CHILD M

SERIOUS CASE REVIEW

28th August 2018

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ABBREVIATIONS.

ABBREVIATION/TERM	DESCRIPTION
ANCC	Antenatal Cause for Concern
A&E	Accident and Emergency Department
CAF	Common Assessment Framework
CDOP	Child Death Overview Panel
CIG	Critical Incident Group
CSC	Children Social Care
EHAT	Early Help Assessment Tool
EPDS	Edinburgh Post Natal Depression Scoring Tool
GP	General Practitioner
HV	Health Visitor/Visiting
LSCB	Local Safeguarding Children’s Boards
LSCB	Local Safeguarding Children Board
NORT	Neonatal Outreach Team
SCR	Serious Case Review
SIDS	Sudden Infant Death Syndrome
SUDIC	Sudden and Unexpected Death in Infancy and Childhood.
LADO	Local Authority Designated Officer

SECTION 1: THE REVIEW PROCESS.

1. ***Thanks**:* The Independent Reviewers would like to thank Child M's parent for their willingness to participate and contribute to this review process and professionals, managers, multi-agency and the provider organisations who openly and honestly reflected on and shared their experience of working with the family. Their contributions were extremely advantageous, enabling enhanced learning and the identification of good practice. The motivation and passion of front-line professionals, to make a difference to the life of Child M and the family was evident throughout the process.

2. ***Anonymity:*** The review has been written to protect the identity of Child M, the family and involved professionals. The emerging themes, key lines of enquiry and significant events have been discussed in a style which minimises the risk that either the child or family's identity will be un-intentionally revealed. Multi-agency professionals will be described in respect to their job role to protect their anonymity. This approach was taken to encourage open and honest reflection of safeguarding practice.

3. ***Copyright:*** This serious case review (hereinafter known as SCR) has been jointly produced and authored by the Independent Reviewers: Jane Carwardine and Melanie Hartley. Its content has been quality assured by the Local Safeguarding Children Board (hereinafter known as the LSCB) and the Critical Incident Group (hereinafter known as the CIG). It is owned by and copyright remains with the LSCB. Permission should be gained from the LSCB prior to sharing the content of this review either in paper form or electronically with any organisation or individual.

4. ***The Critical Incident Group (hereinafter known as the CIG):*** The LSCB invited partner agencies from cross border Local Authority areas to contribute to the review process as well as local providers. The CIG was represented by;
   - Two Independent Reviewers to chair, author, lead and support the review process.
   - LSCB: Business Manager, Business Support Manager.
   - Police: SCR Unit, Detective Inspector, Police (Cross Boundary).
   - Local Authority: Principal Manager CSC, Clinical Development Lead Tier 2 and 3 Early Intervention and Prevention Service, Early Years Safeguarding Lead.
   - NHS CCG: Assistant Director Safeguarding Children/Designated Nurse Safeguarding, Children Looked After Lead.
   - NHS Foundation Hospital Trust: Named Nurse for Safeguarding Children, Specialist Safeguarding Nurse.
   - NHS Foundation Trust (Community): Named Nurse for Safeguarding Children.
   - Drug and Alcohol Services: Operations Manager.
   - Housing: Team Leader.

5. ***The Decision*:** In July 2016, following the death of Child M, the case was subject to a rapid response[1] and notified to the Child Death Overview Panel [2] (hereinafter known as the CDOP), which is a sub-group of the LSCB. A decision was taken to await the outcome of the criminal and Coronial Investigations before the review process was initiated. Subsequently there were no charges levied in the criminal investigation and the Coronial Verdict found "*it was not possible to ascertain the cause of death".* In May 2017, further information came to light and the CIG had an initial discussion, followed by a second discussion in July 2017, post the Coronial Inquest. The discussion related to; leaving the children unattended, alcohol consumption, and leaving the baby in the car seat, did not reach a consensus opinion. However, it was felt that the parents going against expert feeding advice was neglectful parental behaviour and required further analysis. Child M was a premature baby, with a low birth weight and a consistent feeding routine would have been critical to healthy development and wellbeing. The feeding routine was not adequate at that time. The professional advice offered was

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[1] A Rapid Response is initiated for any child/infant death which was not anticipated as a significant possibility either 24 hours before the death or as a result of an unexpected collapse or incident precipitating the events that led to the death, the rapid response process is a coordinated multiagency approach intended to secure the best information available to understand how the child/infant has died.

[2] The CDOP works on behalf of its respective LSCB to collect and review information about each child death to prevent further deaths. Downloaded 25.11.17 www.gov.uk

reported by services to be explicit and repeated, so parents should have been fully aware of their responsibilities. During discussions with parents during the review an alternative perspective was offered which is described later in this review. The CIG membership advised that the criteria[3] for undertaking a serious case review had been met in that Child M "*had died*" and "*abuse or neglect of a child is known or suspected".*

6. *The Serious Case Review:* A comprehensive SCR was commissioned, and a hybrid methodology was used to complete the review, combining several theoretical models and techniques.[4] [5] [6] This format ensures key events, lines of enquiry and themes relating to safeguarding practice are critically analysed, with practitioner and service user participation. It was felt this approach would provide a greater insight of the issues raised in this case. Most of the service provision were employed by organisations within the responsible Local Authority area. Services from three other Local Authorities are also referred to as they provided services during the timeline of the review and following the death of Child M.

7. A combined multi-agency chronology of key events was developed from the initial agency information which had been provided to the CIG and further information was sought as gaps in data emerged. A learning event was facilitated for agencies authors, to support them in the production of learning summaries.[7] The learning summaries produced were of high quality and identified learning, recommendations and good practice points. These are contained in the appendices of this document. A timeline of significant events was subsequently developed in preparation for practitioner conversations.

8. *Agency and Practitioner Participation*: Two events were facilitated for multi-agency professionals; an initial event to develop the information in the timeline and a second event to feedback the review's findings. Practitioner feedback was positive and provided additional opportunity for multi-agency professionals to share their experience of working with the family, under such distressing circumstances. Additional verbal and e-mail conversations were convened with professionals when necessary. The following agencies were represented in events, conversations and other communications;

- Drug and Alcohol Services: Partnership Recovery Coordinator.
- Primary School: Deputy Head, Deputy Safeguarding Lead.
- Early Learning and Child Care Team.
- Neonatal Unit: Sister Outreach Team, Staff Midwife Outreach Team, Lead Nurse, 2 Staff Nurses.
- NHS FT: Health Visitor.
- Housing.
- Social Worker.
- Probation Services: Senior Probation Officer.
- Rapid Response Team (Cross Boundary): Specialist Nurse Responder.
- The Local Authorities Designated Officer. (hereinafter known as LADO)[8]
- Tier 2 and 3 Local Authority Early Intervention and Prevention Service, Clinical Development Lead.

9. *Timeline:* The CIG agreed the timeline should start from 1s December 2014 (the beginning of the 1st twin pregnancy) to 8th August 2016 (the completion of the section 47 investigation following Child M's death)

[3] HM Government (2015) Working Together to Safeguard Children- a guide to inter-agency working to safeguard and promote the welfare of Children. Crown Copyright. Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews.

[4] Welsh Government (2012) Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Model.

[5] SCIE Learning Together to Safeguard Children: A Systems Model for Serious Case Reviews.

[6] HM Government (2015) Working Together to Safeguard Children- A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children. Crown Copyright.

[7] A learning summary provides a brief statement of the learning gained by an agency/individual from a significant issues/event following a period of reflection and analysis into the issues under consideration. Recommendations and actions to develop practice can then evolve from the learning achieved.

[8] The LADO is the Local Authority Designated Officer and whose function is to monitor and provide advice or guidance to employers and voluntary agencies in respect to the management of allegations against individuals who work with children.

A contextual historical perspective of information held in agencies, in line with the review's terms of reference was also requested.

10. ***Research Question.***

"*Is the LSCB assured that multi-agency partnerships work cohesively and effectively with infants, children and their families to provide Early Help and protection where there is a history of parental alcohol misuse, mental ill- health issues and domestic abuse?"*

11. ***Terms of Reference.***

No.	Issue
1.	Was relevant historic information about the family/parental functioning known and considered in the multi-agency risk assessment, planning and decision-making in the pre-birth and neonatal period?
2.	Was the multi-agency planning robust, appropriate, effectively implemented, monitored and adequately reviewed in the pre-birth and neonatal period to reduce the risk of harm to the infant?
3.	To what degree did agencies challenge each other regarding the effectiveness of the risk management, planning and decision making?
4.	Were the respective statutory duties of agencies working with the infant, parents and family fulfilled?
5.	Were there organisational or contextual obstacles or difficulties in this case that prevented agencies from fulfilling their duties?

12. ***Parallel Investigations:*** All agencies/services were requested to share information relating to single agency incident reviews, however agencies advised no incident reviews had been completed in respect of the case. The case will also be discussed at a perinatal mortality meeting within the NHS Foundation Trust Paediatric Department, following completion of this review. It has also been subject to a preliminary discussion within the CDOP, which will be concluded following completion of this review. In May 2017, the Coronial Investigation was concluded. The narrative verdict was as follows: "*having been fed at 02 30 hours, Child M fell asleep whilst secured in a car seat which was placed in an upright position on a bunk bed in a room of a hotel. Shortly after 10 20 hours later that morning the infant was found deceased and still seated in the upright car seat. Despite a subsequent forensic post mortem, it was not possible to ascertain the cause of death."* The criminal investigation was concluded, and no criminal charges were levied. The case of one of Child M's older siblings was chosen as a case study within an audit prior to an Ofsted visit. The information would have also included details of Child M. There was no inspection write up available to understand these findings.

13. ***Equality and Diversity Considerations*****:** There are complex ethical dilemmas when considering interventions in pregnancy with parents, who have complex social or health support needs and are engaged in behaviours that may have the potential to cause harm to the unborn infant. A significant dilemma is the complexity of the statutory pre-birth assessment in part because the foetus has no legal status. In addition, early intervention in the United Kingdom can be problematic as a pregnant mother can seek a termination of pregnancy up to the 24th week of pregnancy under the Abortion Act (1967). As a result, in practice there may be conflicts between the pre-birth procedure for intervention and the instigation of legal proceedings which is not possible prior to birth. There is also limited focus on the pre-birth assessment in research which only forms a small part of the literature assessment base in safeguarding and protection work.[9] [10]

14. There is a growing body of evidence to demonstrate very young babies are extremely vulnerable to abuse either intentionally or unintentionally.[11] Early work with parents and families to assess the risk, plan intervention and assess parental motivation to manage the risk in the antenatal period can reduce

[9] Hodson A., (2012) How Research on Pre-Birth Assessments Should Affect Practice. Community Care 30.8.2012. Downloaded comunitycare.co.uk 27.8.17.

[10] Calder M., Hackett., Et Al (2013) Assessment in Child Care –- Using and Developing Frameworks for Practice. 2nd Ed, Russell House Publishing.

[11] Ofsted (2011) Messages from Serious Case Reviews.

the risk of harm to an infant. This intervention can be offered under the framework of Early Help or through the statutory social work pre-birth assessment process.

15. Members of this family had protected characteristics[12]. Father had significant long-term mental health issues. There is an increasing recognition in society, that parents with mental health issues have the right to family life and the right to become parents, with the outcome that the infant/child remains a part of family life. However, to be successful in this outcome and ensure the risk is managed for the infant, these parents may need reasonable adjustments in the provision of both Adult and Children's Services. They are entitled to these adjustments under legislation (Equality Act 2010). Whilst father received a range of Adult Services to support a desired improvement and stability in his mental health, there was limited evidence at the time of collaboration between Adult and Children's Services to assess and support his parenting capacity, considering this was to be his initial experience of parenting. This provision may have provided the additional support required to develop Child M's fathers parenting capacity. **(LP 1)**

16. Child M's sibling (11months older) had complex health and developmental needs. It is positive this child was referred for specialist support through the Early Learning and Childcare Team through outreach support at a time when the family were experiencing significant stressors. The Neonatal Outreach Team (hereinafter known as NORT) provided outreach and long-term support to mother in her management of Child M's sibling. These are positive example of services making reasonable adjustments in their intervention for the child with disabilities.

17. Pregnancy and maternity is a protected characteristic but applies to discrimination in respect of breast feeding and employment rights. Mother voluntarily resigned from Education employment towards the end of her first twin pregnancy. The review understands this was due to the challenges in working and balancing the requirements of family life whilst heavily pregnant. There was evidence her employers were attempting to support her in the workplace during the pregnancy.

18. ***Family Participation:*** The CIG considered family participation in the review process. The family moved to another Local Authority area after Child M's death, which created a delay in securing communication. An information leaflet and letter was sent to mother in respect of the serious case review process. A meeting was facilitated with Child M's parents and the Independent Reviewers in March 2018, just prior to the presentation of the final overview report to the LSCB. The parents asked for their perspective on the provision of services, should be was described within the report, as it may help other parents who were in their situation. Their perspective on the provision of services is presented as part of the executive summary. In June 2018, prior to publication a further meeting was convened with the parents, an Independent Reviewer and the LSCB Board Manager to share the review's learning, recommendations and to discuss to plans for publication. Child M's parents were in agreement with the learning, recommendations and the plans for publication.

19. ***The Independent Safeguarding Reviewers.***
Jane Carwardine has worked as an Independent Safeguarding Consultant since April 2015 and has completed eleven case reviews (adult and children) for health, social care and LSCB organisations across North West England. She holds an MA in Child Care Law and Practice (Keele) and a BA Honours in Health Studies (Bolton). Her professional background is a 42-year career in nursing (Nurse, Health Visitor and Midwife). Jane has undertaken a range of strategic, provider and commissioning management roles. Prior to commencing consultancy work she had 15 years experience in a variety of safeguarding leadership roles including; senior and line management, Named Nurse, Designated Nurse for Safeguarding (adults and children) and Head of Safeguarding. Examples of her safeguarding activities includes; supporting the completion and quality assurance of SCRs, leading on multi-agency safeguarding learning and development, assuring the quality effectiveness of safeguarding activity, complex case management, development of multi-agency teams, developing and facilitating

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[12] The Equality Act (2010), Section 4, introduced the concept of "protected characteristics" and other multiple forms of discrimination. There are nine additional characteristics under the legislation to be in force under the legislation on or before 25th November 2017. These are known as; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation Downloaded 25/11/17 legislation.gov.uk.

supervision systems, developing and leading safeguarding advisory services, membership on safeguarding boards and providing advice to a range of strategic boards. Jane has been directly involved in the completion of more than twenty serious case and multi-agency learning reviews. She has worked intensively to improve the quality effectiveness of the case review process and has previously represented the Royal College of Nursing on the Royal College of Paediatrics and Child Health Child Protection Committee and within case review work. Jane was previously employed within one of the cross boundary local authority areas, however her employing organisation at the time is not aligned to this review.

20. Melanie Hartley became an Independent Safeguarding Consultant in August 2016 following her retirement from the NHS after 41 years of service. She holds an MA in Child Welfare and Protection (Huddersfield) and firmly believes that effective multi-agency working is vital if vulnerable children and adults are to be adequately safeguarded. The case review process is a key component in this work. It ensures that multi-agency lessons are learnt and that actions are implemented leading to improvements in multi-agency safeguarding practice. Melanie's professional background is also in nursing (Nurse, HV), including 20 years' frontline experience as a Health Visitor, working with complex and vulnerable families and 10 years' specialist safeguarding experience (Named Nurse Safeguarding Children, Designated Nurse for Safeguarding Children/Children Looked After and Head of Safeguarding including safeguarding adult responsibilities). These roles required the development of expert skills and knowledge in all areas of multi-agency operational and strategic safeguarding work. Melanie has been involved in the production and quality assurance process for numerous single and multi-agency case reviews. She has significant experience of leading and chairing a Safeguarding Board's case review panel which enhanced her experience in case review methodologies and practitioner involvement. This is her 7th review as an Independent Reviewer. In preparation, Melanie has undertaken relevant training and fully participated in and shadowed a serious case review process undertaken by another Independent Safeguarding Reviewer. She has not been employed by any organisation aligned to this review.

SECTION 2: EXECUTIVE SUMMARY.

Keywords: Early Help, Pre-Birth Risk Assessment, Pre-Birth Early Help, Pre-Birth Social Work Assessment (Section 17 and 47), Assessment and Intervention with Parental Substance Misuse (Alcohol), Domestic Abuse, Assessing Parental Capacity, Thresholds of Concern, Understanding History and Assessing Capacity for Change, Parental Alcohol Behaviours, LADO.

2.1 Family Table.

Member	Relationship	Detail	Residence
Mother	Birth mother to all children		
Father	Birth father to 1st and 2nd set of twins		Lived with his parents and family
Child 1	Primary School age		Lives with mum
Child 2	Primary School age		Lives with mum
Child 3	Primary School age		Lives with mum
Twin 1	Died aged 3 days.	1st twin pregnancy born June 2015	N/A
Twin 2	Died aged 16 months old	1st twin pregnancy born June 2015	Lived with mother
Twin 1		2nd Twin Pregnancy born May 2016	Lives with mother
Child M Twin 2	**Died aged 10 weeks**	2nd Twin Pregnancy born May 2016	Lived with mother

2.2 A Portrait of Child M.

21. In May 2016, Child M was a 2nd twin, delivered at 28 weeks gestation, by normal delivery, weighing 920g (just below the 9th centile).[13] Child M required resuscitation at birth, received neonatal care, made good progress and was discharged from hospital (aged 8 weeks) having maintained the required growth curve. On discharge home, Child M remained under the care of the NORT, who had also been involved with the family following the birth of the previous set of twins. At the time of discharge, it was documented that Child M was bottle fed, although it was later recorded mother was breast feeding or giving expressed breast milk with some supplementary infant formula feeds. Documentation identified inconsistencies relating to feeding practices and mother described the advice she was given as unclear. **(LP2)** Child M's growth was sub-optimum. Professionals advised Child M initially lost weight on discharge, and this was monitored, requiring a change in the feeding regime. Overall, Child M remained small and the infant's growth when plotted for this review, had dropped to around the 2nd centile[14] with some slight improvement, prior to death **(LP 3)** This is a known risk factor in sudden and unexpected infant deaths.

22. Child M was in the high-risk category of infants at risk of sudden and unexpected infant death due to; extreme prematurity, low birth weight, sub-optimum growth, an infant from a multiple birth and living in a household where there was parental/caring smoking and alcohol use. There was evidence that professionals (Midwifery, Neonatal and Health Visiting Services) regularly provided information through literature and conversation in respect to Safer Sleep advice and the prevention of Sudden Infant Death. They discussed the associated risk factors including; smoking in the same environment, the infants place of sleep and alcohol use. The sleeping plans on holiday were discussed prior to the holiday and the planned sleep system included the use of cots. There was some discussion in respect to the use of car safety seats.

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[13] Centile recordings are recorded on a growth chart and are used by health professionals to follow a child's growth over a period. The range of centiles on the chart reflect the range of size within the population and the growth chart plots the weight and height of the infant/child. Charts are adjusted for premature infants. The 9th centile means that 9% of the infant population are below this growth curve. The trend of growth is the most significant importance rather than a single weight.

[14] The 2nd centile means that 2% of the child population are below this growth curve.

23. Normally the first few weeks of a full-term infant's life is developmentally exciting as they begin to smile, communicate and settle into family life. However, a premature infant may respond differently as the brain and neurological system is immature and may not respond in the same way as a full-term infant. Therefore, up to Child M's death, the infant was still very immature developmentally and it was difficult to gain a character portrait. Professionals described Child M as a settled baby who would wake for feeds, looked well, was alert and well cared for. Child M appeared content to professionals, in the busy household, interacting with the sibling group and vice versa.

2.3 The Family Context.

24. Child M lived at the family home with mother and five siblings. Father did not formally cohabit but visited regularly. He was only documented to be living with the family after the death of Child M. Three older maternal half-siblings were of Primary School age and lived with Child M. Child M's twin sibling and an older sibling with complex needs (aged 14 months) were also cared for in the home. The family had some contact with paternal grandparents, aunts and uncles but it is not known how these relationships supported childcare arrangements. Mother was reported to be isolated from her own family.

25. ***Child M's Sibling Group***: Child M's twin sibling was discharged from hospital on the same day as Child M and was described as settled, fed well on infant formula and maintained his growth trajectory. An older sibling (11 months) with complex health and developmental needs, required mother's engagement with multiple service providers at a time she was struggling due to the twin pregnancy, bereavement issues, relationship difficulties and housing challenges. The older sibling died following Child M's death following an acute infection. Child M's three older siblings attended a local Primary School. Their attendance at school was good, they made satisfactory progress and there were no concerns about their educational attainment. The children communicated well in school and interacted well with their peers. They were generally well presented in the school environment, with only one documented episode when concerns were expressed. Mother participated in the school community.

26. ***Parental Relationship:*** In August 2014, Child M's parent's relationship commenced 2014, following fathers release after serving a custodial sentence. They experienced significant relationship difficulties partly due to bereavement, up to the point of Child M's death. In the early days of their relationship, mother was subject to two assaults in the community which she thought were because of her newly formed relationship with Child M's father. They conceived two twin pregnancies, delivered at an interval of 11 months, of which only one of the infants survived. The parental relationship was not always stable, with father disappearing for periods of time and mother left to care for her six children alone.

27. ***Mother:*** Child M's mother had mostly resided in the responsible authority area and had a positive history of engagement with services and professionals. She had no prior criminal history. Professionals described mother's childhood as difficult at times as she was "*in and out of care*" and she had vocalised "*she wanted a better life for her children*". Her relationship with her own mother was not assessed as supportive. She had no significant prior health history, although following the birth of the 1st set of twins, her mental/emotional health was understandably compromised. This was not always known by key professionals in contact with her during this period. A close friend described as supportive unfortunately died around the same time as Child M, which was an additional significant loss for mother. All the professionals involved observed mother to have a positive relationship with her children and vice versa and advised she had previously provided her three older children consistently good enough parenting as a single parent. Police were called two incidents involving alcohol and aggression with family members and although mother was present, she was not involved directly in the incidents. It was documented she was trying to resolve the issues. There were four documented events that her alcohol behaviours were a cause for concern and these were a potential point in time for early intervention and are explored in this report.

28. ***Father:*** Father had lived mostly in the responsible authority area. His criminal history was extensive resulting in a range of convictions which included a custodial sentence. He was supervised by Probation Services during the timeline of this review and "*was keen to turn his life around*". Father had a significant history of challenging behaviours that were linked to his alcohol misuse and mental health challenges. Professionals advised he appeared at times to be quite immature and would get irate then

argued with mother. His reactions could be volatile, and he was known to punch walls in anger, although there were no notifications, professional concerns or disclosures in respect of domestic abuse against Child M's mother. He often was not present at the home when services visited. Professionals highlighted they had observed father to interact well with all the children and he had a good relationship with his older step-children. The children responded well to father. Father reported to his General Practitioner (hereinafter known as GP) he was happy to become a father. He lived with his own family locally. Father's contribution to the tasks of caring for the sibling group was not fully understood or effectively assessed. **(LP4)**

2.4 The Trigger Event.

29. One morning In July 2016, at approximately 10 00hrs, father found Child M (aged10 weeks), un-responsive in a baby car seat in the hotel room. Father carried Child M downstairs to the hotel reception, where the Hotelier telephoned the Ambulance Service (10 21hrs) and commenced resuscitation. The Paramedics (First Responders) arrived at the scene within 2 minutes and continued to resuscitate Child M. A Senior Paramedic then arrived at the scene, noted there were signs of rigor mortis[15] on Child M's body and a decision was taken to discontinue resuscitation. At 11 15hrs Child M was transferred to the local Accident and Emergency Department, where the death was confirmed at 11 23 hrs by the on-duty Paediatrician.

30. The history given by Child M's parents was; the family was on short four-day holiday at a nearby holiday resort (35 miles away from home) with their six children. Child M's death occurred in the morning, following the 2nd night of the family's holiday. The three youngest children were settled for the night in the attic bedroom anytime between 19 00hrs and19 30hrs the previous evening. The twin infants were placed to sleep in their car seats, **(LP 5)** which were upright on the bottom bunk bed. The parents had planned to use a sleep system which included carry cots, but this was reported to be too heavy to carry up the three sets of stairs to the attic room. Their sibling (aged 13 months) was placed to sleep in a bunk bed, although it was not known whether this was in the same room. Child M's parents and their three older children then went downstairs to the hotel lounge to socialise, and the parents disclosed they were drinking alcohol in the hotel bar during the evening. The three younger children were reported to have been checked on every 30 minutes. Some of these checks were verified by a review of the hotel's CCTV [16] and the Police conversations with the Hotelier. The parents returned to their bedroom at approximately 01 00hrs and Child M was fed by her mother with a feed of 3oz infant formula at 02 30hrs. The Hotelier advised parents were not excessively intoxicated the previous evening.

31. The Police were notified, and the rapid response process was initiated, in line with local protocol. The scene was secured as a possible crime scene where it was noted there were empty cans of lager and beer bottles, as well as empty infant feeding bottles in the room. There were no cots or sleep systems present in the room, which was described as tidy and clean. At 12 05hrs, following the confirmation of Child M's death, parents voluntarily consented to forensic tests to determine their blood alcohol levels, as part of the investigation process. These tests were requested due to the parental disclosure of their alcohol intake, in the previous 24hrs. The blood tests are taken by a Forensic Medical Examiner, who is required to visit the Hospital to obtain the samples and the results were within an acceptable range. There were professional concerns expressed during the process of the review, about possible delay in securing the blood tests. This meant the parents had to remain in the hospital for a longer period, at an incredibly stressful time. Further enquiry identified the challenges in securing such samples as parents must be questioned, kept engaged during this traumatic period and will also be subject to an investigation by social care, following the loss of their child. Therefore, requesting their consent to blood tests can be a sensitive issue to manage. Professionals must ensure parents have the capacity to volunteer to such tests at an extremely stressful time, rather than feeling coerced into giving the blood samples. Once consent is secured a Forensic Medical Examiner must be identified who will often need

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[15] Rigor mortis is a recognisable sign of death, is caused by chemical changes in the muscles post death, which causes stiffening of the limbs. It can occur as soon as 4 hours following the death. Downloaded Wikipedia 20.1.18

[16] CCTV is also known as video surveillance, is the use of a video cameras to transmit a signal to a specific place, on a limited set of screens.

to travel to secure the samples. This can cause further delay in securing timely blood sampling when parents voluntarily consent. The only quicker alternative would be to arrest parents to obtain samples in a custody suite through PACE[17] requirements, however the arrest of parents is inappropriate when the evidence does not indicate a clear case of homicide. **(LP 6)**

32. Parents reported during their holiday Child M was feeding, settled and content. Further discussion identified in the 24 hours prior to Child M's death the infant had only three feeds. This was a low number of feeds considering; the infant's sub-optimum growth, gestational age and the feeding pattern was not thought to be in line with expert advice. The NORT had advised that there should be "*no longer than 5 hours between feeds and to wake baby to feed".* This was considered as potential neglectful parental behaviour by the CIG and was a key factor in triggering this review. However, the conversations with mother during this review highlighted that she was very much left to manage the feeding patterns with very limited advice and support. She thought this was due to her previous experience of breast feeding and motherhood.

33. There were four referrals to CSC (2006, 2014, 2015, 2016) which are discussed in this review. It is positive three referrals of these referral converted to Children and Family Assessments. One of these assessments resulted in the case being closed whilst the other two led to recommendations for an Early Help Plan and a Child in Need Plan. Mother's use of alcohol was a repeated focus of concern. There was some evidence that professionals attempted to work with the parents to assess their alcohol use. Father would seek support in respect of his alcohol behaviours and mental health challenges. The subsequent interventions with father appeared to promote more stability in his complex presentation, with significant relapses following bereavement which was managed by Adult Services. Mother's patterns of alcohol use were not well understood, and her disclosures of nil-alcohol were not always supported by professionals' observations or evidence. There were challenges for professionals in understanding how they could more effectively work with mother when they felt she minimised her alcohol use. **(LP 7)**

34. It is positive there was a strong focus in the assessments on assessing the children's wellbeing. The welfare of the unborn infants was less of a consideration. At the time the multi-agency system to work with pre-birth safeguarding concerns was not robust, this has been strengthened. There was evidence of agencies working to support the family members and of interagency communication. In 2015, the outcome of a Children and Family assessment was the initiation of an Early Help plan. The focus of concern for the welfare of the unborn infants and parental alcohol use was lost during the process and the case was closed. The rationale to not initiate Early Help planning was unclear, became confused and ineffective. It is positive a more co-ordinated multi-agency approach to the provision of services was observed in 2016, after the birth of Child M. This was instigated by the Portage Service in respect to the child with disabilities, it considered the welfare of the other children and was fully agreed by parents. There was minimal interface between Adult and Children's Services. This meant the assessment of father's parenting capacity was ineffective and Children's Services had very minimal information to support their assessment of risk. Whilst father was regularly seen by professionals and spoken to, his role in family life was not fully understood. He was a "*hidden male*" as the focus of professional's attention was on the mother, with no real understanding of how the parents worked together in the provision of care to their children and the sibling group.

35. At the time of Child M's death, the family were subject to Section 17[18] intervention following a referral to CSC by the Local Neonatal Unit, prior to Child M's discharge, due to concerns about maternal alcohol use and her attachment to Child M's sibling. Mother had not been made aware of the intention to refer

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[17] PACE relates to the code of practice which establishes the powers of the police and the protection of public rights under the Police and Criminal Evidence Act 1984.

[18] Section 17 Section 17 of the Children Act 1989 defines a child as being in need. The Local Authority is obliged to offer the following specific services/support for children in need in their area: advice, guidance and counselling, occupational, social, cultural and recreational activities, home help (including laundry facility), facilities or assistance with travel to and from any services provided under the Act or similar service, assistance to enable the child and the family to have a holiday. Downloaded from protectingchildren.org.uk 24.11.15.

the issue to CSC and was shocked to receive a telephone call from CSC informing her of the referral, whilst feeding her babies on the local NNU. This will be discussed later in the report.

2.5 A Parental Perspective.

36. This perspective is provided from the notes of the meeting held with Child M's parents, the Independent Reviewers and the LSCB Board Manager in March and June 2018. The review has identified learning points and good practice in respect of some of the issues raised by Child M's parents

37. Mother said "*a key issue had been changes to practitioners involved in providing support which she felt made things very difficult for them as parents. Her main concern was having to tell a new practitioner everything again and again, including about the deaths of their children. They are trying to move on as a family and having to talk about the loss of their children again made that more difficult. At times, this led to both parents refusing further support e.g. counselling when the counsellor was going on maternity leave and a new counsellor was offered."*

38. Child M's parents said *"they weren't made aware of referrals to Children's Services beforehand by NICU staff. Mother found this upsetting, as it meant she received a phone call from a Social Worker, out of the blue, whilst in the NICU Unit. Mother felt that several NICU staff members knew the family, given that one of her first set of twins had been cared for there the year before and then her second set of twins. They should have told her if they had concerns, it made it difficult to go back into the unit".* **(LP10)**

39. Child M's parents said *"they had been offered bereavement support. In 2015, Father was referred by his GP to the Hospital Counselling Service in the local area, following the first infant death. He rang for an appointment but didn't receive one. Father found the Mental Health Crisis Team support very good at home following the death of Child M. He felt it would have helped if one service could have provided bereavement support to all the family and home visits are beneficial. Mother attended for counselling in the local area via her GP service and then again when she moved areas but does prefer to talk to people she knows. The staff at the Primary School in the LSCB area had been very supportive of the children and mother which really helped. The school in the new area also has a service for the children which mother feels is very valuable. In the new area the counselling provision for parents is available which mother found helpful, but the counsellor left for maternity leave and she didn't want to see another counsellor. Child M's parents found it difficult to understand how bereavement services were provided".* ***(LP 21)***

40. Child M's parents said that *"they received plenty of advice and support in 2015, when their 1st set of twins were in the Regional NICU, the staff were brilliant and provided practical advice and support without being prompted, which included information regarding travel expenses, meal vouchers etc. In addition, they were offered a parent's room and father felt well supported by the hospital chaplaincy service. It was much harder when the babies were being cared for in the local NICU as little practical advice was given and it was difficult to get there. They had to get two buses to the hospital, walk or get taxis which were expensive. Some of the staff in the local NICU Unit were lovely, but some could be funny, abrupt and didn't seem to appreciate the parent's other child care responsibilities, if they had to leave the unit e.g. to collect the older children from school".* ***(LP16, 20)***

41. Parents discussed attending safeguarding meetings*; "father disclosed having avoided attending the CIN meetings. He understood at the time he was drinking alcohol a lot or all the time, but felt his criminal history being raised was unfair as it was in his past. He felt he was being blamed or judged to be the bad one. He acknowledged that might have been also due to how he was feeling. He felt excluded, the children were also his and Child M had died. Father felt that services tried to help them as parents attend meetings e.g. by arranging the CIN meetings in school at appropriate times. Mother disclosed that father not attending meetings caused problems between them. She had never missed a meeting but didn't like attending. She felt they could have supported each other at these. She disclosed that she is an independent person and doesn't like having to rely on other people. Father said they had not had the opportunity to sit down with professionals together."* The discussions with the Independent Reviewers and the LSCB Board Manager were their initial opportunities for shared such discussions and valuable.

42. Mother recalled *"a delay (around 12 weeks) in the coordination of the transfer-in meeting when she moved areas following the death of Child M. They were told this was due to documentation needing to be transferred first but felt overall the transfer was 'ok'. A new HV quickly visited then another HV took over at a meeting who is also nice. Initially they met one SW at the meeting but then a new SW was allocated, remained their SW and was brilliant. Both parents really liked the new SW. Father said it was helpful for him to have a male SW and this helped him to move on. A referral for support for father by a male worker had been made in the LSCB area but this support ultimately couldn't be provided."*

43. Mother discussed *"both twins slept a lot after they were discharged. Mother disclosed knowing she only had enough breast milk to feed one baby and decided to breast feed Child M after discharge. Breast feeding was more difficult than in her previous experience. She was also expressing breast milk which was difficult (getting 40-50 ml at a time) and didn't get much support, being left to her own devices. She supplemented Child M with a couple of bottles of formula milk if she felt Child M hadn't had sufficient breast milk in a day. Mother's understood was Child M was gaining weight and was feeding Child M whenever she needed/wanted feeding. Her recollection was that Midwives had told her to carry on as you are doing. She understood that the infant's growth is monitored through plotting the weight on a centile chart, however advised the red book was never used in this way. She gave Child M's sibling only formula milk after discharge". (***LP2 and LP 3)**

44. Child M's parent's perspective was that *"safer sleep advice was given in 2015, prior to her surviving twins discharge but that it wasn't given when Child M and sibling were being discharged. The Neonatal Outreach Midwives had observed the sleeping arrangements in the home and given advice. Mother said they had a double pram which came off the base, but it was too large and heavy to get up the hotel stairs to their room. She would never have let the babies sleep in car seats at home. They weren't offered a cot or anything else in the hotel, but the hotel manager said a cot had been offered after Child M had died."*

45. Child M's parents said that *"Following Child M's death parents reported the blood samples were taken 60-90 minutes after getting to the hospital. The other children were all cared for on a ward while they were at the hospital. Mother understood the Police had a procedure to follow and had to ask a lot of questions. They also had to wait for confirmation from CSC before they could take their children home. Both parents found a Police Officer having to be in the room while they were spending time with Child M very difficult. However, this Officer appeared upset when they were leaving and that helped them as they could see he was sympathetic. The attending Paramedics had also been visibly upset. On returning to the hotel, they couldn't collect their belongings and had to come home without them, but the Police returned everything to their home afterwards. They felt this aspect of service provision was positive."* ***(LP6)***

46. Father said that *"he had one Probation Officer, who knew him well. He could communicate well with this officer and had helped him a lot. The officer moved to a new post but saw him one day after while he was waiting to see his new worker. The officer took him into a room and spent time asking him how he was doing which he appreciated. Father also found the Alcohol Service workers to be brilliant, they keep in touch with him to check how he is doing and to offer appointments."* ***(Good Practice 3)***

2.6 Predictability and Preventability

47. The review of this case identifies that there were complex interacting risk factors that possibly precipitated the death of Child M. Child M was an infant identified to be at high risk of sudden infant death due to; being between 2-4moths of age,[19] being a premature infant from a multiple birth, being a small baby with sub-optimum growth and living in a household where the main-caregivers smoked and used alcohol. Child M's death was potentially predictable due to these high-risk factors. Professionals attempted to work with parents to reduce the risk through the provision of regular advice and checks

[19] Research data varies to some extent, however 90% of deaths occur in the first 6 months of life and the level of risk peaks between 2-4months of age.

that the advice was being followed. Information leaflets were provided, and professionals believed Child M's parents understood the advice being offered in how to reduce the risk for Child M. This was evidenced by professionals observing where Child M was placed to sleep at home, parents smoking outside the home and agreeing that only one parent would consume alcohol if they were drinking. There were further professional discussions with parents to plan for safer sleep whilst on the holiday and new baby car seats were bought to ensure Child M and the twin sibling were transported safely. Whilst the review has identified areas of multi-agency practice that could be strengthened, it has not identified any serious omission in practice that contributed to the death of Child M. The parents could not follow through on the plans to ensure Child M could sleep safely in the hotel and made the choice to place Child M to sleep in a car seat. This is one of the most significant risk factors in sudden infant death.

SECTION 3: A CHRONOLOGICAL ANALYSIS OF EVENTS AND THEMES.

3.1 A Perspective of Significant Safeguarding History Up to December 2014.

48. ***Relevant Maternal History:*** Mother had a difficult childhood and was looked after by the Local Authority, for periods. This experience made her determined to provide her own children with a good childhood. Following the birth of her first child, mother was introduced to her Health Visitor (hereinafter known as HV) who remained allocated to the family following all her children's births and had good insight into the family's functioning. Documentation and practitioner conversations indicated mother's engagement was always positive, and her three older children attended for all the routine developmental assessments and immunisations. This engagement continued as the older children entered school and their care was transferred to the School Nursing Service. Mother attended the GP Service regularly and appropriately for consultations about her children's health. On some occasions the GP made referrals for her children to consult with Specialist Consultants at mother's request. There is evidence mother followed through in attendance and medical investigations for her children. The children attended NHS Accident and Emergency Services appropriately and not excessively. Education were also in close contact with mother and her three older children, advising the children were never a cause for concern. They had good attendance rates, were well presented and always a positive part of school life. They made expected progress academically and their attainment was within the average range for their ages. The children socialised well in school and had positive peer groups. There was also indication that mother was able to find solutions to challenges e.g. when she presented as homeless she was able to find a solution.

49. Prior to December 2015, there was no significant history presented in respect of maternal ill health. In 2005, during her first pregnancy, mother disclosed to cross-boundary Maternity Services, she had cut down her alcohol consumption to 2-3 units per week, from 25 units per week. At that time, it was acceptable for women to consume 2-3 units per week, however 25 units per week was more than double the recommended intake for an adult female. Mother was open in her disclosure and at that time Midwifery Services, would not have had concerns as she had reduced her alcohol intake in response to her pregnancy. However, research evidences that users will frequently minimise their intake. There is now greater professional awareness about the negative impact of maternal alcohol use on infants/children and working with maternal disclosure. Currently, the commissioning organisation in the responsible area monitors direct enquiry about alcohol use in Maternity Services, and is assured that mothers are asked about alcohol and substance misuse. This is crucial, so Maternity Services can then target intervention to women at risk of excessive alcohol use. **(Good Practice 1)**

50. In 2010, the Health Visiting records identified mother had been the victim in two domestic abuse incidents. These were described as domestic conflict between mother, Child 1's father (who was her ex-partner) and his extended family. The couple had by then separated, so no further action was taken. It is evidenced that later mother's relationship became more positive with her ex-partner and his extended family. In 2011 and 2014, the Police documented two significant incidents involving extended family members and friends when alcohol misuse was a feature. Mother was present but was not directly involved in the incidents, she was acting as a protective factor during these incidents and her children were not present. There was no evidence mother was engaged in anti-social behaviour or criminal activity and she was not known to the Criminal Justice System.

51. ***Relevant Paternal History:*** Between 2000 and 2013, father was involved in significant levels of criminal activity. Convictions were secured for a range of activity including; assaults, damage, theft, fraud, robbery, firearms, and a court offence. Probation Services advised father's alcohol misuse was a contributory factor and that he had used alcohol as a coping mechanism to support his mental health/emotional challenges. A variety of punishments were levied against him including reprimands, warnings and a thirty-month prison sentence for robbery. At the time of his custodial sentence he was assessed by Probation Services as a high risk of serious harm to the public and had no stable protective factors in his life. He was assessed as a low risk to children. In August 2014, he was released from custody on licence, following which he commenced a relationship with Child M's mother. In October 2014, he was reassessed by Probation Services as a medium risk of re-offending and violence and remained a low risk to children. In November 2015, his supervision by Probation Services ended. Probation Services worked with father to support his attendance at Drug/Alcohol and Mental Health Services. Probation Services have continually strengthened their approach to ensure their Offender Managers maintain a focus on the children that service users may be involved with. They have developed a consistent approach with CSC to cross reference their service users link with children. **(Good Practice 2).** His behaviours were assessed by Drug and Alcohol Services not to be due to an alcohol dependency, so he was offered an Early Help intervention (6 sessions of 1:1 work to enable increased knowledge and motivation to change) The service was persistent in trying to secure his engagement but unfortunately was not always successful. (**Good Practice 3)**

52. The first set of twins (June 2015) were to be father's first children and there was no evidence he had prior parenting experience. He was living at home with his parents and brothers at the time he found out Child M's mother was pregnant (December 2014) and reported to the GP *"he was looking forward to his role as a father and wanted to be a good father"*. He moved to reside with mother and her children around the time of Child M's death. It was known that mother found it difficult to keep track of him and he would go missing for days at a time, sometimes on drinking binges.

53. In August 2014, at the beginning of father's involvement with Drug and Alcohol Services, he advised his worker that he was not a parent. Whilst he was not a parent he had developed a relationship with mother, who had three children and may have therefore assumed child care responsibilities. The worker was not required to revisit the issue of child care responsibilities. There was no system in place in the service to cross reference information with other agencies and enable the risk to be robustly assessed on an ongoing basis. It is positive the service has now strengthened this system to ensure there is more comprehensive partnership working with Probation and CSC. In addition, the service has completed workforce development in respect of; professional curiosity, hidden males in families and improved the supervision of such cases by introducing a "*huddle*"[20] approach in response to this review.

54. In August 2014, post-release from custody, father consistently approached his GP for support in respect of his mental health. The GP assessed his mental health with the support of the recommended questionnaire.[21] He was diagnosed with a moderately severe depression and was prescribed medication. The GP continued to monitor his progress over the following months in line with expected practice.[22] There was some evidence the GP understood father was not living with the family and in practice the question regarding childcare responsibilities would only be asked once, although it is probable a GP would have commented on interaction if father had attended with the children. Father was registered with a different GP practice than mother and the children, so therefore didn't see father with the children which may also have acted as a trigger. The GP was not aware of the significance of father's criminal history **(LP 8)**

[20] A "*huddle*" is a regular peer to peer discussion, around 30 mins in duration, designed to support a self-directing and self-correcting workforce. It is led by the frontline professionals although supervisors and managers may be present.

[21] A Patient Health Questionnaire-9 (PHQ-9) is a type of assessment tool and is designed to facilitate the recognition and diagnosis of depression in patients. For patients with a depressive disorder, a PHQ-9 can be calculated and repeated over time to monitor change.

[22] National Institute for Health and Care Excellence (NICE) Depression in adults: recognition and management Clinical guideline [CG90] (April 2016).

55. Father was a "*hidden male.*"[23] Professionals saw him but tended to focus their intervention on mother. He did not have parenting or child care experience. Therefore, professionals did not have a historical context to base their assessment of his parenting capacity. His motivation and happiness to become a parent was evident. However, there were indicators of risk (unstable mental health, aggressive outbursts, extreme alcohol behaviours) in his presentation that should have alerted Adult Services (Drug and Alcohol Services, Probation, General Professionals) to the need to assess his capacity to provide childcare on an ongoing basis. This could have supported the development of further risk assessment, analysis and intervention. This issue has been recognised area of learning by agencies (General Practice, Drug and Alcohol Services).

56. ***Initial Referral to Children's Social Care (CSC):*** In 2006, Child 1's birth-father reported concerns to CSC that mother was misusing alcohol. Child 1 was eighteen months old at the time. Child 1's father was advised "*to seek legal protection for the child*" and the case was closed with no further action. This response was not uncommon in practice at that time. However, this could have been an early opportunity to begin to understand whether the maternal alcohol misuse was impacting directly or indirectly on the child, it provided an opportunity for early multi-agency support and the prevention of an escalation in alcohol behaviours. This was a historical issue and current expectations of practice have been strengthened. These types of contacts with CSC would now trigger discussions with other agencies who may be involved with the family such as Education, Early Intervention Services, Health Visiting and School Nursing. It would not be routine practice for CSC to contact the family's GP, which is an omission when considering GP's have ongoing responsibilities for families and hold significant amounts of relevant information**. (LP 8)**

57. Child concerns expressed by family members can be difficult to assess, however such disclosures provide an opportunity to assess the risk, rather than families having to resolve the issue respond through legal action. It is positive that current practice has been strengthened, however the search for information following a contact/referral to CSC should include securing relevant information from GP Practices. A new electronic information system is evolving within GP practices "*share to care*" which will make the search for information easier. **(LP 8)**

58. ***2nd Referral to CSC:*** In August 2014, Child 3's Nursery School made a referral to CSC. The concerns were; mother who was employed in the Nursery to work with children had bilateral black eyes and could be a victim of domestic abuse, thereby placing her own children at risk of physical/emotional abuse. Her youngest child had not attended Nursery for over two weeks. A child's parent from the Nursery, had also requested her children were not supervised by Child M's mother in the Nursery or attached Primary School, as she was misusing drugs and alcohol. The referral was converted to a Children and Family Assessment. The family strengths were assessed. The children's health, educational, cognitive developmental and social needs were all assessed to have been met by their mother and the children were relaxed in their home environment. They communicated and interacted well and there were no concerns regarding the home environment.

59. The risk factors identified were that; mother had recently commenced a relationship with Child M's father and his own mother was unhappy about the relationship. Child M's mother advised the Social Worker she thought father's mother was asking people in her local community to assault her and tell malicious lies about her in the Nursery i.e. drinking alcohol, taking drugs and leaving the children unsupervised. Child M's mother advised she had been assaulted twice in the presence of her children. Once when she was at the local shop a member of the public pulled her to the ground by her hair and punched her. A few days later she was outside her own house when a car pulled up, three people got out of the car and head butted/hit her. Mother sustained the two black eyes and injuries to her face from the second incident. Mother did not report these incidents to the Police as she did not want to cause any more trouble. She was frightened to leave the family home. Mother denied using drugs or drinking alcohol to excess. She disclosed she drank alcohol a few times a week (4 cans of lager at each

[23] NSPCC "Hidden men: learning from case reviews, summary of risk factors and learning for improved practice around "hidden men". Downloaded NSPCC 14.2.18 nspcc.org.uk

session), which dependent on the strength of alcohol consumed, was more than double the recommended units per day at that time. [24]

60. It is positive there was communication between the Social Worker and Education, Probation Services and Drug/Alcohol Services and the referral converted to a Children and Family Assessment. The outcome of the assessment was a referral would be made to the LADO by the Social Worker, as mother was employed to work in the Nursery School. The referral was made and assessed. The threshold for a LADO initial action meeting was not met but the Nursey School, as mother's employers, were asked to monitor her presentation during her employment. This was necessary to assess and manage the risk she could pose to the school population, if she presented for work intoxicated. There were no concerns for her children's welfare and the threshold for Social Work intervention was not met. Mother was offered early support from the Local Authority[25] but refused to take up this offer and so the case was closed to CSC.

61. More focus on the maternal alcohol behaviours could have been beneficial. The Social Worker's conclusion was mother was meeting her children's needs and there was no evidence to substantiate she was using alcohol to excess, using drugs or leaving the children unsupervised, was not entirely robust. Mother's own disclosure of her alcohol intake should have prompted more professional enquiry given the disclosure indicated a maternal alcohol intake which was above the safe recommended level. This was an opportunity to focus on the risks of alcohol use. **(LP 7)**

62. In conclusion, prior to the conception of the first set of twins (2015) there is considerable evidence mother was able to provide her children with good enough parenting. There were no concerns expressed about her relationship with her children, who were well presented with no professional concerns about their behaviour, self-esteem or levels of educational attainment. Multi-agency services were in contact with the family and it was their assessment the children and family met the criteria for universal service provision, with no additional needs during this time. There were occasions when mother's alcohol behaviours were raised as an issue. However, there was no apparent professional curiosity into her use of alcohol, with a professional belief that it wasn't an issue. The parents had commenced their relationship around the point father had been released from custody and key Adult Services were involved in supervising and supporting his return into the community. Whilst Adult Services asked about whether he had children this was not a broad enough enquiry and should have been more focussed on understanding his contact with children, whether he had assumed child care responsibilities, irrespective of his registered address. This would have supported an improved hypothesis of the risk and also would have created an opportunity to work with father to support his parenting capacity positively. (**LP 9)**

3.2 Significant Safeguarding Events and Themes: January 2015 to 8th August 2016.

63. ***Confirmation of Twin Pregnancy 1:*** In early January 2015, mother's pregnancy was confirmed by the GP. She was just 5 weeks pregnant and at that time was not cohabiting with father, who had continued to live with his own family. She received specialist maternity ante-natal care at the hospital, as is expected practice in twin pregnancies, due to the high risk of complications. Her pregnancy appeared to progress normally, although it was difficult for her due to pregnancy related minor ailments.

64. ***3rd Referral to CSC**:* In April 2015, when mother was 20 weeks pregnant, she attended the local A&E Dept with a rash. A series of tests were undertaken, to eliminate cholestasis.[26] It was documented

[24] Policy Paper 2010 to 2015 Government Policy: Harmful Drinking, Department of Health and Social Care. Downloaded www.gov.uk 9.3.17 – the lower risk guidelines in 2014 suggested women shouldn't regularly drink more than 2-3 units per day. Regularly was defined as drinking most days or every day. 1 unit of alcohol was equivalent to a 1/3rd pint of normal strength beer/lager.

[25] Support Services 0-19years which provides a locality-based approach and provides a wide range of support, advice and information for families.

[26] Cholestasis is a liver disease that only happens in pregnancy when the normal flow of bile is affected by the increase of pregnancy hormones.

mother smelled of alcohol[27] and the blood results showed a high level of alcohol. A&E staff made a referral to CSC due to concerns for the welfare of the unborn infants, informed the organisation's Named Midwife,[28] who in turn informed Maternity and Health Visiting Services with responsibility for providing mother's ongoing care. There is no documentary evidence mother was aware or informed of the planned referral to CSC. **(LP 10)** It is positive that CSC progressed this referral to a Children and Family Assessment. (**Good Practice 4).**

65. Information was gathered by CSC, to support the risk assessment and most of the required checks were completed. Historical information was secured. The assessment identified; Primary School 1 had noted the children's presentation had recently deteriorated. Mother worked in school, and there were significant concerns for her wellbeing at the time, resulting in the LADO being re-contacted for advice regarding her employment. Her mood was low, and it was thought this was having a negative impact on her children. The Social Worker completed a home visit, seeing the parents and children. It is positive the children were spoken to and they did not disclose any issues of relevance. Mother denied she had consumed alcohol prior to attending the A&E Dept, despite the conclusive evidence. She advised she had only drunk alcohol (lager) 3 times during her pregnancy. It is positive the Social Worker undertook an assessment with mother, using a valid alcohol tool. This identified mother's alcohol consumption during a session was of concern. **(Good Practice 5)** Mother advised before her pregnancy she used to drink once a week and was previously drinking more when at her previous address because of issues with her neighbours. She advised the previous few months had been difficult, due to pregnancy related pains and discomfort. Father advised he had now cut down his alcohol intake and previously had drunk alcohol every day. He reported he had been released from custody in August 2014 and had attended an alcohol awareness course. He admitted to drinking alcohol once a week, and then had 3-4 pints. The Social Worker thought that both parents understood the concerns and the impacts of excess alcohol consumption on their own and their children's health and wellbeing. They did not consider it to be a problem for them.

66. During the timeline of the Children And Family Assessment, father was under the care of Community Mental Health Services due to concerns about his mood, having been referred to the Criminal Justice Liaison Team[29] by his Probation Offender Manager. The GP was aware of this plan and was treating father for depression. It was understood at the time father had; long term anger issues, a diagnosis of depression, struggled with sleep, a history of alcohol and illicit substance use and had continued to experience anger issues. A referral was made to the IAPT Service [30] to provide access to psychological therapies. Father was assessed to meet the criteria for step 2 therapy by the IAPT service, due to his depressive illness. There is no evidence that this information was known by the Social Worker undertaking the Children and Family Assessment.

67. The Social Work assessment included discussion with all relevant family members, including the children. There was evidence of multi-agency communication to gather information by professionals who were involved in the mothers and children's lives. There was also evidence of management supervision, with a plan to support the family. However, there was no evidence of enquiry with Adult Services (Community Mental Health, Drug and Alcohol, Probation and GP) who were all involved in providing support to father. This information would have supported an improved understanding of father's challenges and provided a base to hypothesis the potential impacts of the challenges he was facing, on his parenting capacity. **(LP 8)** Whilst father had attended a couple of sessions of the alcohol awareness course, he had not completed the sessions. Probation would have been aware of the risk he posed from a public protection perspective and the GP was in regular contact with father to support the management of his depression. It is important that there is a joined-up approach including Adult and

[27] This was documented within the LADO service recordings
[28] The Named Midwife for Safeguarding provide a leadership role and safeguarding expertise to the organisation, its workforce and multiagency partnerships. The post-holder will have local knowledge for safeguarding children and promoting their welfare.
[29] Criminal Justice Teams are present in Mental Health Trusts to work with those individuals who have been accused of a crime but also exhibit mental illness. The work is undertaken through a variety of approaches including links to Probation Services.
[30] IAPT Services provides improves access to a range of evidence-based treatments for people with anxiety and depression. They are characterised by evidenced based psychological therapies, routine outcome monitoring and regular outcomes-based supervision for Professionals to provide high quality care. Downloaded NHS England wngland.nhs.uk 10.3.18

Children's Services to develop a clearer understanding of the children's daily experience of life. Building the jigsaw of family life must include the assessment all relevant adults within the family unit, who provide care to the children, irrespective of their residence, to provide a robust account of the current situation. **(LP 1)**

68. The assessment could have been strengthened by exploring father's role in family life and creating an initial hypothesis of his parenting capacity, given the impending birth of twins, increasing the sibling group to five children. (**LP 4)** Assessment in safeguarding work requires an investigative approach to ensure all relevant information is secured. There is a risk that crucial information is missed if key Adult Services (Mental Health, Probation, Drug and Alcohol, GP, Police) are not contacted as part of the assessment of risk. **(LP1)** At the time nationally, Probation Services were undertaking significant transformational change which may have impacted on the quality of information sharing with CSC. It is positive that local information sharing between CSC and Probation Services has been strengthened and it would be now being routine practice for these services to share information during a Child and Family Assessment**. (Good Practice 2)**

69. The outcome decision was to step down the case to Early Help intervention. It was assessed the risks associated with mother's alcohol use could be managed under the framework of Early Help and the concerns did not meet the threshold for statutory on-going CSC involvement. The children and mother were seen every day by Education, who had agreed to continue to support and monitor the children. The LADO closed the case as the threshold for a Section 47 investigation was not met, the allegations were "*unfounded*" and soon after mother left her employment in the school, due to her pregnancy related health challenges. Midwifery Services had agreed to complete direct work with parents around alcohol consumption and the impact on the children and had agreed to continue monitor mother during the pregnancy. There is no documentation to evidence this work was undertaken by Midwifery Services or whether there was consideration of referral to the Specialist Substance Misuse Midwifery Service who had the experience and skills to work with mothers with these types of problems. **(LP11)**

70. In conclusion, it was positive this referral quickly progressed to a Child and Family's Assessment. However, the welfare of the unborn twin infants should have received the same focus as was on the older children's welfare, considering the clear evidence of maternal intoxication in the pregnancy. There was professional acceptance into parental reasoning regarding alcohol use, despite evidence that disproved this perspective. The parental lack of insight into alcohol behaviours, greater understanding of the father's functioning, improved understanding of how the adults worked together as caregivers to the children, the hypothesis of paternal parenting capacity and the inclusion of Adult Service information should have been more of a focus in the assessment. The CSC learning summaries have made recommendations to strengthen future practice. The step-down plan was agreed between the Social Worker and Education. It was agreed the Primary School would initiate an Early Help Team around the family, to support the planning. There is no evidence the provision of an Early Help plan was agreed with Child M's parents, prior to formalising the step down to Early Help. (**LP 12)** The focus of the step-down plan was to offer support around; children's presentation, parenting emotional needs, managing the children / routine and parental alcohol use. However, there was no focus on managing the risks to the unborn twins, through the pre-birth Early Help framework. (**LP 13)**

71. ***May 2015 - 1st Early Help Meeting***: An Early Help meeting was convened, 8 days after the referral had been made. The Social Worker was not in attendance although had recorded all professionals had been spoken to during the assessment process and were willing to engage with an Early Help plan of support. Education had been identified as the agency to act as the lead professional. The meeting was attended by mother, Health Visiting, Education and Midwifery professionals. Adult Services were not in attendance. **(LP 1)** The review has not been able to secure the minutes of the Early Help meeting so the narrative is gained from practitioner conversations and Health Visiting documentation.

72. The outcome was an Early Help Plan would not progress, and the case would be stepped down. The rationale for this decision was confused. The initial feedback was mother would not consent, therefore an Early Help plan could not progress without consent. However, professionals advised they had not considered escalating this issue for further supervision or feeding back the outcome to the Social Worker who had stepped the case down to Early Help. This was not an expectation of practice. **(LP 13)**

As the review progressed new evidence emerged through conversations to clarify it could have been the professionals in attendance who made the decision a plan was no longer required. The Health Visiting Service had documented "*It was deemed by all that an Early Help wasn't necessary*" following the meeting. The decision not to progress was also clarified during practitioner conversations yet a perspective that mother would not consent was also offered. The children's presentation had improved therefore the plan was not required. Education understood they had been asked to coordinate the plan for the children attending their school, rather than the pre-birth concerns. Mother agreed to follow-up visits by Midwifery and Health Visiting Service. The Health Visiting Service quickly offered mother a home visit following the decision not to progress with the Early Help process. This home visit was an antenatal contact which was offered earlier than expected but allowed the HV to conduct a more thorough assessment, which included mother being asked about alcohol use. There is no evidence in respect to the additional support offered by Maternity Services or whether they continued to work with the plan which had been agreed with the Social Worker following the Children and Family assessment. (**para 56)**

73. An expectation of practice is the minutes of all safeguarding meetings are distributed to all attendees and form part of the agency records. However, services have not been able to retrieve these minutes for this review. Maternity Services cannot be certain whether they received the minutes. Education understood they were transferred with the children's records when they moved schools into another Local Authority area. It is crucial in safeguarding work that professional's records contain this information as part of their chronology of safeguarding events. **(LP 14)**

74. The concerns for the older children's welfare was addressed and quickly resolved. Mother was feeling very tired due to her pregnancy and was suffering from pregnancy related minor ailments. She was struggling to manage with the everyday household tasks and mother and father were not co-habiting at that time. This provided a rationale for her children's presentation, however the planning to support the welfare of the unborn infants through Early Help, was not adequate. It may have been more appropriate to allocate the lead professionals role to Midwifery Services, who at that time had a Specialist Midwife able to work with pregnant mothers on issues related to drug and alcohol use. Education advised they are regularly asked to lead on cases when children attend their school, when the areas of concern are about parental behaviours. They advised the management of parental alcohol behaviours are not within Education's sphere of expertise. This regularly results in cases being closed at the first meeting if the children's presentation is not a concern, resulting in minimal or no effective planning or intervention for families. **(LP 13)**

75. It is positive the Early Help system has been strengthened centrally to ensure more robust monitoring of cases stepped down to Early Help within tier 2/3 Early Intervention Service. This was not robust across all the partnerships. At the time it was not expected practice the Social Worker completing the Children and Family Assessment would coordinate or attend the initial Early Help meeting. The Social Work presence was crucial to support the transition to Early Help and would have supported more effective information sharing. **(LP 12)** CSC were unaware that the Early Help planning had not been effective, when the Children and Family assessment was signed off 4 weeks later, a few days before the birth of the 1st set of twins. At the time there was no step back into the CSC system, to feedback the outcomes of Early Help to CSC. **(LP 12)** Universal Services did not consider informing CSC of the outcome or seek supervision when it was documented mother had refused to engage in Early Help processes, which may have been an opportunity to re-consider the risks and the options for statutory social work intervention. **(LP 15)**

76. It is crucial Social Workers inform the family of the intention to step down cases into Early Help and have received parental consent for that level of intervention. Professional's reflection was they felt out of their depth, especially when mother refused to consent and that this is a recurrent issue in practice. This case was stepped down to Education, who advised there are significant challenges for Education leading the pre-birth Early Help process when the issues to be managed are adult focussed. At the time locally, there was multi-agency pre-birth guidance, however this focussed on the statutory responsibilities for Children's Social Care if their threshold was met for pre-birth intervention.

77. The review has not been able to secure single or multi-agency guidance that may have been operational at the time of this event, to support professionals in their management of pre-birth concerns through Early Help processes. During practitioner conversations there was a lack of understanding as to how this process would be managed. It is positive this issue has been recognised by Midwifery Services, who have now developed an internal flow chart/policy to support professionals in this area of work. The LSCB has developed guidance to support the multi-agency management in cases of pre-birth Early Help and this should be made accessible and hyperlinked in other relevant multi-agency guidance, policies and procedures. The issue of Early Help in the pre-birth period is not adequately reflected in key guidance.[31] **(LP 13)** There needs to be a focus on the development of the workforce and monitoring of the Early Help provision in the pre-birth period by single and multi-agency partners. (**LP 13)**

78. In conclusion, Early Help is not a new concept and national guidance provides a clear expectation of Universal Agencies. Their function is not only identifying pregnant mothers with complex health and social needs who may require additional support, it is also about their role in working with pregnant mothers to achieve the optimum outcomes for the infant/s through Early Help processes. In May 2015, the provision of pre-birth Early Help by multi-agency professionals working with this case was ineffectively co-ordinated and the process was not always understood. It is positive that the use of these systems has evolved in practice locally. This improvement should continue in frontline practice and assurance provided to the LSCB of the effectiveness of this system by its partner agencies. Single agency policies and procedures should reflect the expectations of professional practice and link to multi-agency guidance. Frontline professionals should be provided with development opportunities to ensure they can work effectively with Early Help in the pre-birth period in a consistent and co-ordinated way to improve maternal engagement and secure more positive outcomes for the unborn infant. **(LP 13)**

79. ***The Birth of The First Set of Twins:*** In June 2015, a few days after the Children and Family Assessment was closed, the first set of twins were born at 26 weeks gestation, extremely prematurely. It is expected practice that infants born so prematurely, with weights less than 1,000 grams are cared for in a Level 3, Regional Neonatal Intensive Care Unit (NICU) due to their possible need for specialist care and long-term ventilation. The local unit was not a Level 3 NICU, so the infants were transferred to a unit with the provision in a town approximately, 12 miles from their home. Tragically, twin 1 was a neonatal death at 3 days, due to extreme prematurity. After around 5 weeks, twin 2 returned to the local Neonatal Unit, prior to discharge to the family home, in September 2015. There were no safeguarding issues highlighted whilst twin 2 was cared for by both NICUs . Parents visited regularly, although professionals highlighted the challenges for parents visiting infants when placed in Level 3, NICU, which can create significant travel costs and pressures for parents who have other children. **(LP16)** When Twin 2 was discharged home and it was recognised the infant had complex needs with a range of health and developmental challenges. Mother was supported by the local NORT, her GP and the Health Visiting Service.

80. Following the birth of the twins, prior to their transfer a Midwife had noted the recent safeguarding concerns and referral to CSC (April 2015). The Midwife contacted CSC to gain further information in respect of the outcome of the recent safeguarding investigation. The Midwife was advised the case had been closed and Early Help had been initiated by Education. The information provided by CSC regarding the provision of Early Help was inaccurate. Midwifery had attended the Early Help meeting, so there should have been documentation that an Early Help plan had not been formulated. This information was not available to the Midwife at the point of delivery of the 1st set of twins.

81. It was good practice the Midwife attempted to understand the outcome of the referral and contacted CSC. (**Good Practice 6)** However, there were systems within Maternity Services to share this type of information, although it has not been possible to understand why up to date information was not available. CSC expressed the view that these types of contacts are "*cursory"* and are not about raising concerns. This can create significant pressures for CSC and Maternity Services should ensure they

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[31] Multi Agency Protocol for the Pre-Birth Assessment and Interventions Wigan's threshold document, Early Help Local Safeguarding procedure GM procedures

have robust information systems to ensure relevant safeguarding information is available. **(LP 14)** The multi-agency system has been strengthened and professionals are now able to get feedback about the progress of Early Help cases through a Central Hub.

82. ***Mother's Mental/Emotional Health and Alcohol Behaviours:*** The Health Visiting Service asked mother about her emotional/mental health in the antenatal period (Early Help Meeting May 2015), when it was documented mum was suffering from depression. The HV followed this disclosure up with a home visit and completed a mood assessment tool[32] prior to the birth of the 1st set of twins. (**Good Practice 5).** Whilst mother disclosed she felt depressed in the antenatal period, her answers to the questions did not support a diagnosis of depression. At that time mother was clearly under significant pressure with the twin pregnancy, struggling to cope with everyday tasks and had also been involved in a Children and Family Assessment due to safeguarding concerns. It was understandable she would have felt emotionally challenged. The Health Visiting Service went on to discuss with mother how she was feeling on at least 8 occasions during the timeline of the review, with maternal disclosure of depression raised again only after the death of Child M.

83. The Health Visiting Service was not aware mother had attended the GP surgery, 5 weeks after the 1st twin delivery, feeling very low in mood due to the death of her infant. She had run out of medication originally prescribed in the cross-boundary Maternity Unit for vomiting and nausea and was requesting a repeat prescription. During this visit mother was distressed and crying. The GP diagnosed post-natal depression and prescribed antidepressants with a plan to review in the surgery after one week. She was reviewed by the Practice Nurse who documented "*obvious depression*". However, the anti-depressants had a positive effect and mother started to feel better after 11 days. There is no evidence mother had further anti-depressant prescriptions. It remains unclear how Midwifery Services monitored mother's emotional/mental health wellbeing in the post-natal period, which has been a long term expectation of practice.[33] During practitioner conversations it was understood that Midwifery Services routinely assess women in the post-natal period for mental health well-being. Any deviations from the normal are identified, documented and referred on to Specialist Services.

84. It is positive the Health Visiting Service was focussed on monitoring and supporting mother's emotional and mental wellbeing both in the antenatal and following the birth of the 1st set of twins. This monitoring was ongoing up to the death of Child M. Mother's depression was not prolonged and her symptoms resolved. The Health Visiting and Maternity Services did not appear aware that mother had been prescribed antidepressants for a diagnosis of post-natal depression. Conversations highlighted that the NICU Outreach team liaised with the GP in November 2015. They were offering mother support as she was run down, and father was unsupportive and going out drinking all the time. Communication between interagency professionals is essential in the management of maternal post-natal mental/emotional health and can support assessment of the impacts on parenting capacity. However, there is limited evidence of a co-ordinated approach to manage mother's mental and emotional health by NHS Services.

85. Following the event in May 2015, there were no further recorded incidents of maternal intoxication, until after the birth of Child M when there were concerns expressed by the local Neonatal Intensive Neonatal Unit. This event will be described later in this review. Mother was during this time in regular contact with a range of Health and Education Professionals who were aware of the previous concerns. Practitioner conversations highlighted during home visits there was no evidence that mother was intoxicated. Documentation evidences mother was regularly asked by Health Professionals about her alcohol consumption and her most common response was that she did not consume alcohol.

86. ***Father's Mental Health and Associated Alcohol Behaviours:*** Father had a significant history of depression and emotional challenges resulting in outbursts of anger that were exacerbated by using alcohol as a coping mechanism. However, during mother's 1st twin pregnancy he was monitored and

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[32] National Institute Clinical Excellence Mood Assessment Tool

[33] Guideline Obs. 92, Division of Surgery Directorate of Obstetrics and Gynaecology Antenatal and Postnatal Mental Health 20th May 2015.

supported by his GP /Probation Services and referred to Mental Health Services for specialist support. He expressed a desire to be a good father was his motivation was to address his mental health issues. During this period father appeared to be more settled with no reported escalation in his alcohol behaviours. The GP managed father's mental health positively and according to expected practice. Father's presentation was variable, sometimes feeling depressed and other times feeling better. Following the death of twin 1 in June 2015, he visited his GP feeling stressed, unable to sleep but felt stable. He was prescribed his anti-depressant medication and sleeping medication. The GP explained the addictive nature of sleeping tablets and prescribed them for only for 8 weeks.

87. In August 2015, two months after Twin 1 death, father attended the GP. He disclosed he was drinking 15 cans of lager every night and was counselled to support his alcohol reduction in line with NICE guidance.[34] This amount of alcohol was excessive, in one night he was consuming between 30-45 units of alcohol, the weekly recommended amount being 14 units.[35] This counselling would have covered the potential harm caused by his level of drinking and provided reasons for changing the behaviour, including the health and well-being benefits. Three weeks later father was seen by Specialist Psychological Services who documented he was experiencing difficulties due the bereavement. These included difficulties managing his emotions, isolating himself from his family and avoiding rooms at home where baby equipment was kept as he felt angry and was overwhelmed by them. He requested support in managing his emotions around the bereavement. The service made a referral to the Obstetrics and Gynaecology Counselling Service that offers therapeutic support for a range of issues including neonatal deaths. The service is hospital based and does not offer outreach support. During conversations with father he reported he contacted this service but did not receive an appointment. There was evidence of written communication from Specialist Mental Health Services to the GP.

88. In August 2015, 16 days after his consultation with the GP, the Police were called to a dispute between father and his brother. The incident was initially called in by a male caller as "*a male stabbed by girlfriend*", however the caller hung up. The Police Operator rang back, and a different male explained that no-one had been stabbed. Police attended the address where father was outside. He made no allegations and had no apparent injuries. Father and his brother were described as "*very drunk*". A witness stated both brothers had been drinking heavily, father had become upset and the argument began for no reason. The death of his infant was shared. There were no offences alleged and none apparent. It is positive that the Police responded, and father was taken home by the Police.

89. In September 2015, a 12-year-old passer-by telephoned the Police and made a report of a "*domestic on-going".* The argument was between father and his own mother. Father had left the scene before the Police's arrival. There was no suggestion of any assault or threats other than a public verbal argument. Father had a previous history of conflict with his own mother.

90. In November 2015, the GP received a telephone call from a NORT Nurse who expressed concerns that mother "*is very run down and her partner goes out drinking and isn't very supportive".* The Neonatal Nurse advised the GP the service would "*monitor the situation".* During practitioner conversations the NORT discussed the challenges for mother in that for period. Father would disappear for days at a time on drinking binges and mother had no idea of his whereabouts. At this point the surviving twin from the 1st twin pregnancy had been discharged home from the local NICU, with complex health and developmental needs.

91. In July 2016, following the death of Child M, father consulted with the GP. He was exhibiting extreme distress, crying and self-soothing by hugging and rocking. An urgent referral was made for outreach support by Specialist Mental Health Services Home Treatment Team and the recognition that bereavement counselling would not be appropriate at that crisis point. This was responsive and provided the right level at the point father was in crisis point. Father was compliant with this intervention

[34] NICE Screening and Brief Interventions for harmful drinking and alcohol dependence. Downloaded 10/03/18 http://www.nice.org.uk/ Guidelines advise that adults who have been identified via screening as drinking a hazardous or harmful amount of alcohol should be offered a session of structured brief advice on alcohol which takes around 5-15 minutes

[35] Provided by Drinkaware- Alcohol limits and unit. Downloaded 10.3.18 drinkaware.com

with insight into his behaviours and mental health challenges. Father identified during conversations with the Independent Reviewers that this provision was very supportive at a critical time.

92. Father had a significant history of alcohol as a coping mechanism to emotional distress. He engaged at times with Specialist Services to support management of his alcohol behaviours. There was an obvious deterioration in his presentation following the death of his baby which was clearly linked to the bereavement. Father was open and honest with services about his alcohol use and services responded appropriately. Adult Services were focussed on trying to stabilise father's presentation however there did not appear to be sufficient consideration of how his behaviours were impacting on his parenting capacity, at a time his surviving infant with complex needs, had been discharged. The NORT had considered this issue and approached the GP to discuss the concerns about the impact on family life. A hypothesis could be that Adult Services believed father was not a primary carer and not living with the family, therefore his behaviours would not have an impact or increase the risk for the children. At the time due to his custody conditions, he was required to live at his family's address.

93. ***The Impacts of Loss and Bereavement:*** Professionals were aware during this period of the need to offer and provide bereavement support, in the aftermath of the neonatal death. There was significant evidence of professionals working with the parents and children to ascertain their needs for support. Mother was asked on frequent occasions if she needed support, however she mostly appeared to decline referral to bereavement services. A hypothesis could be that at that time she was; an unsupported mother with four children, one of which was a neonatal infant with complex health and development needs, she was accommodating father's challenging behaviours, was recovering following the twin birth and in addition she already had significant professional involvement in her life to accommodate in her daily routine. **(LP 20)** Therefore given the responsibilities she had to focus on, it was not realistic that she would be able to attend a service for bereavement counselling. It is positive that the NORT and HV service were able to provide her with the opportunity to talk through her feelings which was evidenced during practitioner conversations. However, whilst there was an Obstetrics and Gynaecology Counselling Service its accessibility would have been challenging for both parents. Father's issues were complex requiring ongoing specialist mental health support and it would be difficult to envisage that mother had the capacity to attend for counselling session. During a conversation with mother she reported her children's Primary School was extremely supportive during the aftermath of her children's deaths and that she eventually did access local bereavement services following a referral from the GP in the LSCB area.

94. In September 2015, following the infant death Education supported the children with bereavement issues proactively. One of the children disclosed "*wanted to take pills*". The School quickly responded through a plan of early intervention. The child was offered counselling within the school with parental consent with a clear escalation plan to Specialist Mental Health Services if there was no improvement. This was a successful intervention with the child responding well to the support. **Good Practice.**

95. Professionals advised that in the area the provision of bereavement support is inconsistent. Professionals were not always clear on the most effective type of bereavement support offer, especially when families had complex health and social issues they were dealing with. Whilst the services attempted to work with the parents the accessibility and offers of specialist bereavement support services was unclear. Professionals highlighted they were unaware of a bereavement pathway to guide them. The provision of specialist outreach bereavement support following infant and child deaths is currently not available but was felt would help parents in the same situation as Child M's parents in recognition of the challenges parents have in attending a place where they may have experienced loss. **(LP 21)**

96. ***Twin Pregnancy 2 and Increasing Family Pressures:*** In December 2015, the GP confirmed mother's pregnancy, she attended for all relevant antenatal appointments. In February 2016, it was confirmed this was to be her 2nd twin pregnancy. She again experienced pregnancy related ailments including bleeding, dizziness and a collapse which resulted in her being taken to hospital via the Ambulance Service.

97. In this period the family experienced significant pressures in addition to mother's twin pregnancy. In January 2016, mother contacted the Housing Provider to say the family had been affected by flooding on Boxing Day and her home was not suitable accommodation for her children. Extensive housing repairs were ongoing. She was staying at father's home with her 4 children including an infant with complex needs, who at the time needed oxygen therapy. The house was overcrowded with 9 people living in a 2-bedroom house. Her own property was privately rented, so housing liaised with the private landlord and offered mother alternative accommodation. This accommodation was not located locally to her children's school, so mother chose to remain in father's parents' home the until work completed, which was estimated would take a further 7 weeks.

98. Whilst housing followed the process required to re-house the family, there was no further enquiry in respect to the welfare of her children. The living environment was clearly not suitable for the children. Overcrowding and safer sleeping arrangements should have been a concern. There should have been further conversations with mother when she refused the temporary accommodation to secure more local accommodation. Mother's viewpoint was valid in that she would have struggled with her commitments to move away from the local area. The offer of more local property would have been more acceptable.

99. The Housing Service has reflected on this case and have suggested that they should have considered the safeguarding issues related to the environment and the impacts on the children. On reflection they consider this issue should have been referred to CSC as a safeguarding concern. Whilst it is positive they have reflected on this issue as a potential safeguarding risk, the threshold for CSC statutory involvement would not have been met. There was an opportunity for housing to work with the family and other professionals to encourage re-housing. The consideration of instigating Early Help with mother's consent should have been a consideration or communication with the professionals involved with the family may have supported their assessment of the risks. All agencies should be competent and confident in their assessment of risk according to the multi-agency threshold document and be able to instigate the provision of Early Help. The area has made significant investment into the Early Help process and professionals are now more effectively supported and monitored in this work. In addition, significant transformation work is underway to provide key services on a locality basis, which will make it easier for professional communication. Statutory intervention into family's lives should always be carefully assessed according to the presenting risks and the option of Early Help should always be an option for intervention if the issues raised could be resolvable through alternative processes. **(LP 13)**

100. During mother's pregnancy she had to attend frequent follow-up neonatal appointments, including physiotherapy, with her infant (born in twin pregnancy 1), with which she was fully compliant. In April 2016, the Physiotherapist referred the infant for support from the Early Learning and Childcare Team Portage Service[36] due to increasing concerns relating to development delay. Mother consented to this as she felt it would be of significant benefit to her infant. The initial visit for portage work was undertaken 5 weeks later, but by this time mother had delivered her 2nd set of twins who were being cared for on the local NICU. A series of visits were arranged to be flexible around mother's need to visit the NICU.

101. At the time of the visit, the information contained within the referral form was inaccurate and detailed only one professional's involvement, when there were nine professionals involved with the family. In addition, the provision of an Early Help Key Worker Service should have been discussed with the parents by this point, as the infant met the criteria under the local threshold arrangements. The key working approach builds partnership working with children and young people with additional needs, and their families. Support through a key worker is provided to prevent families from becoming overwhelmed and to help them to make sense of what is happening in relation to the involvement of other agencies providing different types of support and services. It promotes partnership working. The parents were keen to use this approach and the worker ensured the needs of the older children would be considered

[36] Portage is a home teaching service for young children who have an additional need. It supports children's development by helping parents and children to learn together. Portage helps parents and children play and learn together in their home through regular home visits; this involves planning for family focus time, child led play and structured teaching activities.

through partnership working with the school. This was a positive example of the approach to encourage parents to accept Early Help (**Good Practice)** and the service has made recommendations in its learning summaries to address the areas of practice where improvements are needed.

102. It is evidenced that mother's pregnancy was a challenging time for the family, having to accommodate complex issues. Fathers mental health and alcohol behaviours appeared to stabilise and there was no documentation of relapsing behaviours.

103. ***The Birth of the 2nd Set of Twins:*** In May 2016, mother presented in premature labour. The twins were delivered at 28 weeks gestation. Child M was the 2nd twin, delivered by normal delivery, required resuscitation at birth, was ventilated but responded well spending a total of 59 days in the local NICU. The first twin was initially more poorly than Child M, requiring higher level neonatal care in a Regional NICU outside the local area, but returned on day 4 to the local NICU and then made satisfactory progress. Professionals discussed mother's relief that this 2nd set of twins were able to be cared for in the local NICU.

104. Practitioners discussed their concerns that; during the period of neonatal care parents were missing opportunities to visit the twins, mother's use of alcohol was increasing as she sounded intoxicated during telephone contacts (2 occasions) and her attachment to Child M's sibling was of concern. During this period there were increasing pressures as the parents began to accommodate the ,complexity of the health and development needs of their surviving infant from the 1st twin pregnancy. There was increasing involvement from the team around that child, at a time parents were required to spend significant periods of time at the local NICU. This had to be balanced with the needs of their older children, the twice daily school runs and providing care to their infant at home. They had minimal support networks for babysitting their other children and were reliant on lifts or public transport to visit the hospital. All these issues provide a hypothesis as to why visiting may have been challenging. This could have been a period that provided an opportunity to work with the parents and other professionals through Early Help processes. This would have created the opportunity for improved communications, assessment and planning intervention for the family. At this period the family were involved with at least nine professionals which creates significant challenges for parents in compliance.

105. ***4th Referral to CSC***: In June 2016, when Child M was almost 7 weeks old, mother visited the twins on the local NICU. Professionals recorded mother was smelling "*stale alcohol*" but did not appear to be under the influence of alcohol at the time of visiting. There were concerns that mother was not demonstrating attachment to Child M's twin sibling and was only wanting to breast feed Child M. The referral was made to CSC, 2 days later, following case supervision by the organisation's Safeguarding Team. This was the professionals first referral to CSC. The professional discussed the emotional challenges undertaking the referral but felt well supported by the organisation at the time. The parents were not made aware of the referral which is expected practice. During a conversation with mother she said she was surprised that she had not been informed as she thought she had a good relationship with the staff on NICU and was shocked to receive a telephone call from the SW whilst feeding her babies on the unit. The referral stated; "*Parents do currently not know about this referral as they have not been on the unit today and we feel it would cause tension between staff and parents at this moment in time".* This approach is not in the ethos of partnership with families. It is essential that front line professionals can have an open and honest approach in their engagement with service users, irrespective of the challenges in giving difficult messages related to child welfare concerns. (**LP 10)**

106. At the time the professional, a newly qualified Staff Nurse did not challenge mother. The agency learning summary highlighted; "*There had been an ethos on the NNU to preserve the relationships between nurses and parents which had deterred staff from challenging in the past." The* agency learning summary has made recommendations to improve practice. The Staff Nurse said also babies were being cared for in the Special Care Nursery and other parents were present. There was no other place at the time to take mother to have a private conversation. There was only one parent's room which was often busy. The Staff Nurse on reflection understands she should still have found a way to challenge and have a conversation with mother and feels in the future would have much more confidence when dealing with such complex issues. It is positive the unit now has more rooms to enable private conversations with parents.

107. The practitioner conversations enabled reflection on the process followed in this event. At the time there was an ethos on the preservation of professional relationships with parents and this may have impacted inadvertently on safeguarding practice. It is positive there are plans in place to support the unit in development opportunities to increase awareness and skills in professional challenge and professional curiosity.

108. The referral progressed to a Children and Family Assessment. It is positive the Social Worker and a Neonatal Nurse made a joint visit to the family to discuss the referral and the decision to proceed to an assessment. It was apparent the parents were ready and prepared for their babies to return home and the Neonatal Nurse was confident the twins could be discharged home. Prior to discharge CSC made the decision that the family would become subject to Child in Need intervention, under the Section 17 of the Children Act, due to the concerns regarding parental alcohol use and the risks this behaviour posed for their children. Parents consented to this intervention, appearing to understand the risks.

109. ***Discharge Planning:*** Prior to discharge a meeting was convened on the NICU. Key professionals were in attendance who would have ongoing responsibilities for the care of the infants. The preparation for the infant's discharge was completed and included an equipment checklist. A discharge plan was completed and included the plan of visiting by the NORT, Social Worker and the Heath Visitor. Mother was keen to commence breast feeding Child M and at the time was giving expressed breast milk, supplemented by infant formula. An action to refer mother for specialist breast feeding advice was suggested, if mother decided she wanted to establish breast feeding Child M. Practitioner conversations supported greater understanding of mother's decision to only breast feed one of the twins. Child M was the smaller twin and mother was aware would be a greater risk of a life-threatening condition called "*necrotising enterocolitis".* Breast feeding Child M would be a protective factor against the condition.

110. The notes of the discharge meeting did not document whether the key messages to prevent sudden infant death or the use of baby car seats were discussed. Practitioner conversations highlighted this would be normal practice, but there was no documentary evidence. The parents had no recollection of safer sleep issues being discussed prior to Child M's discharge. This has been highlighted in the agency learning summary as an area to strengthen practice. Child M's parents confirmed that they had support from the paternal grandparents and fathers brother. It was a unanimous decision that he infants should be discharged home together the same day.

111. In the following weeks professionals observed what were described as "*good standards"* of care for the children in the family. Mother advised professionals that things are going well at home although felt the burden of the caring fell to her. However, a plan was put in place to encourage father to become more involved. This was documented in the minutes of the 1st Child in Need meeting.

112. ***1st Child in Need Meeting:*** This was convened,11 days after discharge. Parents and all involved professionals (HV, Education, NORT, SW) were in attendance. It was identified the parents were planning a short holiday with their children, although there was no documentary evidence of discussion to support the parental planning for this holiday. Professionals advised during conversations that there were several discussions to support the planning including safer sleep and the safe use of infant car seats for travel. These discussions were not documented. All the children were considered within this meeting and there were no concerns highlighted in respect of their welfare. Father was to be referred to a local Advocacy Service to be allocated a male supporter to help him provide more support to mother. CSC allocated had allocated a Children and Families Support Worker to start looking at direct work with parents. Another meeting was planned for approximately 6 weeks later.

113. This meeting was well documented in professional's records. All professionals were clear in respect of their specific roles and responsibilities. However, the intended outcomes of the Child in Need Plan in relation to the child welfare concerns were not documented. There was no certainty in respect of planned interventions with parents to manage the risks and intervention related to alcohol and mother's attachment to Child M's sibling. There was no documentary evidence of progress that had been made in the work with parents since the twin's discharge.

114. CSC learning summary has made several recommendations to improve practice including the development and implementation of a signs of safety approach to assist in ensuring there is a focus on intervention, to manage the presenting risks, with the outcomes being clearly focussed on and documented in these meetings. The Child in Need Model is being strengthened and this refresh will include a roll out to partner agencies and the workforce through locality briefings.

115. ***Child M Growth and Infant Feeding:*** Following discharge home Child M's feeding routine and growth were closely monitored by the NORT. In addition, the HV service monitored feeding patterns. On discharge it was documented Child M was bottle fed with infant formula and was having some small amounts of expressed breast milk. Mother intended to commence breast feeding and was offered the opportunity for specialist breast feeding support to help her establish breast feeding. She had previous experience of successfully initiating breast feeding so an hypothesis could be that professionals may not have felt the need to offer this service. There is no evidence that this expertise was requested or provided. During conversations with the Independent Reviewers mother highlighted her difficulties in establishing breast feeding Child M. Practitioner conversations highlighted that whilst Child M was in the NNU, mother's breast milk was not established, Child M had not fixed on the breast and the breast milk mother expressed would not have been sufficient for Child M. It was recorded in the discharge meeting notes that Child M was "*Feeding on demand – 5 hourly at present although this length in between feeds is not usually advised for premature babies, if is okay because they are gaining weight"*

116. The Health Visitor completed a home visit, 5 days after discharge, when it was noted Child M was breast feeding. The Neonatal Outreach Nurses were monitoring Child M's weight which indicated that she had lost weight after discharge, which is not uncommon as infants settle into their home routine. At 11 days post discharge, during a joint visit with the NORT Midwife the Children and Families Support Worker documented there were some concerns about Child M weight gain, which was only at the lower acceptable range. Mother was upset regarding Child M's weight gain and advised that "*Child M was demand breast feeding every 3-4 hours and is having one formula feed 90ml, once a day with her medication in it".* It was positive that the NORT Midwife spent time reassuring mother and explained the challenges faced when establishing feeding with a premature infant, who must work harder when suckling at the breast to establish feeding. Mother was advised to continue breast feeding and top up Child M up with 25 ml of formula milk at each feed to increase the calories. Child M was weighed 2 days and 4 days later, it was noted the weight gain had begun to stabilise. During practitioner conversations there was differing perspectives offered in respect of feeding practices. The most common perspective being that Child M had not breast fed and was given expressed breast milk only, that mothers breast milk would not have been sufficient. Professionals could not confirm they had observed Child M to fix and suckle at the breast which would be an expectation in practice. Mother could not recollect that she had been observed breast feeding Child M. Practitioners were confident they had repeatedly discussed with parents the expectations to feed Child M frequently, around 3-4hrly with only one longer period in a 24hr period. However, there was other evidence that parents were advised Child M could be demand fed 5 hourly. Mother advised during conversations she fed Child M on demand and often the infant would sleep throughout the night. At the strategy meeting following Child M's death it was clarified, the parents had been told "*never to leave the feeds for the babies more than 5 hours but given Child M was still small it was recommended every 3 hours, however due to the twin sibling being heavier could go longer at night but a maximum of 5 hours".* There is therefore a lack of clarity in respect of feeding practices as described by professionals and the parents.

117. There is an expectation that all infant's growth is plotted on a growth chart. The centile recordings on a growth chart enable health professionals to follow an infant's growth over a period and are adjusted to accommodate prematurity. The trend of growth is the most significant importance rather than a single weight. These charts were not fully populated at the time and were re-plotted as part of this review process by the agency representative. Overall, Child M weight was significantly less than the twin sibling. Child M's growth curve had dropped from just below the 9th centile on discharge, to below the 2nd centile. There was a slight upward trend in the two weights prior to the death. Child M did not present with any organic cause that could account for the sub-optimum growth pattern. Child M's mother understood that both Child M and sibling was thriving well. During conversations mother highlighted she understood that the weights would be plotted on a chart but has no recollection of this happening. The red book (Parent Held Child Health Record) did not have these entries.

118. In conclusion, during the process of the review it has been challenging to gather the information to be able to comprehensively assess feeding practice, differing professional opinions have at times been offered and whilst Child M was weighed regularly the expectations of growth monitoring practice was not always followed. The agency should reflect on the issues raised and monitor there is accurate documentation of feeding practice and growth monitoring practice is maintained in line with the expectations of national guidance. **(LP 2 &3)** Sub-optimum weight gain is one of the risk factor in sudden and unexpected infant death, therefore this area of practice should always be robust especially when supporting families who have infants with numerous risk factors.

119. ***The Prevention of Sudden Infant Death:*** It was recognised that Child M was at high risk due to extreme prematurity, from a multiple birth, between 2-4month of age, low weight and living in a household where the main carers both smoked and consumed alcohol. A range of Health Professionals regularly provided safer sleep advice to Child M's parents. This advice was generally provided throughout the timeline of the review, during both twin pregnancies and following the births in the NNU and in the community. The advice was given verbally, the sleep arrangements were checked, and written information was provided. The prevention of sudden infant death was re-iterated regularly by healthcare professionals. Professionals advised that the family adhered to the safer sleep advise when at home. Safe Sleep information is provided and discussed by Neo-Natal Nurses, Health visitors and Outreach/Community Midwives. This information is also noted in a clients red child health book when discussed. This review has enabled other agencies outside of health, to consider their role in the prevention of sudden infant death. Both Housing and CSC have made recommendations to develop this area of practice. **(LP 17)**

120. The Health Visiting Service was able to provide clear documentary evidence of the provision of Safe Sleep advice; however, Midwifery and Neonatal Services documentation was less robust at the time and the agency learning summary has made recommendations to improve documentary practice. The CCG as a commissioning organisation, regularly audits this area of practice and has noted continual improvement in how safe sleep advice is given and recorded. Midwifery Services also undertake monthly audits in respect of the provision of safe sleep advice which also identifies an improving trend. The current method of documenting safe sleep advice and discussions is now more comprehensive than at the time of Child M's death. It includes a dedicated safe sleep assessment and action plan template which requires professionals to ask 15 questions to the parent/carer. This will enable professional to identify and risk factors and formulate and action plan

121. A safe sleep assessment includes the use of car seats and this was reported to have been discussed with the family prior to their holiday. The family bought their car seats to transport their babies to their holiday resort and had not used them prior to their holiday. The NORT provided advice that the family should take regular breaks when travelling and advised there was at the time a time limit of 2 hours for babies to be in a car seat. Further research identifies that guidelines are currently inconsistent with some advice saying 30mins, others 60mins and most recently a differing body said 90 mins.

122. The NORT worked with the family to prepare for their holiday. The team advised they discussed their plans for safer sleep in the hotel. The family had adjoining rooms and had planned to take their pram, which had a sleep system to enable the infants to sleep in the correct position. On arrival at the hotel, they would have had to carry the system up three flights of stairs. A professional who attended the scene advised it would have been very difficult to carry the system up the stairs, which were steep and narrow. The parents made the choice to sleep the infants in the car seat. The CSC learning summary identifies learning for its services when working with families with high risk infants going on holiday to work with families and encourage them to explore the issues this case raises i.e. the accessibility of the hotel room to accommodate the family safely.

123. In conclusion, there is considerable evidence that professionals with responsibility regularly and consistently provided safer sleep advice in line with the expectations of practice. **(Good Practice 7)** Practice is continually evolving, and services have updated their processes in line with new national guidance. The commissioning organisation and the different agencies monitor the effectiveness of the system through regular audit mechanisms. The discussions have highlighted new learning in respect to

the need to focus on safer sleep advice when families are sleeping away from their normal environment, families need to be certain about the facilities available and the accessibility of sleeping accommodation. **(LP 18)** There is a national message evolving about the safety messages relating to the use of car seats. This requires a Governmental response to rewrite or create legislation, to insist that manufacturers provide clear directions about placing an infant in a travel car seat. **(LP 5)** There is also an emerging role for wider services than just health to become involved in the safer sleep campaign. All services who provide support and intervention to families should be aware and able to give the safer sleep messages. **(LP 19)** This review identifies similar features to the review of other sudden infant deaths in that how can services work with adults to change their behaviours and ensure the messages are transferred to circumstances when sleeping arrangements may be compromised.

124. ***Post Child M's Death:*** The circumstances and the initial rapid response to Child M's death have been discussed earlier in this review and will not be repeated. Following the initial rapid response, the system was effective, the SUDCI protocol was correctly applied, and the death was treated as unexplained. The SUDCI response was triggered in a cross-boundary area and co-ordinated by a cross-boundary Police Force. Communication pathways were prompt and effective.

125. A Multi-Agency Strategy Meeting was convened on the same day as the death occurred, At the time there were concerns that neglect may have been a feature and the death was unexplained. The meeting was well represented by all involved agencies. The outcome was that a Child Protection enquiry would be initiated, and the case would be stepped up into a Section 47 investigation, to enable a thorough risk assessment to be undertaken, in respect to the children in the family. Parental behaviours were a cause for concern at the time and were thought could have been a contributory factor in the death of Child M

126. It is positive that following the Strategy Meeting, the same day, the SW along with the Principal Manager visited the family. This visit was conducted sensitively but also with a clear focus on protecting the welfare of the other children. There was a focus of discussion about the use of alcohol and the risks to the children and the grandmother was present. A verbal safety plan was made.

127. The day after Child M's death the SW and the Principal Officer undertook a second home visit to commence the Section 47 assessment and reinforced the outcome of the strategy meeting and the rationale for convening a case conference. The factors being;

- the circumstances surrounding Child M's death raise concerns about alcohol use and this has been a previous logged concern with CSC.
- the use of car seats at night time was an inappropriate place for the babies to sleep.
- the level of supervision provided to the younger children was not adequate even though they were regularly checked.
- frequency of feeding was of concern but not discussed

128. There was further evidence of safety planning with the parents and grandmother, with a request that no alcohol should be brought into the house. This safety planning was positive however it wasn't formalised in written form which would have supported the families understanding and retention of information at an extremely challenging time. CSC learning summary has made recommendations in respect of this issue.

SECTION 4: CONCLUSION.

129. The review has considered whether the death of Child M could have been predicted or prevented. The table below provides an analysis of the interrelating risk factors.

<table>
<tr><th>BACKGROUND HAZARDS KNOWN AT THE TIME</th><th>SITUATIONAL HAZARDS KNOWN AT THE TIME</th></tr>
<tr><td rowspan="2">Parental substance misuse (alcohol)
Extended family use of alcohol
History of family violence (both parents)
Father alcohol risk behaviours as a coping strategy
Father assessed as medium risk of re-offending by Probation Services
New and unstable parental relationship
Maternal post-natal depressive illness
Father long term depression and emotional challenges.
Mother intermittent evidence of excess alcohol misuse although minimised
Minimal maternal support networks
History of conflict in father’s family.
Mother no family support and loss of key support (friend died)
Manufacturers guidelines for the use of baby car seats not visible
Emotional impact of bereavement and loss.</td><td>No documentary evidence of safety planning re alcohol use.
Accessibility of and suitability of accommodation in hotel unassessed
High risk infant: suboptimum growth, low birth weight, pre-term, multiple birth, parental smoking, parental alcohol, between 2-4months of age.
Housing challenges.</td></tr>
<tr><td>Hidden or not appreciated
Managing safer sleep in a different environment (holiday)
Unknown that access to attic room with sleep system might be difficult.
Feeding practices unclear
Use of car seats to sleep infants on holiday for longer than 30-90min not recommended
Feeding practices unclear
Coordinating professional involvement.</td></tr>
<tr><th>STRENGTHS/PROTECTIVE FACTORS KNOWN AT THE TIME</th><th>DANGERS KNOWN AT THE TIME</th></tr>
<tr><td rowspan="2">Mother focussed on needs of the children.
Father was keen to be a good parent
Father assessed as low risk to children (Probation Service)
Older children received good parenting.
Positive interaction observed between older children and step-father and vice versa
Some extended paternal family support.
Safer sleep advice given by NHS professionals repeatedly (NORT, HV)
Sleep system and positioning of infant checked by NHS staff
Maternal good engagement with services: GP, NORT, HV, Education,
Father had some engagement with drug and alcohol services.
Father’s engagement with Probation Services
Father some engagement with Mental Health Services.
Father positive engagement with GP
Fathers understood trigger to the use of alcohol and sought help as behaviours escalated</td><td>Interpretation of compliance issues
Maternal alcohol use evidenced intermittently: triggers not understood, maternal denial and maternal normalising alcohol use</td></tr>
<tr><td>Hidden or not appreciated
Joint parenting capacity (mother and father) not fully assessed
Paternal parenting capacity unassessed
Evidence of previous events of maternal intoxication including in previous pregnancy- possibility alcohol used as a coping strategy
Paternal participation in family life unassessed</td></tr>
</table>

Table 1: Analysis of interacting risk factors (factors known at the time of Child M's death)[37]

130. This provides an overarching conclusion as throughout the report the differing issues have been concluded. The review identifies that at times multi-agency partners worked cohesively together and were responsive to attendance at a range of safeguarding meetings. There was evidence of positive multi-agency communication and relationships, however there was also significant evidence of "*silo working"* as the complexities for the family increased. The interface between Adult and Children Services was not robust at the time, resulting in multi-agency Children's Services not having relevant information about key factors in the parents lives that may have supported their assessment of risk and planning for intervention. It is positive that Adult Services have begun to reflect on their involvement in child welfare cases and that the systems for sharing relevant information are now evolving positively between agencies. The Independent Reviewers have been made aware there is significant transformation underway to encourage a locality-based approach to multi-agency service provision which will support the opportunity for improvements in multi-agency communications.

131. The system for professionals to work with Early Help in the pre-birth period was not always supportive during the timeline reviewed. Practice guidance, policies and procedures were not robust and front-line professionals did not appear to have experience of working with pre-birth concerns through Early Help. Their experience was these cases would normally be managed through statutory Social Work intervention at Section 17 or 47 of the 1989 Children's Act. It is positive that multi-agency guidance and policy documents are now in place to strengthen this area of work. Frontline professionals will need developmental work to improve their confidence and competencies when working with the threshold of Early Help in the pre-birth period. There was positive evidence of the co-ordination of the Early Help process by the Portage Team when working with a child with complex needs, including consideration of the needs of the family in 2016.

132. The review of this case identifies that there were complex interacting risk factors that possibly precipitated the death of Child M. Child M was an infant identified to be at high risk of sudden infant death due to; being between 2-4 months of age, being a premature infant from a multiple birth, being a small baby with sub-optimum growth and living in a household where the main-caregivers smoked and consumed alcohol. Child M's death was potentially predictable due to these high-risk factors.

133. Professionals worked with parents to reduce the risk through the provision of regular advice and checks that the advice was being followed. Information leaflets were provided, and professionals believed Child M's parents understood the advice being offered in how to reduce the risk for Child M. This was evidenced by professionals observing where Child M was placed to sleep at home, parents smoking outside the home and agreeing that only one parent would consume alcohol if they were drinking. There were further professional discussions with parents to plan for safer sleep whilst on the holiday and new baby car seats were bought to ensure Child M and the twin sibling were transported safely.

134. Whilst the review has identified areas of multi-agency practice that could be strengthened, it has not identified any serious omission in practice that contributed to the death of Child M. Ultimately, parents could not follow through on the plans to ensure Child M could sleep safely in the hotel and made the choice to place Child M to sleep in a car seat. This is one of the most significant risk factors in sudden infant death.

[37] Acknowledgement to Ball K (NSPCC) for the use of the Analysis of interrelating risk factors methodology, SCR repository.

SECTION 5: LSCB RECOMMENDATIONS.

The LSCB should;

1. Be assured that agencies have considered and acted in respect of the learning points identified within single agency learning summaries and within this review.

2. Seek assurance partner agencies have in place a robust Early Help offer, the required systems and processes in place to enable effective Early Help work which includes the unborn child. This should be monitored by the Commissioning Organisations as part of their assurance process

3. Ensure multi-agency and single agency early help pre-birth guidance is robust, it is crucial in managing the risk to unborn infants.

4. Be assured the threshold guidance has clear step up and step-down escalation processes when working with Early Help.

5. Support the development a bereavement pathway for service users, with the opportunity for outreach work.

6. Be assured that the participation of adult services is secured in child safeguarding work to support the assessment of risk, planning and intervention with families when they are working with adults who have childcare and or parental responsibilities.

7. Seek assurance from CDOP and Public Health the current provision of safe sleep advice to families with SIDS risk factors has been reviewed and options for more effective interventions explored considering recent research findings.

8. Influence nationally to encourage the Government to act as regulators for the safety hazards warnings on car seat equipment.

9. Support a review of the process in respect of the timelines of parental/carers blood testing when intoxication is suspected in SUDI.

10. Improved focus on the "*hidden male*" and the visibility of paternal figures in assessment, planning and intervention as this review shows a strong focus is on mothers.

11. Support the development of the workforce to build confidence and competence when working with parental alcohol behaviours through early intervention.

SECTION 6: COLLATED LEARNING AND GOOD PRACTICE POINTS.

Learning Point 1 Adult and Children's Services across multi-agency partnerships should federate to assess and manage the risk when working with adults who have complex health and social presentations and also have childcare responsibilities to strengthen parenting capacity.

Learning Point 2 It was difficult to gain understanding in respect to feeding practices following discharge into the community. Professional conversations highlighted inconsistencies in written documentation.

Learning Point 3 Growth monitoring through centile plotting remains a significant factor in assessing the well-being of a pre-term infant. This area of practice should be re-enforced, and its compliance monitored by the organisation.

Learning Point 4 The maternal parenting capacity was the focus of professional assessment, with minimal focus on father until just prior to the death of Child M. The assessment of parental capacity should include all adults that undertake a parenting/caretaker role with children.

Learning Point 5 Infants should never be left to sleep in a car travel seat except for the recommended time span. Currently the timespan is documented anytime between 130 -90 minutes. This is not currently visible as a safety hazard on car seats. The LSCB should consider influencing the Government to encourage more safety regulation of baby car seats.

Learning Point 6 The review has highlighted there can be regular delays in securing parental blood tests following a SID when parents have consented and disclosed they have consumed alcohol in the previous 24hrs. The arrest of parents is not recommended unless there is a clear case of homicide. The delay can result in the parents having to remain in an environment, away from their family for a longer period than is necessary. This was reported to be a national issue for resolution.

Learning Point 7 Professionals did not always find it comfortable to challenge or even discuss mother's alcohol behaviours with her, even when the evidence was strong. Professionals need to have developmental opportunities to develop competencies in this area of work.

Learning Point 8 GP Practices are one of the only services that work with adults and children for long periods of time. They are often a hub of information but regularly not a part of multi-agency communications when there are child welfare concerns and parents have complex health and social needs. Communication should be two-way between multi-agency partners and the GP and vice versa.

Learning Point 9 Adult Services asked whether father was a parent, this was not a broad enough enquiry and should have been more focussed on understanding his contact with children and whether he had assumed child care responsibilities irrespective of his registered address. This would have supported an improved hypothesis of the risk but also created an opportunity to develop his parenting capacity positively.

Learning Point 10 Parents should always be informed of child welfare concerns unless this would place the child/unborn infant at increased risk of harm. This should always be documented in the records and is crucial in developing true partnership based on honesty and trust.

Learning Point 11 There was an opportunity to refer mother to Specialist Midwifery Drug and Alcohol Services when she presented with high blood alcohol levels at 20 weeks gestation

in the first twin pregnancy. The rational for not considering this action was because she had disclosed nil alcohol at booking. This was a missed opportunity to reduce the risk to the unborn infants.

Learning Point 12 Following a Children and Family Assessment the outcome to step down to Early Help planning should be agreed with family prior to de-escalation. Professionals allocated to lead and coordinate the Early Help Planning should routinely provide feedback to CSC in respect of case progress and closure. The Social Worker having completed the assessment should attend the initial early help meeting or an appropriate representative from the agency leading the Early Help should be invited to attend the final CIN meeting to share information and agree the plan reflects the findings of the assessment.

Learning Point 13 The Early Help pre-birth process was unclear, and guidance was not robust Professionals were not focussed on the needs of the unborn infant and the benefits of Early Help. Professionals experience was that these cases were managed under statutory social work intervention and practitioners felt out of their depth when asked to coordinate early help cases where the issues were adult focussed for instance; alcohol, substance misuse and mental health challenges. Development opportunities would be of benefit.

Learning Point 14 There were instances where safeguarding historical information wasn't retrievable, and documentation did not evidence the work and communications undertaken e.g. safer sleep, clear feeding practices, growth monitoring, outcomes of safeguarding meetings.

Learning Point 15 Single agencies should ensure their safeguarding case supervision systems work with Early Help cases where there is drift, refusal of parental consent and closure without the desired outcomes are not achieved.

Learning Point 16 The North West NNU network has 3 regional high dependency units to accommodate infants potentially requiring long term ventilation and complex neonatal care. This can create significant financial hardship in travel and parking costs and challenges in childcare for existing siblings. Currently there is no evidence on the website to detail how parents can be supported when faced with these challenges. (NW Operational Neonatal Delivery Network). The local NNU should strengthen its approach to support parents with this issue.

Learning Point 17 This review has enabled other agencies outside of health, to consider their role in the prevention of sudden infant death. Both Housing and CSC have made recommendations to develop this area of practice.

Learning Point 18 There is a need to focus on safer sleep advice when families are sleeping away from their normal environment, families need to be certain about the facilities available and the accessibility of sleeping accommodation.

Learning Point 19 Several agencies have highlighted they have recognised their role in the promotion of the prevention of sudden infant death. There should be consideration of a wider agency approach to this issue which currently is health focussed.

Learning Point 20 Professional need to coordinate their response and planning for families with complex needs to reduce the risk of overwhelming parents and setting them up to fail in the adherence to planning.

Learning Point 21 Professionals advised that in the area the provision of bereavement support is inconsistent, and the service offers were unclear and not reactive. Professionals highlighted they were unaware of a bereavement pathway to guide them. The

provision of specialist outreach bereavement support following infant and child deaths is currently not available but was felt would help parents in the same situation.

Good Practice 1 The commissioning organisation in the responsible area and the agency monitors direct questioning in Maternity Services and is assured that mothers are asked about alcohol and substance misuse. There have been significant improvements.

Good Practice 2 Probation Services have continually strengthened their approach to ensure their Offender Managers maintain a focus on the children service users may be involved with. They have developed a consistent approach with CSC to cross reference their service users link with children.

Good Practice 3 Drug and Alcohol Services were persistent in trying to secure fathers engagement but unfortunately were not always successful.

Good Practice 4 It is positive that CSC converted three separate referrals into Children and Family assessments. This was crucial information to help build a jig saw of family functioning.

Good Practice 5 The use of proactive screening tools. The HV, CSC and the GP were proactive in their use of screening tools to assess parental mood and alcohol use.

Good Practice 6 A Midwife was proactive in contacting CSC to get an outcome of an investigation

Good Practice 7 The family were consistently provided with safer sleep advice, this was a focus of most health professionals intervention with the family.

APPENDIX 1: SERIOUS CASE REVIEW ACTION PLAN.

This will be completed following the LSCB meeting and the recommendations and learning points have been agreed.

APPENDIX 2: SINGLE AGENCY IMPLEMENTATION PLANS

AGENCY+ THEME	LEARNING POINT	RECOMMENDATION
Drug and Alcohol Services	**Understanding Family Information when Working with Adults.** Since this case we have completed work with all staff on professional curiosity Work on hidden males in families. More comprehensive partnership working.	To be able to cross reference each case that comes into treatment with social work team. As part of the 7 SDF, are now taken case to the huddle.
Housing Services	**Housing Challenges** We need to ensure that all officers are reporting any potential safeguarding issues through to children central duty team, also that officers are aware of any potential risks regarding overcrowding and safe sleeping.	Ensure that all officers are up to date with relevant training regarding making referrals under safeguarding. Training to all housing officers in respect of safe sleeping.
NHS Trust Community	**Maternal Alcohol Use** In cases where there is known or suspected alcohol use that may impact on parenting, a robust multi-agency plan which includes a risk assessment should be in place and regularly reviewed and updated. The thoughts and feelings of the family need to be clearly captured to demonstrate they been able to participate in the decision-making process and action plans.	To review how agencies, work together when parental alcohol use is felt to be negatively impacting on parenting.
NHS Trust Community	**Safe Sleep Messages** There is evidence within the child health records that safe sleep was discussed with mum on multiple occasions by the HV and other professionals over a series of pregnancies and births. Despite this there were some concerns regarding safe sleep practice. On the night of Child M's death when she was left to sleep for long periods in a car seat.	To review how safe sleep messages are delivered across the borough and to understand what are the barriers that prevent families/communities adopting these messages.
NHS Trust Community	**Maternal Mental Health** It appears that whilst there were concerns regarding mum's mental health, she was not always open and honest regarding this. It is important to understand why parents may not be open and honest regarding this. It is also worth considering if self-reporting tools in relation to mental health are the most appropriate way of recognising depression following the loss of a child.	To consider the reasons why mothers may not be open and honest regarding their mental health. To consider if the most appropriate tools are used to explore/assess mental health, following the loss of a child.

NHS Trust Community	**Engagement + Disguised Compliance** It is possible that there was a level of disguised compliance from the family especially ma. The NSPCC define this as a parent or carer giving the appearance of co-operation with agencies to avoid raising suspicion, to allay professional concerns and ultimately diffuse professional intervention. It is possible that professionals were optimistic about parental parenting capacity as the level of engagement with services and for appointments was very good.	
CCG	**Mental Health and Bereavement** When GPs are managing patients with depression who are also parents it is vital that the GP considers how this may impact on parenting capacity and evidence this within their record keeping. This may include contacting relevant professionals who are working with the family.	To consider further exploration of: How GPs evidence they have considered the impact on parenting capacity when working with patients with depression, particularly fathers; When it is appropriate for GPs to contact other key professionals. Note: There are 62 GP Practices in the Borough and therefore it is difficult to generalise about current practice following the review of one GP record.
CCG	**Paternal Alcohol Use** When patients disclose to their GP that they are consuming a significant amount of alcohol on a daily/regular basis it is vital that the GP considers how this may impact on parenting capacity and evidences this within their record keeping. This may include contacting relevant professionals who are working with the family.	To consider further exploration of: How GPs respond to patients disclosing significant alcohol misuse and how often the impact on parenting capacity is considered. When it is appropriate for GPs to contact other key professionals Note: There are 62 GP Practices in the Borough and therefore it is difficult to generalise about current practice following the review of one GP record.
CSC	**Maternal Alcohol Use** Reiterated the importance of information sharing and gathering key chronology of events to assess risks and concerns and to inform decision making process. Thorough response undertaken from the referral and assessment team in respect to information gathering which was also completed within smart time scales. Pro	

	forma utilised within the team was able to ensure key agencies were spoken too and a thorough analytical approach to previous CSC involvement to ensure the right course of action was taken. Clear manager oversight within the decision-making process.	
CSC	**Maternal Alcohol Use C&F Assessment** The need to ensure a more joint up approach to working with colleagues from alcohol services and exploring if families are known to them or if families would be willing for support and interventions to look at reduction of risks and escalation of alcohol use.	To look at how we can access records better from alcohol services regarding families working with them and to ensure joint visits are taking place where appropriate to look at alcohol use and risk reduction plans regarding this – Note: Audit of cases open to alcohol services and CSC has been arranged on 1st December and alcohol services are also going to give an overview of joined up working and risk assessing within the locality briefings in 2018.
CSC	**Gathering of Information** The need to ensure a joined-up approach with agencies to create a clearer understanding to what life is like for a child and the need to ensure 'all the jigsaw puzzle pieces' fit together to give a true account to the family's current circumstances.	
CSC	**Recording of Contact Information** Case recording has now moved on within the referral and assessment team and a pro forma is now in place for case recording when contacts are made from agencies in respect to open and closed cases to CSC. These ensure that the information captured the purpose of the need for information sharing and being clear and outcome focused	
CSC	**Information Sharing re 1st Child Death** The need to ensure that families' vulnerabilities are collectively being addressed and assessed within case discussions and informing further action planning for all agencies. To ensure robust mechanisms are in place for the help and support provided at any level, considering the importance of review at Early Help to consider progress against the original plan and to identified emerging	The need for all agencies to ensure the transfer of information across departments to ensure evidence-based interventions

	needs and ensure that support is in place to meet identified need. For example, within this family I feel that bereavement support could have been identified at this stage given the emotional pressures the mother and father would have been feeling which in turn may have impacted upon their alcohol use and coping mechanisms It is of concern that it is noted that the staff on the hospital ward appeared unaware of the concerns previously addressed with mother by CSC, even though it is evidenced that discussions had taken place with health professionals at the time of CSC being involved. There is a clear need to ensure information sharing is being recorded on recording systems to ensure effective safeguarding is being adhered too and families are getting the right support and interventions, ensuring the transition between services is smooth and that information is shared appropriately.	
CSC	**CP Referral Following Birth of Child M From NNU** Need to ensure on going joint visits take place to assess risks holistically. The need to adopt an honest and open approach to engaging with families, ensuring that information is shared openly regardless of the difficulty in doing so, this will support the development of positive working relationships with professional trust.	
CSC	**Record Keeping** There is a need to ensure that when workers are visiting families that there is a detailed case recording to capture the discussions that have taken place, observations made regarding relationships, parent and children's presentations and in relation to relationships observed. There needs to be evidenced of the conversations that have taken place with parent which are informing our risk assessments and outcomes and how we are addressing and challenge safeguarding concerns.	To ensure that all staff are keeping detailed and appropriate case recording up to date and that our it system reflects the work that is being undertaken during home visits.
CSC	**Discharge Planning Meeting** There is a need to ensure that when workers are visiting families that there is a detailed case recording to capture the discussions that have taken place. There	To ensure that all staff are keeping detailed and appropriate case recording up to date and that our it system

	needs to be evidenced of the conversations that have taken place with parent which are informing our risk assessments and outcomes and how we are addressing and challenge safeguarding concerns.	reflects the work that is being undertaken during home visits
CSC	**SW Introductory Visit** There is a need to ensure that when workers are visiting families that there is a detailed case recording to capture the discussions that have taken place, observations made regarding relationships, parent and children's presentations and in relation to relationships observed. There needs to be evidenced of the conversations that have taken place with parent which are informing our risk assessments and outcomes and how we are addressing and challenge safeguarding concerns. There has been a significant amount of work around voice of the child and the lived experience of the child including the development of the assessment tools in place to ensure that this can be incorporated into assessment and intervention. Need to ensure we are capturing who is present at home visits which needs to make reference to both parents and if a parent is not present the reasons why.	To ensure that all staff are keeping detailed and appropriate case recording up to date and that our it system reflects the work that is being undertaken during home visits
CSC	**CIN Meeting** There is a need to ensure that meetings are outcome focused and recording evidences the conversations that have taken place within the meeting but also capture an overview of the work that has been completed up to date and what is still needed to be undertaken and to measure the ongoing risks and concerns or whether these have reduced. Risks need to be discussed openly and actions set to identify the interventions to continue to address and reduce these issues	The local authority is looking at incorporating the principles of signs of safety within our practice which I feel will ensure that meetings are focused to the risks and will enable parents to identify their own strengths and the actions to be achieved to meet their goals and aspirations as a family. We have also been looking at a strengthened Child in Need model and working in line with an asset-based approach which will be filtered within the service and where it will be hoped that partner agencies are also aligning their work within this model.
CSC	**Follow Up Visit by CYP Family Worker Infant Feeding** To ensure safeguarding questions are being prompted in conversation when working with families where there are additional vulnerabilities. For example, the	This is an area where extensive work has already taken place with all agencies as part of the locality briefings in 2017 and regarding a hot topic

	need to visit the issues around safe sleep and holidays especially when working with infants who are born low birth weight and are premature.	overview summary which again has been sent to all staff. Safe sleep is now a routine section of discussion within all children and families visits and where safe sleep literature is provided.
CSC	**Joint Visit by SW And Principal Manager** **Parental Alcohol Use - Inform of The Strategy Meeting** To ensure the use of interim planning arrangements when looking at working plans with families so it is clear of the expectations from the LA but also from the family and how this will be reviewed and measured through practice.	
CSC	***Section 47 Home Visit*** ***Share Outcomes of Strategy Meeting*** ***Alcohol Use*** To ensure the use of interim planning arrangements when looking at working plans with families so it is clear of the expectations from the la but also from the family and how this will be reviewed and measured through practice. Conversations could have taken place at this point regarding alcohol services and how these referrals could be made, and the alcohol tool could also have been revisited at this stage given changes in circumstances and the increased vulnerabilities.	Extensive work has been completed with the work force through training sessions, locality briefings, supervisions, managers meetings and team meetings regarding IPA'S and the use of these in practice.
CSC	**Home Visit by Principal Manager** Alcohol services were not addressed in this visit nor was the alcohol tool utilised which again could have been considered within this home visit.	The need to ensure we are linking in with partner agencies to support and assist when responding to other vulnerabilities for example alcohol use for this family.
Portage Service	**Statutory Duties of Agencies.** The organisation should feed back to the Early Help team when they feel key partners aren't initiating Early Help in response to the threshold of need in a timely way.	
Portage Service	**Relevant History Known?** The organisation should ensure that all key partners are aware of the importance of providing comprehensive referral forms to enable the Professionals to be provided with relevant historic information and	The organisation to QA referral forms and feedback issues to strategic leads in services.

	information linked to the threshold of need.	
NHS Trust Hospital	**Maternal Alcohol** mother's/patients/service users may not always share the truth if they feel likely to be judged in a negative way	
NHS Trust Hospital	**Maternal Alcohol** Staff to feel confident to challenge parent's risk-taking behaviours. Allocating a room to discuss concerns with Child M mum, even if usual room's occupied	Increased awareness to WWLFT staff of the need for professional challenge and professional curiosity in some cases.
NHS Trust Hospital	**Initial Visit by the NNU: Infant Feeding/Safe Sleep Advice** No documentation in neonatal outreach notes of any safe sleep safety advice being discussed with parents, and nothing recoded regarding viewing Child M & siblings sleeping arrangements at night. When neonatal outreach nurse was interviewed as part of the SCR investigation she clarified that it would be normal practice to cover safe sleep guidance and revisit any previous safe sleep assessments that have been previously carried out on NNU, however the neonatal outreach nurse accepts that on this occasion there is no documented evidence that safe sleep arrangements was discussed. Neonatal outreach nurse suggested it may be recorded in the red book, however we currently have no access to the red book due to Child M's mother moving from across boundaries	To ensure improvements to documentation; any safe sleep advice is discussed and documented on the neonatal unit, this is inputted in the discharge document that the discharge nurse will complete on a one to one basis with parents via a parent craft session. A copy of the safe sleep '21 questions' paperwork in the red book is also completed leaving question 3 'have you seen baby's sleeping arrangements (day & night)' as discussed but not completed as this is to be completed on first initial visit at home by outreach nurse. On the first initial home visit by neonatal outreach (NNO) safe sleep assessments to be more clearly documented in the neonatal outreach records. Neonatal outreach nurse to ensure surveying of the day and night sleeping arrangements completed.
NHS Trust Hospital	**Follow Up Visit by NNU prior to Holiday Car Seat Documentation** No documentation evident of any discussions with parents regarding where Child M and sibling would be sleeping whilst on holiday, No documentation of discussions regarding safe transport of the twins from home to holiday	To ensure all discussions, concerns, advice and any actions or plans are clearly documented in the NORT notes. To ensure continuity and accuracy of ongoing care.