterilising bottles and was advised to feed Child C 60mls every three hours.

2.3.3 Contact was made by the Family Outreach Worker with the Health Visitor who requested that additional home visits be undertaken as a result of mother's vulnerability. A Young Parent Pathway Worker was allocated and visited both the parent and the child at home on the 16th May 2017. However, this visit was unproductive as a result of Child C's mother having forgotten the appointment and maternal grandfather being asleep on the sofa; a further appointment was made for the 23rd May 2017.

2.3.4 On the 17th May 2017, Child C was seen again at the antenatal clinic at the GP surgery; Child C's mother was in attendance. Further weight loss of 45g was identified and Child C's mother was reminded of feeding cues and to offer Child C larger feeds. A plan to re-weigh Child C in two days was put in place, records from a home visit undertaken on the 19th May 2017 by the Midwife do not record information pertaining to Child C's weight.

2.3.5 On the 6th June 2017 Child C's mother was seen by her GP '*feeling low'*, she was accompanied by a friend who is described as the current partner of Child C's father. Child C's mother indicated that she was '*bonding well with the baby'* and the GP has recorded a diagnosis of '*baby blues'*. However Child C's mother asked the GP for medication and Sertraline[7] was prescribed.

2.3.6 Child C was found unresponsive on the morning of 8th July 2018. Despite full resuscitation, the child did not respond and death was confirmed at Scarborough General Hospital. Following a post mortem examination the cause of death was concluded to be 1a. Sudden Infant Death Syndrome (SIDS). Following the post mortem report, H.M. Coroner, Mr Oakley closed the case, thus no inquest took place.

3.0 Analysis of practice (in line with the agreed terms of reference)

3.1 What stood out about the child and the family – how was she viewed by professionals/organisations and how did this impact on intervention?

3.1.1 It is the clear from reports submitted as a result of this review that there were no specific issues which led practitioners to believe that there was anything in particular which stood out about the family. The Prevention Service were undertaking interventions to support Child C's maternal grandfather in respect of his youngest child and management of her emotional wellbeing and school attendance. The family had suffered a bereavement when Child C's maternal grandmother died and it could be argued that the impact of this event on all family members was not fully considered, in particular in relation to Child C's mother and her imminent transition to parenthood.

3.1.2 Housing Practitioners describe having had no involvement with Child C other than as an observer when visiting the property and were not aware of the pregnancy or the birth of the baby prior to making a home visit following the birth. However, It is noted in their report that Child C's grandfather '*appeared to be extremely pleased to be a Granddad and all appeared to be ok with mother of baby'*. They had attended the family home on a number of occasions regarding routine repairs and had not identified any significant issues regarding the home conditions.

3.1.3 The Family Outreach Worker working directly with the family has described Child C's mother as a '*devoted loving mum, who was meeting the needs of her*

[7] Sertraline is an antidepressant used to treat depression, obsessive-compulsive disorder, panic disorder and anxiety.

baby'. Information from Child C's GP records indicates that '*nothing really stood out in relation to Child C's presentation in the practice'*. Child C was treated for umbilical discharge, upper respiratory symptoms with some reflux and nappy rash. These problems were seen to represent a common occurrence within children of Child C's age group.

3.1.4 Child C's mother had shared information regarding her medical history which, when triangulated was established as untrue. She had indicated that she had been born with a hole in her heart and had an ongoing heart condition. She was seen on a number of occasions by her GP and Midwives during her pregnancy and information was shared appropriately between them, including contact with the GP to verify the health information given to midwives on booking. No correlations appears to have been made between the disclosure of unsubstantiated health information, the potential for her presentation at health appointments and Child C's mother's own vulnerability. There is no documented consideration of possible Fabricated or Induced Illness Syndrome. It is not fully understood why some parents or carers fabricate or induce illness (in most cases this is induced by the parent in the child, although this was not established in this case). However, it could be argued that a parent or carer will have a history of previous traumatic experiences. Recent studies have shown that mothers who fabricate or induce illness are likely to have abnormal attachment experiences with their own mothers, which *may* affect their parenting of and relationship with their children. For example, repeatedly seeing a doctor to satisfy an emotional need to get attention for the child). It could be argued that had this possible link been made at the time this may have generated additional concerns leading to the potential for a pre-birth assessment.

3.1.5 North Yorkshire Police had limited contact with the family and it was established at the Learning Event for the LLR that within the context of the geographical location of their home, the family did not stand out in any way which would have attracted additional concern.

3.2 What were the key issues in the work with the child and her family?

3.2.1 The family were known to Universal Services and accessed these including GP services appropriately. The Prevention Service had recognised that Child C's mother may require support and had agreed an action plan in respect of Child C's mother which identified the following: '*registration at the local children's centre, attendance at all appointments with Health Professionals and attendance at Prevention Service provision to assist with support and development of unborn child'*.

3.2.2 At the time of pregnancy and Child C's birth the family were still coming to terms with the death of Child C's maternal grandmother. There were ongoing issues relating to Child C's maternal aunt, including exclusions from school and her

maternal uncle who was not engaging in employment education or training and who was exhibiting some antisocial behaviour and minor criminality. Child C's maternal grandfather was receiving support regarding significant rent arrears and debt, including the acquisition of a loan to enable him to arrange a suitable funeral for his wife.

3.3 Were there opportunities to respond to the child and the family which were missed by services?

3.3.1 The report from the Prevention Service indicates that '*agencies involved do not share a joint assessment'* but that information was shared between professionals involved. When the Early Intervention Service transitioned to the Prevention Service in April 2015, Team around the Child meetings (TAC) meetings ceased. The Team around the Child meetings would have supported the joint assessment and multi-agency working. It could be argued that, as a result of a lack of an assessment and the development of a shared intervention plan professionals involved with the family did not have opportunity to build a picture of the family, identify needs and to intervene with a joined up strategy. The Prevention Service action plan contains no agreed actions for other agencies involved in providing services to the family.

3.3.2 Maternal grandfather was known to be in debt and on the 15th April 2016 a referral was made to Yorkshire Coast Housing management services regarding; rent arrears; assistance with claiming of benefits including housing benefit; advice regarding loans and other debts and funeral expenses for Child C's maternal grandmother. On the 6th December 2016, an application was made to the Yorkshire Coast Housing hardship fund as a result of debts pertaining to unpaid employment and support allowance (ESA) and the family had no money to access gas and electric. In January 2017, a notice seeking possession of the family home was issued as a result of rent arrears. Information regarding Child C's mother's financial arrangements and support is not documented and not available to review. However, there have been questions raised regarding the significant and consistent nappy rash and whether Child C's mother was changing Child C's nappies as often as she should to address the infection. It is possible that this could be linked to a lack of financial capacity within the family and these issues, in particular as they pertained to Child C were never explored. It is also likely that Child C's mother was aware of the financial difficulties being experienced by her father and the potential that the family would become homeless.

3.3.3 Increasingly professionals have come to understand the importance of the period of pregnancy in terms of child development, and the first few months of a child's life in terms of the development of a child's relationship with its caregivers, future emotional well-being and healthy attachment. An assessment prior to a child's birth can more adequately predict potential risks and needs following the birth and this should be considered as an integral

element of an Early Intervention Strategy to support parents and children. Historically, Pre-birth assessments can be seen to be undertaken when significant concerns exist regarding a child's safety during pregnancy and following birth. A number of risk factors exist within research and Practice Guidance to assist practitioners to make this decision. Moreover, conducting a thorough pre-birth assessment is not just to ensure the child's safety, but also to ensure that parents who are vulnerable and/or in difficulties, receive the support and services they require in order to be able to parent effectively and at the earliest opportunity. It could be argued that consideration of a pre-birth assessment to support both Child C and Child C's mother would have ensured a more holistic approach to intervention with the family and identified a defined multi-agency plan of support.

3.3.4 Reder and Duncan (1993) identified that a lack of preparedness either physically or mentally, for the birth of a child may be an indicator of parental ambivalence and identified this as a factor in many of the child abuse inquiries they considered. At its most extreme this may manifest itself in parents not attending antenatal care, or concealing a pregnancy, presenting at hospital in the advanced stages of labour, or delivering the child at home. The research establishes that the level of parental ambivalence should always be assessed, but particularly when mothers present late to antenatal care, or when there is an early discharge from hospital. Parental lack of involvement or engagement with services may indicate fear of coming into contact with services, due to fears that their child may be removed. This can be shown in this case when Child C's mother tells her father of her concerns regarding her delayed discharge from hospital. Child C's mother had failed to attend three of her planned antenatal appointments, although she was seen to have made physical preparations for the child, having purchased equipment.

3.3.5 Child C's mother was a young parent when Child C was born and had little obvious support regarding her as a parent. Although she was referred to the Young Parents Pathway however, due to the late referral to the pathway which at the time was fully subscribed, the health visiting service was given the case to hold. Child C's mother was offered an enhanced service, following a universal partnership plus model, but this was not delivered as fully as it may have been by a specialist young parenting health visitor using specialist toolkits.

3.3.6 Child C's mother was known to have indicated that she *'did not like the baby's movements during pregnancy especially when woken up at night'*.

3.3.7 Throughout the intervention of the Prevention Service no multi-agency meetings appear to have taken place. But there is evidence of good communication between the Family Outreach Worker, Community Midwives,

the Health Visitor and the school of Child C's maternal aunt. Discussions at the Learning Event for the LLR between practitioners suggested that this was as a result of the '*demise of the team around the child'*[8]*.* Team around the child meetings were developed to ensure that there is a co-ordinated response to families where a number of agencies were providing interventions. A plan of intervention was established by the Family Outreach Worker working with the family and this did include work with Child C's mother, however no actions were developed or included for work to be undertaken by other agencies.

3.4 How were the home conditions noted and included in any risk assessment or intervention plan, prior to and following the birth of C?

3.4.1 The conditions within the family home are the subject of longstanding concerns first raised in 2015 by the District Nurse and which persisted until following the death of Child C on the 8th July 2017. Information and contacts/referrals relating to home conditions have been addressed appropriately and have, on occasion been the subject of Initial Assessment by the Children and Families Service. On all of these occasions when professionals have visited the home following concerns, the home was found to be adequate and no further action was felt to be necessary.

3.4.2 In their report for this review, the Prevention Service have suggested that during the Family Outreach Worker's visits to the home the hall and lounge were seen to be adequate in their presentation which would not have raised *'concerns that would have led to wanting to check upstairs areas*'. Whilst this is an understandable conclusion given the appearance of the communal parts of the home; subsequent Police photographs were taken of the home following the death of Child C which indicated that this was clearly not the case. The Police photographs showed evidence of extremely poor living conditions in the upstairs of the property which were not suitable for a young infant. This poses the question as to whether the family were attempting to deliberately mislead professionals into believing that the concerns regarding the living conditions had been addressed. Disguised Compliance involves a parent or carer giving the impression of cooperating with agencies to avoid raising suspicions, to allay professional concerns and ultimately diffuse professional intervention. Examples of Disguised Compliance could include: a sudden increase in school attendance, attending a run of appointments, engaging with professionals such as health workers for a limited period of time or cleaning the house before a visit from a professional (Reder et al 1993). The emerging pattern of concerns and improvements do not appear to have been considered within the context of possible disguised compliance or subject to professional curiosity. It may be of importance also to recognise that the outside of the property including

[8] Multi-agency meetings to coordinate intervention as part of a common assessment framework approach.

specifically the garden were extremely well presented and this was commented on within the review.

3.4.3 Throughout interventions from all agencies with the family, it appears no consideration was made regarding the potential for the home to have been overcrowded (there were two adults and three children residing in a three bedroomed) property this is not withstanding the subsequent knowledge that at least one of the bedrooms in the property was padlocked and uninhabitable. No consideration appears to have been made in respect of supporting Child C's mother to access accommodation in her own right prior to or following the birth of her child. However, it is possible that this was as a result of her need for additional support and that this was available to her within the family home, from her father. To have lived independently at that stage may not have been in the best interests of both the mother and child.

3.5 Which professionals were involved with the family and what intervention/ support was being provided?

3.5.1 A number of professionals were involved with the family in relation to various issues. Child C's maternal grandfather was being supported by Yorkshire Coast Housing in relation to debt, Child C's maternal aunt was being supported by the Prevention Service and by her school. North Yorkshire Police had had involvement with the family in respect of missing episodes in 2014 and also in response to concerns regarding Child C's maternal uncle committing criminal damage to the family home. Health professionals including the GP, Community Midwife and a Health Visitor were all known to the family.

3.6 What information regarding the parent's history, including information regarding the putative father, was known and considered in relation to the potential / actual impact on parenting of C?

3.6.1 No information was recorded relating to the punitive father of Child C. As a result there would be no medical information available pertaining to the paternal side of the family. Workers were aware that Child C's mother attended Scarborough Hospital accompanied by the current girlfriend of Child C's putative father but failed to pursue any additional information. The Family Outreach Worker was not aware of any details regarding Child C's father and had been informed by Child C's mother that the couple were no longer in a relationship. This information was not interrogated in respect of what level of involvement the putative father might have in the parenting of Child C and the mothers suggestion that he did not want to be involved was not the subject of further assessment. Reports submitted to this review do not identify any information regarding this information being sought during the undertaking of assessments or during interventions. This lack of information also means that further exploration by professionals of the possible support available to Child C's mother and Child C from paternal grandparents or their extended family.

When booking into Scarborough Hospital Child C's mother was asked questions relating to Domestic Abuse, in response she indicated that she was no longer in a relationship with the putative father of Child C and that he was '*in the army'*.

3.6.2 It is the case that a number of concerns had been raised over time regarding the family and the home environment but that on every visit to address this the home appeared to have improved. It is documented in a number of reports for this review that multi-agency practitioners did not seek to access the upstairs of the home to assess conditions. However, this is not routinely part of current assessment protocols.

3.6.3 An inspection study of SCR's undertaken by Ofsted in 2014, identified Neglect as the most common risk factor. The study identified agencies as poor at addressing the impact of neglect and of intervening early enough to prevent escalation and the cumulative effects of neglect on children. A further study suggested that "*the bewilderment and anxiety that neglect could arouse in practitioners could prompt the adoption of a potentially damaging 'start again' mentality where earlier family history and patterns of behaviour are put aside*" (Brandon 2014).

3.7 What was the quality and timeliness of any referrals, responses and interventions and what was the impact of this on the child and the wider family?

3.7.1 Referrals were received by the Children and Families Service on several occasions, three were in respect of Child C's maternal aunt, the final contact was in regard to the death of Child C. On each occasion an appropriate response was made by the Children and Families Service, whom undertook Initial Assessments on two occasions. The case was appropriately referred to the North Yorkshire Prevention Service in 2015 and to the Prevention Service in February 2017.

3.7.2 Appropriate referrals were also made to the Children and Families Service by the school Pupil Safeguarding and Referral Officer and the District Nurse (See 2.1 and 2.1.1 above).

3.7.3 Screening responses to concerns were appropriately undertaken and a good level of questioning was undertaken by the Children and Families Service advisor including obtaining clarity regarding the reason for referrals, use of the signs of safety[9] approach (SOS) to ensure salient information is identified. Initial Assessments undertaken by the Children and Families Service have consistently included observation of the home environment, communication with and recording of the views of the young people in the family.

[9] The *Signs of Safety* is an innovative strengths-based, safety-organised approach to child protection casework

3.8 What was the interface between the support provided for C's aunt and any specific support considered in respect of C or her mother?

3.8.1 Professionals have consistently identified the need to find more effective ways of working across adults and children's services. This has been echoed nationally by the Government in the *'Think Family: improving the life chances of families at risk'*[10] report. The report identifies that a greater priority is needed to be given to ensure that there are joint and collaborative working practices within and across agencies, to respond to the increasing separation between service areas and increasing specialisms within these areas. Without this, it will be very difficult to effectively protect children, support parents and carers. Research has identified that families want services that are multi-disciplinary and which do not withdraw when the crisis is over but continue to prevent or reduce the circumstances that can result in further crisis. The most effective multi-disciplinary work retains a family focus and builds on the strengths of family members and provides support tailored to need.

3.8.2 A more holistic, 'think family' approach to this work may have engendered a more robust response to Child C's mother prior to the birth of her child and a pre-birth assessment could have resulted in the development of a support plan to align services more effectively in their response to the family. Whilst it has been demonstrated that good inter-agency communication did take place with regard to this family, there was a lack of clearly coordinated multi-agency assessment and planning to provide a package of support. Opportunity to collectively consider the number of contacts and professionals who had raised concerns regarding the home environment was not established and although all concerns were appropriately responded to, the potential for deliberate misleading of professionals or disguised compliance does not appear to have been considered.

3.8.3 It could be argued that there were opportunities at some junctures to escalate from the Prevention Services to Children's Social Care as professional interpretations of the household environment and conditions appear to have escalated and to have varied across visits. Specific risk assessment pertaining to the potential risk posed by Child C's maternal uncle in relation to his ability to manage his anger resulting in criminal damage to the home does not appear to have received any significant consideration.

3.9 Was there appropriate information sharing and analysis between agencies?

3.9.1 There is evidence within the reports submitted for this review of a good level of information sharing in particular between the Family Outreach Worker and Health colleagues. However, the Prevention Service report for this review indicates that a '*multi-agency meeting was not deemed to be required'*. This is

[10] London: Great Britain. Cabinet Office. Social Exclusion Task Force, 2008

concerning given that the service was already intervening in the family albeit primarily in respect of Child C's maternal aunt. It is clear that the difficulties within the family will have impacted on all members of the household and a more holistic approach to the family may have identified additional support for Child C both following and prior to the birth.

3.9.2 The GP report submitted for the purpose of this review identifies that the GP practice was only aware of the Midwife and Police involvement in the case; they were not aware of the Prevention Service support being offered to the family at the time. It is somewhat concerning that the GP report states that '*I* (the GP*) was assuming children's social services were involved*' which implies that the information held by the Community Midwives or Health Visitor was not communicated to the GP to augment and support any Intervention with Child C and the mother. The GP practice report asserts that the practice was not in receipt of feedback from the health visitor regarding their home assessment to Child C following the birth and have suggested that this may be as a result of a lack of communication between electronic recording systems.

3.9.3 The National Institute for Clinical Excellence (NICE) guidelines for antenatal and post natal health[11]: provides information for health practitioners when working with vulnerable women and those with mental health difficulties. Child C's mother had attended her GP during her pregnancy and had been prescribed medication to support her *'low mood'*. She had self-disclosed feelings of anxiety and had indicated negative feelings towards Child C when the baby's kicking woke her up at night. On booking in at the beginning of her pregnancy, Child C's mother informed midwives that the family had no current Children's Social Care involvement and as a result this information was not shared with the Prevention Service working with the family. It is possible that this information may have generated additional concerns regarding Child C's mother's emotional wellbeing, the impact of this on her ability to parent and intervention to support this.

4.0 Good Practice

4.1 The 0-5 Healthy Child Commissioned Services are co-located with the Prevention Service hubs offering opportunity for informal inter-professional communication.

4.1.1 An email was sent by secure email by the attending Police Officer to the Named Midwife for Safeguarding Children, who at the time was on long term absence from work with York Hospital. The email was forwarded by the Named Midwife

[11] The National Institute for Clinical Think this needs to be more specific – from June 2016 up until the events on the day of Child C's death (which have already been considered by CDOP).Excellence (NICE) guidelines for antenatal and post natal health : clinical management and service guidance (2014)

to another member of the Safeguarding Children Team to ensure action was undertaken as a result.

4.1.2 The Community Midwife acted appropriately upon findings at booking relating to carbon monoxide reading, gave advice as per guidelines and arranged for a gas safety check to be undertaken in the family home. There is also evidence that discussion and advice regarding plans for pregnancy, routine general health and wellbeing, passive smoking, hygiene and responding to baby's needs were discussed. There is documented evidence of safe sleeping advice which includes: position, co-sleeping, bed sharing and smoking was given on every contact.

4.1.3 York Teaching Hospitals NHS Foundation Trust Policy and Guidance for Non-attendance and weight loss were followed appropriately; as was the Harrogate District Hospital NHS Foundation Trust policy on weight loss.

4.1.4 There was good triangulation of health information given to the Midwife by Child C's mother regarding a family history of cardiac problems.

4.1.5 There was a good level of appropriate questioning undertaken by the Children Families Service advisor on receipt of referral information which included the use of the Signs of Safety framework.

4.1.6 All contacts with the Children and Families Service were responded to appropriately and initial assessments undertaken. The assessments have consistently included the views of the young people within the family and these are recorded within the assessment.

4.1.7 The District Nurse made an appropriate and timely referral to Children and Families Service regarding concerns for the family, being left unsupervised and not attending school regularly.

4.1.8 A referral was appropriately made by the Pupil Safeguarding and Inclusion Officer regarding safeguarding concerns for the children whilst residing temporarily with another family. A good level of support was offered to Child C's maternal aunt and grandfather in respect of her school attendance.

4.1.9 The same Family Outreach Worker was allocated to the case following a subsequent referral and remained consistent throughout interventions with the family. It is likely that this will have positively augmented the engagement of the family and negated the need for a new relationship with the worker to be established.

5.0 Lessons Learned

5.1 Opportunities for professionals working with families to meet together and discuss their individual elements of Intervention and their knowledge of the

case are vital to ensure that there is a joined up approach when working with families.

5.1.1 Pre-birth assessments should routinely be considered in cases where there are concerns regarding the level of support which may need to be offered to a mother and her child; this should not be exclusively applied to cases where there are safeguarding concerns. Pre-birth assessments can be considered by all professionals working with a family and this consideration should take place within all professional environments with accountability for making a referral to request this for a family held by each individual professional.

5.1.2 Practitioners need to ensure that they remain professionally curious and confident to challenge parents appropriately. This should include the ability and confidence to request that parents allow them access to the child's sleeping and bathroom arrangements where there are concerns regarding the home environment.

5.1.3 The quality of referral information received by the Children and Families Service is directly correlated to the quality of the response. Throughout this case good information was received leading to Initial Assessments and contacts/referrals to services being made appropriately. It was noted in this practitioner event that the quality of the North Yorkshire Police's information had developed positively in quality.

6.0 Conclusion

6.1 It is clear in this case that there was a great deal of good practice undertaken by a variety of professionals all working to support the family in all aspects of their lives. Contacts/Referrals appear to have been of a good quality and assessments have been undertaken appropriately as a result. The co-ordination of support to family members could have benefit from a more structured approach. It could be argued that it may have been likely that this could have been enhanced via the use of multi-agency meetings to co-ordinate Interventions, to monitor improvements and importantly to identify reoccurring themes and concerns. For example the oscillating concerns in respect of the home conditions, however it is also important to identify that a multi-agency meeting could have been called at any time during the period of Intervention by any agency.

6.2 Practitioners need to have confidence and display adequate professional curiosity to ensure that issues, in particular the other areas of the home including the sleeping arrangements are considered and that questions are addressed regarding information presented solely by the presenting parent. This was effected by the Midwifery Service who sought clarification from the GP regarding mother's self-represented health information. Further consideration could have

perhaps been afforded by all professionals to exploring the identity and potential role of Child C's father in her life.

7.0 Multi-Agency Recommendations

7.1 York Hospital NHS Foundation Trust:

1. YTHFT will undertake an annual audit of maternity records and share the findings with the Learning and Improvement sub group.

2. The holistic assessment tool to be reviewed to include evidence of comprehensive home assessment; including a review of each room.

3. A Standard Operating Procedure to be developed to facilitate midwifery staff having access to safeguarding and midwifery information in an electronic format.

7.1.1 North Yorkshire Safeguarding Children Board:

1. Review of the Pre-birth practice guidance to ensure that enough emphasis is made regarding consideration of a pre-birth assessment to ensure that appropriate support is offered to vulnerable parents. Once completed for the revised Practice Guidance to be disseminated via the NYSCB.
2. Seek assurance that the 'step up/step down' arrangements in North Yorkshire are robust and ensure that children in North Yorkshire receive the right services at the right time and that their journey between services is effective.
3. NYSCB to produce guidance for professionals when making a referral.

7.1.2 North Yorkshire Prevention Service:

1. Ensure that all practitioners are aware of the NYSCB pre-birth assessment practice guidance and are aware of issues of additional support for vulnerable parents.
2. Ensure that practitioners are aware of issues of potential disguised compliance and ensure that all information pertaining to home conditions are assessed appropriately.

3. Ensure that all practitioners and their managers consider the need for a multi-agency meeting to be convened to coordinate the work with families, and develop a shared action plan with the family.

7.1.3 North Yorkshire Police

1. To provide assurance to the NYSCB that the safeguarding referrals made by North Yorkshire Police remain at a good standard.
2. North Yorkshire Police to implement the new Neglect Screening Tool for use of all frontline Officers.

7.1.4 Children Social Care

1. Work with the NYSCB to review and updated the pre-birth assessment guidance and ensure this is embedded across the service.

8.0 Appendices

8.1 Glossary

8.2 Bibliography

8.1 Glossary

Significant Incident Learning Process	SILP
Serious Case Review	SCR
Learning Lessons Review	LLR
Working Together to Safeguard Children 2015	WTSC15
Children and Families Service	CFS
Children's Social Care	CSC
Family Outreach Worker	FOW
Common Assessment Framework	CAF
North Yorkshire Police	NYP
Harrogate District NHS Foundation Trust	HDFT
York Teaching Hospitals NHS Foundation Trust	YTHFT
General Practitioner	GP

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Report Reviewed: Elaine Wyllie, James Parkes and Sophia Lenton-Brook, July 2018

Report Published: December 2018