Northamptonshire Safeguarding Children Partnership

Child Safeguarding Practice Review (CSPR)

Child Ay

Independent Author: Dr Russell Wate QPM

1.0 Why is a Child Safeguarding Practice Review required?

Child Ay's mother and father went out to celebrate a family occasion during the evening, they left Child Ay and their siblings in the care of their paternal grandmother. By the time they arrived home, both mother and father had consumed a large quantity of alcohol. Following their return home, the grandmother returned to her home leaving the children in the care of their parents. Both of the parents fell into a deep sleep. The following morning Child Ay was found lifeless in the parental bed, having died during the night. The mother and father have subsequently been convicted of the offence of neglect.

The family were known previously to children social care due to neglect concerns which related to the two older siblings. These neglect concerns were raised by health services and the sibling's school.

The Northamptonshire Safeguarding Children Partnership (NSCP) Rapid Review Group recommended that, with reference to the requirements as set out in Chapter 4 of 'Working Together to Safeguard Children' (2018) that the threshold was met to commission a Child Safeguarding Practice Review (CSPR) in respect of Child Ay. The strategic leads for the partnership agreed with this recommendation and the CSPR formally commenced on the 1st of February 2020.

The Rapid Review group set a time period for this CSPR as 1st January 2019 to 27th October 2019. This is from the date that agencies first became aware of Child Ay's antenatal period, to the date of their death. Agencies were asked to include historic events relating to the family relevant to the learning for this review.

All agencies involved with Child Ay and their family were asked to provide chronologies and where they had had extended agency contact, to produce key incident reports. An Independent author was appointed who is Dr Russell Wate he is totally independent of all agencies within Northamptonshire.

2.0 Key Themes, analysis and lessons identified

The following key themes have been identified by the author and panel for this CSPR. These themes have been developed taking account of the analysis and learning from the rapid review process, the agency chronologies, reports and information provided to the questions the author has asked. The review also had the benefit of a well-attended practitioner event where the professionals assisted with the learning for this review. The board manager for the NSCP has already completed, and had circulated to agencies, an initial learning briefing relating to the case. This learning document is seen within this report at appendix A. The themes developed for this review are:

Learning Themes

- Theme One – Knowledge and awareness of the mothers' vulnerabilities, in particular her learning difficulty/disability. The father's role in the house, level of his drug use, and alcohol use by both mother and father.

- Theme Two- Neglect.
- Theme Three-Safer Sleeping.

Theme One –Knowledge and awareness of the mothers' vulnerabilities, in particular her learning difficulty/disability. The father's role in the house, level of his drug use, and alcohol use by both mother and father.

A key learning theme is the vulnerability of Ay's mother, in particular, as to whether or not, she had a learning disability or learning difficulty. In some of her medical records a learning disability is mentioned and in others a learning difficulty. There is a difference to these two vulnerabilities and as a result, how professionals would respond to support her in providing safe care for Ay and her siblings.

Northamptonshire Public Health department describe learning disability and learning difficulty as:

> *'Learning disability is defined as an overall cognitive impairment and can be mild, moderate or severe.*
> *A learning difficulty is defined as an individual has difficulty processing information but there is no impact on general intelligence[1].'*

There is a midwifery record of Child Ay's mother having a learning disability. This information was appropriately questioned by the midwife, showing good practice at the booking appointment. The mother's explanation to the midwife was that she has a learning difficulty, due to a hearing impediment, and is assured by her that there is no issue to be concerned about as she is now well supported by her husband and family. This was accepted. Further questioning might have explored why the mother was in receipt of a disability allowance, what disability did the allowance relate to? At the practitioner event this was resolved as it was established that mother received the allowance for the older siblings and not for any disability of her own.

Further enquiry might also have discovered that the sibling's school, who knew and worked with her, always made sure they catered for her disability. At the practitioner event they stated they were aware in relation to her hearing and reading and writing, but it wasn't significant. At the interview following the mothers arrest following the circumstances of Child Ay's death, the police, based on advice from the father and the grandma, deemed her learning disability of a level that they ensured an appropriate adult was present throughout. The police have a policy that If a person is in custody and presents with vulnerabilities, or apparent learning difficulties, an appropriate adult is appointed to be present whenever the person is interviewed. The appropriate adult advised the investigating officers to ensure they kept their questions short and to the point.

There is practice guidance and associated supporting documentation available to maternity services, focusing on supporting mothers, and where appropriate partners, with learning difficulties.

[1] https://www.northamptonshire.gov.uk/councilservices/health/health-and-wellbeing-board/northamptonshire-jsna

The NSCP have Pre-Birth Practice guidance[2], within this it highlights learning disabilities and difficulties.

> 'Parents with learning difficulties'- *Learning disabilities and learning difficulties can affect parents in their decision making and preparation for the birth of their child. When women with learning disabilities / difficulties attend ante-natal care they may experience difficulty in understanding the information and advice they receive or have problems in putting it into practice. At this point it is important for all practitioners ensure appropriate access to advocacy services and easy read documents are made available.*

Therefore, it would have been appropriate to consider whether further assessment and support planning for this family should have been commenced at the level of an Early Help Assessment.

It needs to be stated that following the review process, that it is still unclear whether Child Ay's mother suffered from a learning disability or difficulty.

Very little was found out by professionals in relation to the father. The mother always stated that he was supportive, but no further details were obtained. The question of Domestic Abuse (DA) was asked, but information provided to the review author only reveals this was asked once each by the midwifery and health visiting services. It is stated that father worked full-time and the mother cared for the children. Post death details of his drug usage emerged that he had drugs concealed in the house, also that he had been out the previous night to the death, where he had taken drugs. He did state that his wife was not aware of his drug usage.

All of the professionals at the practitioner event stated that they knew very little about the father. The school stated that father had no engagement with them or any involvement with any of the children's education, this only took place with the mother.

In terms of the alcohol usage by the couple, the report compiled on behalf of the Health Visiting service by the NHFT agency author is extremely helpful, explanatory and is of assistance in informing this review report. The following has been replicated from their report as it explains and analyses really well alcohol use by the parents.

> *'As part of the routine enquiry during the new birth visit the health visitor is required to ask about the parent's level of alcohol consumption. This mother and fathers' habits are gathered as each drinking less than 14 units per week. This level raises no concern and remains within safe drinking guidelines in the UK. No advice is reported to be given in regard to this. The HV has shown good adherence to and acted in line with NHFT expectations.*
> *"men and women are advised not to drink more than 14 units a week on a regular basis." www.nhs.uk*

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2 https://www.proceduresonline.com/northamptonshire/scb/p_pre_birth_pg.html?zoom_highlight=prebirth+assessment

It is unknown whether this is an accurate recording of the parents drinking habits and research shows that when asked adults are likely to give a lower than actual estimation of their drinking habits.

"potential for participants to downplay their drinking due to the perceived stigma surrounding heavy drinking (which refers to social factors rather than cognitive factors).[3]"

Child Ay was of an age where she would have required feeding, changing and settling attention during the night after the parents returned from their night out. It may not have occurred to parents that the influence of alcohol on their behaviour/ ability to stay awake / ability to wake up at baby's distress during night-time would be compromised by their level of intoxication.'

The review panel feel that practitioners need to be able to identify any evidence of a history of harmful alcohol misuse, both from sensitive conversations with parents and from information that may reasonably be available to them from records. More detailed questioning around alcohol consumption may have provided a more in depth understanding of the level of alcohol consumed by Ay's mother, but also the father, which they were consuming on a weekly basis. If we also consider the NHFT author's recommendation to give parents an option to offer a closer to honest estimation of their consumption, that will enable not only HV's but other professionals that work with a family scope to identify risk and offer appropriate advice and guidance more accurately.

The education of parents about the sedative nature of alcohol and inability to drive to get emergency help through a simple scenario shared universally with parents will ensure one adult remains alcohol free when in charge of a baby or child.

The Department for Education published in December 2018 'Guidance Safeguarding and promoting the welfare of children affected by parental alcohol and drug use: a guide for local authorities.[4]' Within this guidance it highlights research which is important for professionals to understand and acknowledge in their practice into parental substance misuse, which includes alcohol.

'Problem parental alcohol and drug use is a common feature in serious case reviews (local enquiries into the death of, or serious injury to, a child where neglect or abuse is known or suspected, including where drugs were ingested by the child). In a Department for Education analysis of these reviews[5], parental alcohol and drug use was present in over a third of reviews (37% and 38% respectively), with at least 1 of these presents in 47% of cases.

[3] Alcohol and Alcoholism, Volume 46, Issue 6, November-December 2011, Pages 709–713

[4] https://www.gov.uk/government/publications/safeguarding-children-affected-by-parental-alcohol-and-drug-use/safeguarding-and-promoting-the-welfare-of-children-affected-by-parental-alcohol-and-drug-use-a-guide-for-local-authorities

[5] DfE (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews, 2011 to 2014

The same DfE report pointed out that in many families, where there had been a sudden infant death of children aged 0 to 9 months (where maltreatment was not a direct cause of the death) they appeared to have led chaotic lives which included substance misuse.'

There is no information provided to the review author that shows any consideration was made relating to the fact that both of the older siblings have disabilities, and how the added pressure of a new baby may create additional risk. Also, within the home environment there is no consideration of how the five of them, when Child Ay is born, will be living within the families two-bedroom flat. There were two historical incidents of note in relation to Ay's siblings, firstly, where the sibling's school, and then a health professional following on from attendance at a hospital appointment, raised an issue of concern relating to neglect involving the cleanliness of the siblings. There is then a further occasion where the school discover bruising to one of the siblings who alleged his father had caused the injury. An Early Help Assessment would have been a useful starting point to understand how the arrival of a new baby within the family unit might have led to additional support needs.

Theme Two – Neglect

The professionals at the practitioner event, in particular the senior police officer present, were keen to highlight that neglect was an important learning theme for this review and report to consider.

The Tri. X procedures manual has an in-depth section on neglect. The NSCP also has as a supplement to this frontline practitioner guidance, an in-depth and very comprehensive Neglect toolkit[6]. This toolkit is dated May 2016. Within the toolkit it highlights a tool for practitioners to use. This tool is actually an adapted version of the Graded Care Profile Tool developed by Salford LSCB. This has then been further adapted for Northamptonshire by two Doctors from the Luton and Bedfordshire areas. The Graded Care Profile is a tool widely used throughout the country and has a good evidence base to its effectiveness in relation to the recognition of neglect. It is accepted that a number of areas use the same as this version which was initially from Salford and now Northamptonshire have locally adapted it for their own effective use. It must be noted though that there has been in place for almost two years a Graded Care Profile 2. This updated version has taken account of the NSPCC's evaluation of the previous version and includes updated language including sections on obesity and online activity.

Within the agency chronologies and the rapid review meeting summary minutes are highlighted slightly historical (2017) neglect concerns, which are raised by both the sibling's school and a health professional following an ear, nose and throat appointment. The rapid review summary states:

[6] file:///C:/Users/rjwat/Downloads/NSCB-Neglect-Toolkit%20(1).pdf

‘The school has flagged consistent low-level neglect in the form of poor hygiene; children presenting as unkempt, dirty and smelling of urine and one of the children being extremely tired and falling asleep at school.

At an ear, nose and throat (ENT) appointment in February 2017 for a sibling resulted in a referral. Mother’s presentation and the sibling’s presentations was described as unkempt, dirty, matted hair and smelling of faeces. The outcome was a single assessment that concluded CiN Plans were not required**.’**

Although the NSCP neglect toolkit was in place (May 2016) at the time of both the school and hospital concerns, there is no evidence that the neglect tool was used. Neither was it used as part of the single assessment.

Following the death of Child Ay the police attended the home address and found the sleeping arrangements as described in the previous section, they describe the home as having a lot of plastic bags full of rubbish scattered across the apartment, also describing the living conditions as poor, and the family showing signs of living in poverty. It is shame that the joint police-Paediatrician home visit did not take place in this case. The home visit is highlighted as a statutory process in Chapter 5 Working Together 2018, and in the Royal Colleges of Pathology and Paediatric and Child Health report ‘Sudden unexpected death in infancy and childhood Multi-agency guidelines for care and investigation.’ This report is commonly known as ‘The Kennedy Report’. If the visit had taken place, it would have helped professionals to resolve this neglect issue. Learning for NSCP is to ensure that a home visit takes place in all appropriate cases.

At the practitioner workshop extensive discussion took place. This situation though wasn’t observed during any ante-natal or post-natal home visits by health professionals. There were three visits by health visitors and two by midwifes. They do describe the flat though as cramped. One of the professionals who had visited the home said it was ordered clutter and most importantly the Child Ay’s sleeping area was clear. The professional stated they visit homes of babies all the time and, in their view, this home environment when they visited was not one to raise concerns of neglect.

It is not unusual for agencies to have differing views and standards in relation to living conditions, that is why it is important, in particular in relation to Neglect, that tools are used to provide consistency. This consistency in how dealing with neglect is important, as highlighted by the senior police officer at the practitioner event, is learning for the partnership to consider as an area of action. Some areas find a clutter scale tool used in adult safeguarding useful in situations described by the police.

It is important for professionals to understand the impact a home environment has on a child and the consequences a neglectful home could have on the child and their lived experiences. This was the case not just for Child Ay but also in particular their older siblings.

Theme Three-Safe Sleeping

The NSCP subscribe to the Tri. X policies and procedures manual. The only mention of safer sleeping within this manual is within the neglect section which highlights a quote from a previously published triennial review of SCR's, this states:

> *'The majority of neglect related deaths of very young children involve accidental deaths and sudden unexpected deaths in infancy… issues include the risks … and the dangers of co-sleeping with a baby where parents have substance and/or alcohol misuse problems'* (Brandon et al, 2013).

The NSCP have on their website a section titled '*Safe sleeping for your baby - Share a room, not a bed.'* The NSCP has re-launched its Safe Sleep campaign to ensure all new parents are aware of how to ensure their baby sleeps safely at all times. This section was updated in February 2020[7].

The title of the section is extremely relevant to the death of Child Ay who died whilst sleeping with a parent in their bed. Within the information under this section, it highlights risks to avoid which states: *'Don't take risks: Smoking, drinking alcohol and medication or drugs can make you sleep more heavily and further increase the risks.*' This information is in line and supported by the Lullaby Trust (2019) evidence base which states:

SUDI risk factors

- *Unsafe sleep position (prone or side)*
- *Unsafe sleep environment: – co-sleeping in the presence of other risks (including bed sharing) – overwrapping (head covered, use of pillows or duvets) – soft sleep surfaces (soft or second-hand mattress)*
- ***Tobacco – pregnancy and environmental exposure***
- ***Alcohol and drugs – during pregnancy and when co-sleeping***
- *Poor post-natal care – late booking and poor ante-natal attendance*
- *Low birth weight (under 2,500g) and preterm birth (less than 37 weeks' gestation)*[8]

The review author has applied the bold mark up to two of the bullet points above. As the information provided to this review is that the father of Child Ay smoked, and the mother was given advice in relation to passive smoking.

There are numerous times that professionals gave the mother of Child Ay safer sleeping advice. For example, in July 2019 when the mother attended a routine antenatal appointment.

It was documented that, *'Mothers & others' guide given to mother which includes information regarding latest information on reducing the risks of Sudden Infant Death. The guide includes latest A, B, C, D guide for safe sleeping.*

At the end of August this was discussed with the mother again.

[7] http://www.northamptonshirescb.org.uk/about-northamptonshire-safeguarding-children-partnership/news/safe-sleeping-baby-campaign-launched/

[8] Lullaby Trust (2019). The Lullaby Trust: Evidence Base. https://www.lullabytrust.org.uk/research/evidence-base/

In the middle of September 2019 when Child Ay was born in hospital and discharged from hospital the same day the agency author from NGH reports:

> *'That at the time of discharge from hospital, there was no evidence that 'safe sleeping' was discussed with parents/carer. The trust guideline states 'An assessment on safe sleeping should be carried out before the baby is 5 days old. This should be completed in the PCHR'*
>
> *It is to be acknowledged that further information is discussed with the parents/carers by maternity services and is documented in the Personal Child Health Record (PCHR) which is not in the NGH health records.*
> *Midwives to be informed that when completing the safe sleeping assessment in the PCHR, information is to be documented within hospital records in addition to the PCHR.*
>
> *Documentation in medical records upon discharge to evidence key public health messages have been shared with parents, i.e., safe sleeping, smoking cessation, baby safety where there are pets in the home and car safety.*'

The Personal Child Health record is commonly known as the Red Book. The police agency author has scanned the record within this, and the review author has seen the scanned copy which has been filled in appropriately in relation to safe sleeping advice given, the date is recorded within it as completed within the NGH trust guidelines.

Approximately 10 days after Child Ay is born, the final midwife home visit takes place and safe sleeping is again discussed by midwife with the mother.

In relation to the HV giving safe sleeping advice, approximately five weeks before the birth of Child Ay the HV carries out a home visit to see mother. The HV has recorded that:

> *'Mum seen with other children - both appeared happy and content. Home seen to be clean and homely. Good supportive partner described non-smoker mother. Partner smokes outside and does not take drugs. Living in rented council flat and looking to house swap for 3-bedroom house. Mum reported to be aware of HV services as has 2 other children. Domestic abuse question asked - no concern.* ***Safe sleep discussed and mother reported she plans to follow the guidelines****. Mother feeling well, nervous but excited about birth.*'

Ten days post birth a different HV attends and records for the visit.

> *'That Mum came across as a small, quiet, reserved lady. However, the mother did engage with the HV very eagerly. The HV only saw the hallway, living room and briefly looked into the bedroom to see the cot there. It was documented in records that Child Ay was sleeping in a cot.*
>
> *Health Visitors promote the use of cots, Moses baskets etc, as long as the baby sleeps on its back and alone.* ***The risk of co-sleeping was raised with the mother by HV, who***

***recommended ways to avoid it**. It was noted that the flat was tidy but was also very plain. Child Ay was clean and well fed on the visit.'*

Exactly one week later the HV again attends and has no concerns, other than mentions the cramped conditions in the flat.

As can be seen from the above information, there is no doubt that even considering the hospital discharge recording issue, that Safer Sleeping advice was provided by both midwifery and health visiting services on a consistent and regular basis.

One issue to highlight is in relation to the sleeping arrangements. The HV did on one occasion look into the bedroom and saw the cot. The police officers on their home visit following the death of Child Ay describe the sleeping arrangements as follows:

'The two older children share a bedroom, which has a bunkbed in it, but it was evident that they sleep top and tail on the bottom bunk, as the top bunk had no bedding on it. The mother and father slept in separate rooms, with the father on the sofa in the living room due to having sleeping difficulties. The mother slept in the second bedroom, which also housed a freezer and washing machine and was very cramped. There was also not a suitable bed for Child Ay, instead they were in a large cot.'

Taking this information into account may have led the HV to enquire further and to ensure that advice for the mother was more tailored to the specific sleeping environment for Child Ay.

There doesn't seem to be any mention in the numerous occasions that safer sleeping advice was given that account was taken of Child Ay's mother having a learning difficulty and may have needed more detailed explanations. There is also no mention that the father was ever given safer sleeping advice. This could have been important in this case as on interview following the death, he did state that the mother did, on occasions in the past, co-sleep with Child Ay.

The Child Safeguarding Practice Review Panel recently published a report
'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' (Final report July 2020)[9]. Within this report it highlights a risk which directly correlates with the circumstances of the evening and the night that Child Ay died. It states:

'Most incidents that were reviewed occurred when routine infant sleeping arrangements were disturbed by changing circumstances. This could follow a critical incident, or a period of escalating safeguarding risk related to particular family events. They all involved co-sleeping and almost all were alcohol and/or drug related. A key question is the extent to which SUDI in out-of-routine circumstances, while not predictable, can nevertheless be made more preventable'.

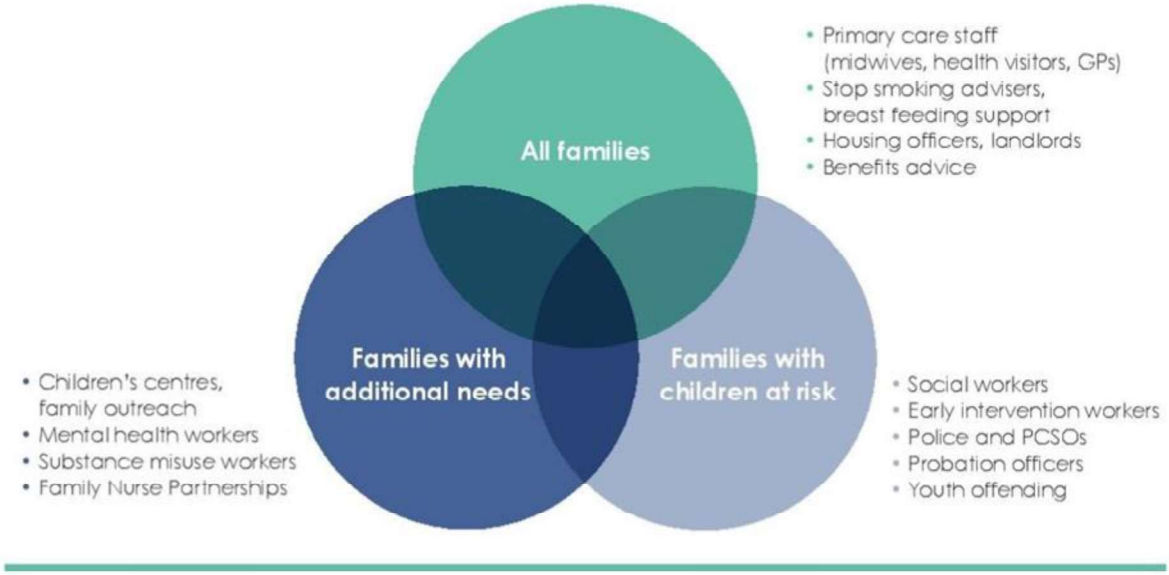
[9] The Child Safeguarding Practice Review Panel (July 2020) 'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' (Final report)

The learning from this publication and the death of Child Ay is for professionals to continue to highlight the risks of co-sleeping, in particular if there is any change to normal routines. It is important that professionals ensure that safe sleeping advice is also given to those who may take on additional caring responsibilities other than the mother and father, for example, in this case, the paternal grandmother.

The national panel publication also highlights the need for safer sleeping advice to be imparted by multi-agency individuals. '*Co-ordinated multi-agency guidance and training can help promote a shared understanding about a safer sleep environment and enables practitioners to reflect on their individual role in promoting safer sleep messages and recognising risk*.'[10]

The figure below from the publication highlights where these key multi-agency professionals could fit in.

Figure 5: The SUDI continuum of risk: key professionals



3.0 Conclusions

There is no information that would suggest that professionals could have predicted the death of child Ay. In terms of mother's pregnancy with Child Ay and during the post-natal period all evidence supports a mother who is fully engaging with professionals.

The three learning themes are:

[10] The Child Safeguarding Practice Review Panel (July 2020) 'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' (Final report)

i) Knowledge and awareness of the mothers' vulnerabilities, in particular her learning difficulty/disability. The father's role in the house, level of his drug use, and alcohol use by both mother and father.

ii) Neglect

iii) Safer Sleeping. These are in essence overarching themes that encompass not only the circumstances of Child Ay's death, but also historical family concerns. Although it could be argued that it was standard practice, the review author is of the opinion that in the main, good practice was demonstrated by the practice of both the midwifery and health visiting services in providing safe sleeping information. The police involvement post death was good, evidenced by the prompt practice to the adherence of the Joint Agency Response to an unexpected child death, with the police themselves positively highlighting the role of the consultant paediatrician at NGH.

4.0 Recommendations

Recommendation 1 (Theme one) The NSCP should ensure that professionals have a stronger understanding of learning difficulties/disability and the difference between both of these terms. This understanding could include guidance on how professionals and services should work with individuals with these needs. It could also include a learning event and measured by how many people attended and the evaluations received focussing on understanding the parental vulnerability.
Recommendation 2 (Theme one) a) The NSCP should ensure that there is a better professional understanding of parental alcohol misuse and how this can be harmful to children. b) The NSCP should ensure that professionals take steps to discover more about fathers and male carers within a household.
Recommendation 3 (Theme two) a) The NSCP should ensure they review their Neglect training to ensure that it is multi-agency focussed to ensure consistency. b) The NSCP neglect toolkit guidance (2016) needs to be updated with decisions made by the key partnership stakeholders on the use of an appropriate neglect toolkit. The Graded Care Profile needs updating to the version 2 as minimum. There is a resource and training pack attached to that which would assist with the training requirement. c) The NSCP neglect strategy needs updating in line with the developments of the toolkit.
Recommendation 4 (Theme three) a) Public Health Northamptonshire will be launching a Safer Sleeping campaign 'Plan a Safer Sleep, every sleep' is to be launched in the spring of 2021. In light of the learning from this review it is recommended that the advice is reviewed ensuring fathers, other household carers and anyone else who has child caring responsibilities are aware of Safe Sleeping advice. Also, that any learning disability is considered when leaving written material for information. Practitioners will offer to assess the suitability and safety of the sleep environment. b) The partnership to examine the learning from the National Panel SUDI review and consider implementation of the National Panel's suggested prevent and protect practice model for reducing the risk of SUDI. (Please see Appendix B for details).

Recommendation 5
Following the unexpected death of child Ay no joint home visit took place as in accordance with Working Together 2018 and the 'Kennedy Guidelines'. The police carried out the visit as a single agency. The NSCP should inform the child death overview panel and the strategic child death review partners, that learning from the case of child Ay, is that the visit would have assisted the neglect enquiry.

Appendix A

SCOPE & TERMS OF REFERENCE

The Rapid Review Group recommended that, with reference to the requirements as set out in Chapter 4 of Working Together to Safeguard Children (2018) that the threshold was met to commission a Child Safeguarding Practice Review (CSPR) in respect of Child Ay. The Strategic Leads agreed with this recommendation and the CSPR formally started 1st February 2020.

The purpose of the review is to identify improvements which are needed and to consolidate good practice. Safeguarding Partnership's and their partner organisations will need to translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

The following principles should be applied by the Safeguarding Partnership and its partner organisations to all reviews:

• There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.

• The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

• Reviews of CSPRs should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.

• Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

• Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process

• Final reports of CSPRs must be published, including the Safeguarding Partnerships' response to the review findings, in order to achieve transparency; and

• Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

CSPRs and other case reviews should be conducted in a way which:

• Recognises the complex circumstances in which professionals work together to safeguard children.

• Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.

• Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight.

• Is transparent about the way data is collected and analysed; and

• Makes use of relevant research and case evidence to inform the findings.

Authors will be asked to provide a detailed chronology that includes a mandatory critical analysis column for completion and a report detailing further analysis of what they deem to be critical key incidents, along with learning and action already undertaken to address the concern. A multi-agency Panel will scrutinise the combined chronology and identify learning. Themes will be examined, and authors are required to update on their own agency learning through the process of the review with an expectation that when the review is concluded, the majority of learning has already been addressed with processes in place to change/improve practice. There will also, and in parallel, be a process of greater collaboration through conducting conversations with the practitioners and clinicians involved and holding a multi-agency practitioner event approximately halfway through the process in order to further identify learning and encourage reflection on their involvement; to examine the actions and decisions taken; and to understand the context.

When the review is concluded, a practitioner de-brief session will be undertaken to share findings and learning prior to publication of the report.

Issues for consideration by Authors and the Lead Reviewer:

• Child Ay's voice.

• What was the life of Child Ay like?

• Mother and Child Ay's relationship.

• Father and Child Ay's relationship.

• Consider standard practice around risk assessment for safe sleeping to make sure that issues such as parental learning difficulties are considered.

• How have agencies responded to their own concerns about neglect in terms of monitoring and support for this family.

• Sibling's voices.

• Family home environment.

• Parent's relationship.

• Role of father within the household. Any Impact of his drug taking on the family

• Engagement of services by the family.

The time period for this Review is **1st January 2019 to 27th October 2019**.

This is from the day of Child Ay's antenatal period to the date of her death.

Agencies should include historic events with the family relevant to the learning aims of this Review.

A template for the Chronology and Key Incident report will be provided, along with guidance for completion.

Chronologies and Key Incident reports are required from:

Children First Northamptonshire

School (for siblings)

MASH

Northamptonshire Healthcare Foundation Trust – 0-19 Service (Health visiting

Northampton General Hospital – Midwifery and Emergency Department

East Midlands Ambulance Service

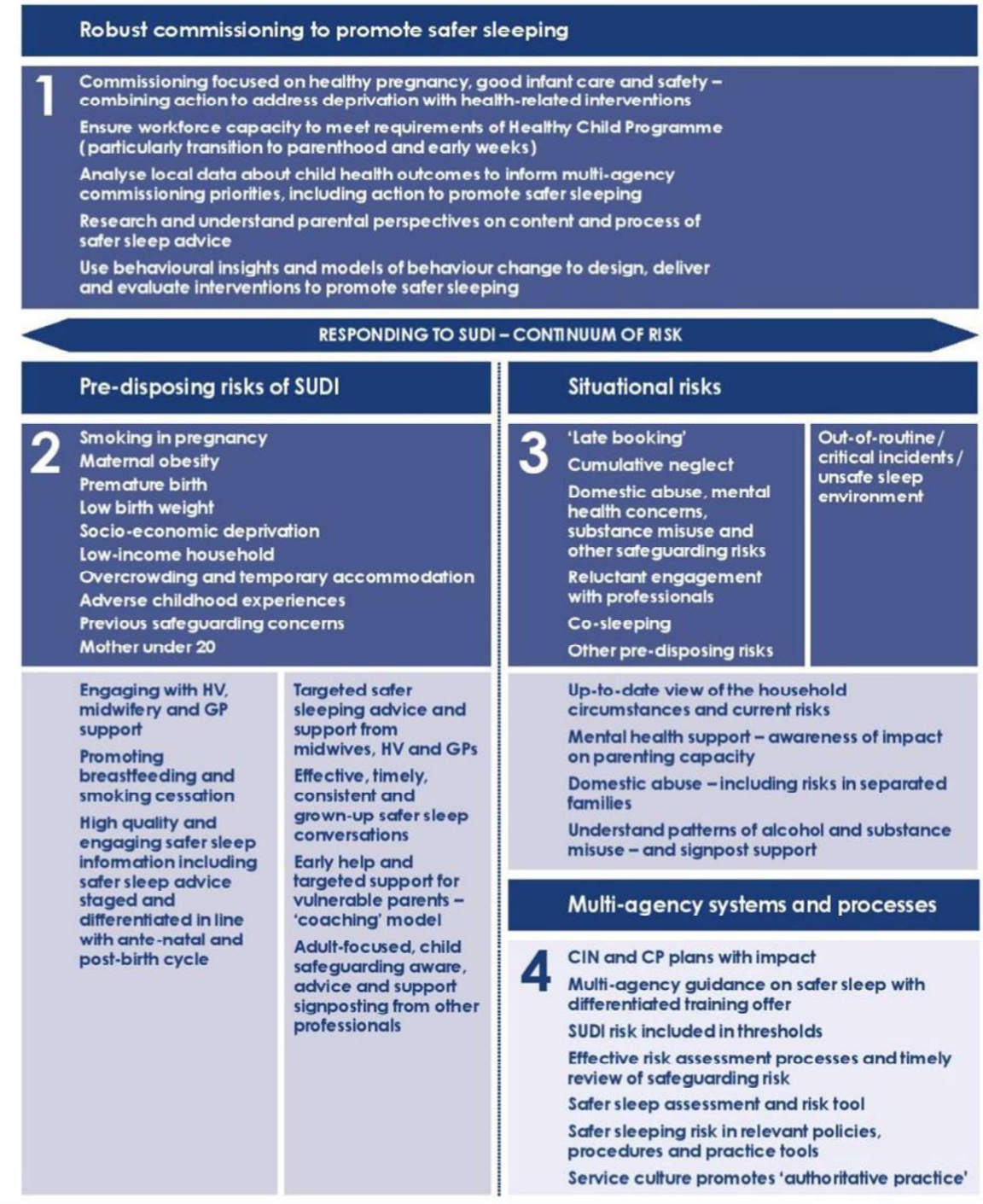
Northamptonshire Police

GP Services

Northampton Partner Homes

Appendix B[11]

Figure 6: A prevent and protect practice model for reducing the risk of SUDI



[11] The Child Safeguarding Practice Review Panel (July 2020) 'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' (Final report)

Appendix C
Learning Briefing Child Ay
Child Safeguarding Practice Review

The Background

Child Ay lived with parents and two siblings. The family has been previously known to Social Services due to concerns reported by health services and siblings' school.

The Incident

Parents had been out celebrating a family occasion during the evening. The following morning Child Ay, a very young infant, was found lifeless in the parental bed.

Early Learning identified during process of review

The learning identified in the early stages of this review reflect familiar concerns from historic reviews. It is important to remember that the learning examples below reflect single specific incidents within this case and are not reflective of the whole service. There is also good practice identified as specific examples of the same concerns.

Voice of the Child

The sibling was spoken to by a Social Worker 2 days after the disclosure of harm. The child was clearly uncomfortable and did not want to talk about the incident. The professional could not understand some of what the child was saying. The second sibling was also spoken to and the same professional recorded difficulty in understanding the child. As the child did not give any information about the disclosure and there were no longer any physical marks on the child, the S47 was closed with a recommendation for a single assessment. Whilst it is not known the approach this professional took to speak to the child, it is hoped they would have considered other methods, such as asking a professional familiar to the child to be present, tried different ways of gaining the child's trust such as play.

Communication between agencies

Following a sibling's disclosure at school of physical harm, the school made a referral to MASH. MASH did not respond to the school, as they expected, the same day and this led to the child being allowed to go home without any risk assessment being undertaken. This could have meant the child was at further risk of harm and gave the parents the opportunity to speak to the child. The following day, the school contact MASH again and Strategy meeting was convened. A more appropriate response to this referral should have been that the child was seen the same day by a Social Worker who would have then worked with the parents and, perhaps, wider family, to establish a family safety agreement.

Sharing information

Both siblings are known to have learning difficulties, however, this was not known to midwifery. If this information had been known, midwives may have considered offering additional relevant support to this already vulnerable mother.

Early Learning identified during process of review continued

Chronologies

There was no chronology for either of the siblings on Children's Services records. If this family become known to Children's Services again in the future, there is no chronology for quick reference that sets out historic events.

Professional Curiosity

Midwives knew Mother was receiving Disability Living Allowance; however, it was not known why. If the midwife had explored this further, it may have allowed her to identify if there was any potential impact the Mother's disability may have on her ability to safeguard her children and offer additional support or signpost to relevant additional services. This has now been included as part of the Level 3 Safeguarding Training midwives receive.

Recording of information

When mother was discharged from hospital following the birth of Child Ay, there was no record within her hospital file that safe sleep had been discussed. Usual practice would be that the information is recorded within the Red Book that parents keep. Midwives are now asked to also record this information on the Mother's file and this has been disseminated through the March edition of the Maternity Newsletter.

Addressing concerns with parents

Child Ay's sibling attended an outpatient appointment and appeared rather unkempt and raised concerns for the attending health professional and a referral to MASH was made. However, if the health professional had discussed and shared these concerns with the parents, it would have given the parents the opportunity to understand and address the concerns to actively safeguard their child.

When the school made a referral to MASH, they did not advise the family they were doing this and this caused the father to become upset and angry. If the school had made the parents aware, this could have encouraged a conversation with the parents that could have identified any potential additional support for them.

Timely Assessment and appropriate decision-making

A Single Assessment was undertaken following a referral from the hospital to MASH regarding concerns for Child Ay's sibling appearing unkempt. The single assessment was not done within the timescale of 35 days due to the allocate work being on leave and public holidays. There was on managerial oversight. Therefore, the children were not assessed and any potential risk not identified. This meant no safety plan could be put in place whilst the investigation continued.

A further single assessment was undertaken following Child Ay's death and the case closed, concluding this to be a tragic event and parents were receiving appropriate support from extended family and the school. Whilst there was evidence of management oversight throughout this assessment, there is no closure record on either of the sibling's Children's Services records nor any record of any closure letter to the parents.

Good Practice

Recording of information

When Mother gave birth to Child Ay, staff on the ward were concerned for her vulnerabilities. They made sure they carefully explored mother's hearing impairment and made sure it was comprehensively recorded.

Supporting sibling's needs

Both siblings have a form of developmental delay. One sibling has a delayed understanding and use of language. Health professionals in Northamptonshire Healthcare Foundation Trust have supported the child and family to be able to attend 6 monthly reviews. The other sibling has two support workers who work with and encourage the child who enjoys their sessions and speaks openly and freely to them so they can clearly hear and record their voice.

Police response to incident

The officers who attended the incident of Child Ay's undertake a thorough, yet sensitive, investigation that has been very clearly and well recorded.

For a comprehensive range of information regarding the NSCP, training opportunities, policies and procedures, visit the NSCP website. Click here for further details.