Northamptonshire Safeguarding Children Partnership

Child Safeguarding Practice Review (CSPR)

Child Ba

Independent Author: Dr Russell Wate QPM

Child Safeguarding Practice Review (CSPR)

1. Why is a Child Safeguarding Practice Review required?

Key Circumstances

Child Ba was only a few weeks old when they died at the beginning of June 2020. At the time of their death Child Ba was co-sleeping with their mother who was intoxicated through alcohol and had taken cocaine. It is suspected by professionals that Child Ba may have died as a result of having been overlaid by their mother.

There were concerns pre-birth with regards to the mother of Child Ba, these included misuse of alcohol, low mood depression (for which she was receiving medication) but primarily it was physically violent domestic abuse concerns in relation to Child Ba's father, who was in prison prior to Child Ba's birth and afterwards, including at the time of Child Ba's death.

Four months prior to their birth, Child Ba, was placed on a Child Protection Plan due to these concerns. This was under the category of neglect. Due to the mother's progress whilst living with Child Ba's maternal grandmother, the case was stepped down to Child in Need (CIN) at a Child Protection Conference review. The Child in Need plan was closed at a meeting at the beginning of June 2020, which was four days before the death of Child Ba.

Although Child Ba lived with their mother at the maternal grandmother's (MGM) address they did on occasions stay at their paternal grandparents' address. On the 27th of May 2020, East Midlands Ambulance Service (EMAS) attended a call to treat the grandfather, whilst there they observed the mother had been drinking alcohol and Child Ba was also present. They also observed that Child Ba was in an unsafe sleeping environment i.e., the Moses basket had a pillow placed over it. When mother was asked about this she became verbally abusive to the paramedic who observed that mother's speech was slurred. Police were not called but a safeguarding concern was generated, however, this information was not shared with relevant partners until after the death of child Ba.

Child Ba and their mother left the maternal grandmother's house because the maternal grandmother did not agree with the mother's alcohol consumption. They went to stay at mother's friend's address temporarily until an unfurnished council flat became available. The mother's friend was known to be a chronic alcoholic. He had apparently not seen the mother for months, but she had turned up unexpectedly and asked to stay as she had nowhere else to go. The friend and mother consumed five litres of alcohol between them on the night of Child Ba's death.

The mother was arrested for neglect and provided a blood sample which subsequently revealed that at the time of Child Ba's death the level of alcohol would have been 194mg per

100ml of blood[1]. Having been released under investigation mother was admitted to hospital as a voluntary inpatient in relation to her mental health.

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), the threshold was met to commission a Child Safeguarding Practice Review (CSPR) in respect of Child Ba. The strategic leads for the partnership agreed with this recommendation and the CSPR formally started on the 1st September 2020.

The Rapid review group set a period for this CSPR as 1st November 2019 - June 2020. The reason for this period is because it covers the time when Child Ba was placed on a Child Protection Plan as an unborn up to the date of their death. Agencies were asked to include historic events with the family relevant to the learning aims for the review.

All agencies involved with Child Ba 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. The Rapid Review document that was completed was particularly useful and the review author is grateful for the work undertaken by those involved. The review has also benefited greatly from a well-attended practitioner event, where everyone freely contributed their views to assist with the learning from this case.

2. 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, agency reports, and information provided to the questions the author has asked and additionally themes raised from the practitioner event. The themes for this review are professionals understanding of:

Analysis Themes

- **Child Ba's voice and lived experience**
- **Alcohol use and misuse**
- **Unsafe sleeping arrangements**
- **Step Down process and basis for decisions- Impact of over optimism by professionals**
- **Safeguarding within East Midlands Ambulance Service (EMAS)**
- **Impact of Covid-19 restrictions**

[1] the drink drive limit in England and Wales is 80mg per 100ml of blood.

2.1. Child Ba's family background, their voice and lived experience

Child Ba was the sole child living with their mother during the period of the review.

Child Ba had four siblings with a different father (FS) with whom they resided from 2017, the mother was allowed supervised access. The father had custody of the children through a private arrangement with the mother. There is information shared with the review regarding father objecting to mother's alcohol consumption which also mentions domestic abuse, including that on some occasions mother may have been the perpetrator of that abuse.

The information highlights two occasions when the mother was violent and abusive to the father (FS) and the police were called. One time was when the father (FS) came to collect the siblings after having received several calls from mother to extend their visit but when he arrived discovered both mother and maternal grandmother (MGM) to be drunk and Child Ba, who was only four days old, was also present. The father (FS) called the police, but they did not deploy until the following day. When the police spoke to the mother and MGM later that day, the police officer accepted their account of events that a malicious complaint had been made by FS. A PPN was submitted on this occasion, this was shared with MASH and the allocated Social Worker.

The second occasion, on 26th March 2020, occurred when mother and MGM attended the father's (FS) house to try and see the siblings and the police were called again. This time the police attended and discovered mother in the vicinity with Child Ba. No PPN[2] was completed by police for the second event although reported as a domestic incident, a DASH (Domestic Abuse, Stalking and Honour based violence) form was completed. The officer who dealt with the incident, subsequently in their reflective account said, they could have, and would now consider neglect of Child Ba in relation to mother being drunk in charge of a child in a public place.

Children's Services had been aware of mother from 2012 including when she was heavily intoxicated and unable to care for her 1-year-old daughter, and in 2014 two of her children were made subject to Child Protection Plans under risk of physical/emotional abuse because of a serious domestic abuse incident. Between 2017 and 2018 Children's Services were notified of ongoing domestic abuse concerns. Targeted support was provided to mother due to concerns regarding alcohol abuse, domestic abuse, homelessness, and neglect. In December 2017, the four siblings moved to live with their father (SF).

Child Ba never met their own father because he was in prison for the whole period of their life. However, Child Ba's father's prolific physical domestic abuse of previous partners and Child Ba's mother is a key factor considered by professionals in relation to Child Ba's life and how their safeguarding was managed. The following historic events, although before the review start date of 1st of November 2019, were included by the police, which the review

[2] Police Protection Notice a referral form highlighting concerns for a vulnerable child

author considers is relevant in building a picture of both mother and father's behaviour which may have influenced subsequent decisions. The domestic abuse against mother culminated in a Domestic Violence Prevention Notice (DVPN) being served on father of Child Ba on the 16th of October 2019 when mother was 21 weeks pregnant. The police also identified that mother needed support in relation to her mental health and did not appear to be protecting herself or her unborn baby. This was another occasion when the police officer did not complete, as they should have, a PPN for the unborn child.

A few days later on the 19th of October 2019, both mother and father (despite DVPN) were involved in heavy drinking and violence against a third party. Father was arrested but mother managed to evade being seen by police. On the 22nd of October 2019, Child Ba's father tried to find mother who was hiding from him, and at the time he forced entry to the premises she was hiding under a bed. He was arrested for assault but then imprisoned for other offences and remained in custody for the rest of Child Ba's life. Probation have stated that father had a history of domestic abuse, some of which he was convicted for, and they feared he would not adhere to his licence conditions on release (including not visiting mother or Child Ba). The father never met Child Ba but has been informed of their death.

Despite the father being in prison his domestic abuse history appears to have been the prime consideration in all subsequent decisions regarding Child Ba's safety. Other key factors relating to mother's behaviour appear to have been given much less significance. This is surprising considering the risk factors in mother's life included domestic abuse, mental health issues, alcohol and drug abuse issues, unstable housing (often homeless and moving between addresses, including MGM and PGM's homes), failing to engage with support services, including health, heavy smoking and avoiding contact with professionals.

As already stated earlier in this report, Child Ba, lived with their mother and maternal grandmother, at the maternal grandmother's (MGM) home. Maternal Grandmother was considered a positive and controlling influence, providing additional support which was considered a key part of the safeguarding plan for Child Ba. There was one occasion, when Child Ba did stay (along with mother and MGM) at another address belonging to the paternal grandparents, an incident of note which occurred at that premises. EMAS responded and the analysis of this response is covered in detail later in the report. However, only 2 days after Child In Need (CIN) plan closed, the maternal grandmother challenged mother regarding her alcohol consumption (did not want mother to drink) and mother took Child Ba to live temporarily with a friend who was a chronic alcoholic. It was at this friend's address that Child Ba died whilst co-sleeping with their mother in a double bed.

Mother was prescribed medication during her pregnancy but continued to drink, although minimalised this, smoked heavily, even though advised of the risk associated with both of these behaviours, missed appointments, e.g., for blood tests and did not engage with support services, e.g., S2S and Bridge (Drug and alcohol services) in relation to impact of domestic abuse on children and substance misuse, respectively.

Family support appears to have been provided mainly by the maternal grandmother, and as highlighted above, sometimes with paternal grandparents.

There was support provided under the CIN plan, but this was closed on the 2nd of June 2020 and after it was closed MGM did not notify services that mother, and Child Ba had left her address on the 4th of June 2020.

In the 'Voice of the Child' report by OFSTED (2011)[3] there are three areas of learning in it which have resonance with the life of Child Ba.

a) 'Parents and carers prevented professionals from seeing and listening to the child'

The Mother was often found by professionals as very hard to contact - she kept changing her phone number and sometimes shared the phone with her abusive partner (could be a coercive controlling element of domestic abuse). She moved between addresses and this was given as a possible explanation as to why she did not receive letters. She failed to attend several appointments with several services e.g., blood tests during pregnancy to monitor effectiveness of iron supplements – checks to Child Ba's low growth rate, mother did 'not support a referral', mother did not engage with 'Bridge'. The Health Visitor was told not to attend home by MGM with her concern re COVID-19, The Freedom Program was 'stopped as needed a break' and also attendances at case conferences. These all point to mother being unable to prioritise Child Ba (unborn and born) and her health needs e.g., continued heavy smoking during and after pregnancy against advice regarding its impact on Child Ba and her own health, failed to keep some appointment with midwife. Although when asked she denied drinking alcohol, but this does not compare with the facts.

There were some face-to-face meetings with mother where positive comments regarding her interaction with Child Ba were made. Also, sometimes when seen on a WhatsApp video call. Whilst these were helpful the face-to-face interaction would have helped to establish if mother was actually drinking, as the Health Visitor could have been able to smell alcohol if present. Disguised compliance, telling services what they wanted to hear appears to be evident in this case coupled with avoiding contact to support their non-compliance.

b) 'Practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child.'

Implications for Child Ba were clearly carefully considered, as is evident from them being placed on a Child Protection Plan when still an unborn child in relation to neglect. However, the key factor this plan focused on appears to have been the domestic abuse in relation to father. Although it was indeed an important factor, it, however, seems to have been considered the overriding factor with a continued emphasis that mother must accept that the domestic abuse's impact on her child Ba. When the father was imprisoned at the end of

[3] Microsoft Word - The voice of the child.doc (publishing.service.gov.uk)

October 2019 there were clearly factors reducing that particular risk, primarily because he was in custody, but on release there were licence conditions regarding contact.

What does not seem to have been given the emphasis it deserved were all the risk factors in mother's life:

- alcohol abuse
- neglect of unborn child - continued heavy smoking and drinking alcohol against advice, evidenced by low growth rate and induced labour because of these concerns
- Historic involvement with children services in relation to some of her other children including being found intoxicated in care of one-year old daughter and Child Protection Plans in relation to two of her children where domestic abuse between her and partner. All four of her other children are now with their father (SF) with a private agreement where she has supervised access. On one of these visits both her and MGM had been drinking.
- housing issues/homelessness
- mental health - low mood depression/ADHD
- Unplanned pregnancy
- committing criminal offences with the father
- domestic abuse where she might have been considered the perpetrator
- not keeping appointments

As well as these general safeguarding risk factors there was also evidence that Child Ba had a low birth weight, a premature birth and coupled with the mother's heavy smoking are all important risk factors for Sudden Unexpected Death Infancy (SUDI) including Sudden Infant Death Syndrome (SIDS)[4].

[4] Statistics on SIDS - The Lullaby Trust

c) 'Agencies did not interpret their findings well enough to protect their child'

Hindsight bias in reviews can feature in reports, but in this case, there does appear to have been more than sufficient grounds for maintaining the Child in Need plan rather than deciding to close it. The practitioner event discussed this and there were conflicting opinions. There is equal weight to argue for Child Ba to not actually have been stepped down to a Child in Need from the Child Protection Plan at its review. Father was also due for release on 3rd July 2020, removing the protective factor of him being in custody, with control relying on his licence conditions and mother not contacting him.

These statutory safeguarding processes are multi-agency and so the agencies with these important jigsaw puzzle pieces were involved but unfortunately do not appear to, or were not able to build a more accurate picture of the risk to Child Ba. It is now clear that Probation did not attend the closure meeting. Police did not attend either the first, or second, Child Protection Review meetings stating "*no relevant information to share at conference at this time*" however, it was subsequently identified by police that if their records had been checked on the day of the conference there was relevant information to be shared in relation to incidents involving her other children and their father (SF), mentioned earlier in this report, which involved mother having been drinking and a very young Child Ba being with her. (Identified as a learning action by Police report author).

2.2. Alcohol use and misuse

This theme of alcohol use, and misuse, are a recurrent theme from Child Ba's birth up to their death and is a constant factor in mother's life prior to this, including with her other children and in her relationships.

The mother's use of alcohol whilst pregnant, combined with her heavy smoking is very likely to have impacted on Child Ba's development in the womb and resulted in their low birth weight and subsequent growth below the 10th percentile at one stage at 0. Whilst this damaging behaviour is recognised and, in this case, the mother was quite rightly strongly advised about it by health professionals.

Alcohol was not only a factor pre-birth and during Child Ba's short life but also appears to have been a contributory factor in Child Ba's death.

In early June after the Child in Need plan had closed, the mother left the maternal grandmothers address as the maternal grandmother was concerned at Child Ba’s mothers alcohol consumption, she went to stay with a friend who was a chronic alcoholic, together they consumed over five litres of alcohol plus mother took cocaine. Levels at time of death following mother voluntarily supplying a blood sample were subsequently recorded as 194mg/100ml blood when drink drive levels are 80mg/100ml.

The mother left the home address where there were some protective factors from MGM and moved to a high-risk environment with Child Ba where she not only consumed alcohol but also cocaine (Drug use - cocaine discovered post incident.) As there was apparently no appropriate sleep arrangements for Child Ba, they shared a double bed with their intoxicated mother, who it appears, overlaid them and they died.

It is very difficult for pathologists to give conclusive proof of cause of death (as tell-tale signs of suffocation for an adult are not always observed in a very young child). Although as discussed at the practitioner event there is not an offence until after a child has died. If the advice given was stronger in relation to co-sleeping, including that there is a specific criminal offence of:

> *s.1 (2) (b) Children and Young Persons Act 1933 (amended from 3/5/15 under Serious Crime Act 2015)*
>
> *Death of infant under 3 caused by suffocation while the infant was in bed (in or on any kind of surface or furniture being used for the purpose of sleeping) with some other person over 16 years who when went to bed or at any later time before the suffocation, was under the influence of drink or prohibited drug be deemed to have neglected the infant in a manner likely to cause injury to its health.*
>
> *Penalty Max 10 years imprisonment.*

The fact that this might occur in these circumstances should be used as a stronger preventative message. Many professionals, including some police officers, are not aware of this specific offence which was amended as recently as 2015 to include drugs as well as alcohol (drink drive limits used as a guide) and clarify that 'bed' would include other sleeping surfaces e.g. sofa.

There appears to be a general over optimism by professionals that the mother was doing well in relation to her use of alcohol. This was agreed by professionals at the practitioner event as an area for learning. It was known that the mother had a significant history in misusing alcohol; however, she self-reported that she was not drinking, and this appeared to have been accepted rather than taking the opportunity to check out what mother was saying to confirm how she was managing. The mother self-reported she was accessing services, but this was not checked by professionals.

'Bridge' is a substance misuse programme based in Northampton primarily funded by Northamptonshire County Council that mother attended, but mother had a pattern of limited engagement and showed no expressed desire to change by the mother of Child Ba. See below:

- 30.1.20 - inducted
- 6.2.20 - missed appointment due to family emergency (missing other appointments also at this time)

- 13.2.20 - completed paperwork
- 4.3.20 - telephone call in which mother expressed her intention to attend
- Despite numerous calls, letters (problems with changing telephone numbers and addresses) no further contact with mother.

Although some professionals, were not seeing mother drinking, (other than the police and EMAS) there is clear evidence that alcoholism does not just go away and if there had been some professional curiosity around mother's self-reporting, this may have led to a different level of monitoring and support to her and Child Ba.

It can be difficult for many reasons for professionals to challenge alcohol use, however, the focus should be on the impact that alcohol misuse has on a parent's ability to care for their child safely and appropriately. In this case, it appears professionals have differing recordings on the level of alcohol mother may or may not have been drinking.

In March 2020, the Department for Education published *'Complexity and challenge: a triennial analysis of serious case reviews 2014-2017'*. Within this report it highlights from the study an extremely high-risk factor of parental alcohol abuse.

Table 12: Parental characteristics - frequency noted in SCR final reports (n=278)

Characteristic	Mother	Father	Father figure/ mother's partner	Both	Total number (%) where characteristic reported
Alcohol misuse	40	25	3	31	99 (36%)
Drug misuse	29	23	7	40	99 (36%)
Mental health problems	93	17	5	38	153 (55%)
Adverse childhood experiences	59	11	1	31	102 (37%)
Intellectual disability	20	6	2	8	36 (13%)
Criminal record	10	42	18	13	83 (30%)
Of which, violent crime (excluding domestic violence)	8	22	7	4	42 (15%)

The Department for Education (DfE) published in December 2018 'Guidance Safeguarding and promoting the welfare of children affected by parental alcohol and drug use: a guide for local authorities.' 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, 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.'*

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.

Parental misuse of alcohol is a key issue for this review.

2.3. Unsafe sleeping arrangements

There are several records of safe sleeping advice being given to mother and recorded in the Personal Child Health record which is commonly known as the Red Book. As previously mentioned in this report there were numerous risk factors present linked to SUDI and SIDS.

The EMAS attendance and the observation of the Moses basket and pillow over it are an example of behaviour being challenged but the mother not accepting it.

When no-longer under a CIN plan the mother left MGM's home and moved to a friend's house where, as already explained in this report, she drank alcohol and took cocaine. She then went to sleep (although she could not remember details nor recall what time she had gone to bed) with Child Ba in a double bed. Mother woke up in the morning and discovered child Ba in the bed purple in the face and not breathing. They had marks on face, chest and knee which suggested they had been laid on. Together with white skin compression marks on forehead, nose and around mouth to suggest they were lying face down.

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 Serious Case Review's which state:

> *"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.'* This section was updated in September 2020[5]. Northamptonshire Public Health are in the process of updating its Safer Sleep guidance and a campaign to ensure all parents are aware of how to always ensure their baby sleeps safely.

The title of the section on the website is extremely relevant to the death of Child Ba who died whilst sleeping with their mother in a 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)*[6]

The review author has applied the bold mark up to two of the bullet points above. The information provided to this review is that the mother of Child Ba was continually being given advice pre- and post-birth about alcohol and smoking.

The National Child Safeguarding Practice Review Panel published a report (July 2020) titled. '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)[7]. Within this report it highlights a risk which directly correlates with the circumstances of the evening and the night that Child Ba 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*

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

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

[7] 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)

question is the extent to which SUDI in out-of-routine circumstances, while not predictable, can nevertheless be made more preventable'.

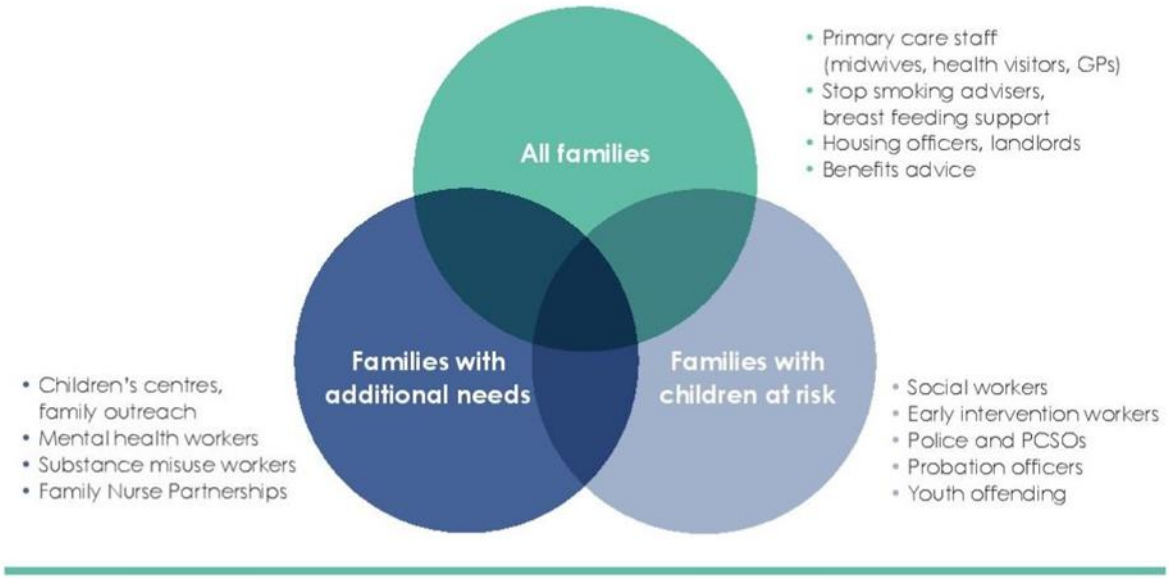
The learning from this publication and the death of Child Ba is for professionals to continue to highlight the risks of co-sleeping, in particular if there is any change to normal routines. For example, in this case where the mother left MGM and went to stay with her friend. The professionals at the practitioner event were also of the opinion that the safe sleeping advice should be as wide as possible, not just to mothers, but also other carers such as fathers and other family members.

The 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.'[8]

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



Northamptonshire Police Officers are being urged by their management to think broader when called to incidents. This would include consideration of Safer Sleeping.

[8] 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)

Northamptonshire health colleagues have created a crib sheet to support multi-agency partners which include Police Officers and Social Care staff in reviewing sleeping arrangements.

2.4. Step Down process and basis for decisions

A referral was made by a Health professional as soon as they became aware that the mother was pregnant for the fifth time. The Social Worker reviewing the referral information, whilst brief in detail, rightly made the decision to proceed straight to assessment. Once considered by the Duty and Assessment Team, a Social Worker was allocated and made efforts to contact mother but with limited success.

The case was firstly being assessed under the Child in Need criteria. Due to the numerous (six) attempts to contact mother as part of the assessment and the information held by professionals it was felt that there was a need to hold a strategy meeting. This was held on 23rd October 2019, and concerns were raised by Social Care, Health and Police surrounding historical domestic abuse, current incidents of domestic abuse, mothers' previous children not being in her care, non-attendance at health appointments and general difficulties in getting mother to engage with assessment and professionals.

The outcome of the Strategy discussion was for the case to proceed to Initial Child Protection Conference (ICPC) and a conference convening request was made the following day with ICPC being held on 13th of November 2019 which was good and positive work.

The outcome of the ICPC was that the unborn should be made subject of a Child Protection (CP) Plan under the category of Neglect.

At the first review CP conference on 23rd March 2020 (conducted by phone due to COVID-19 restrictions) it was recorded that:

- Mother and MGM were awaiting housing
- No concerns re parenting
- Focus on understanding Domestic Abuse and its impact on children
- Father does not have access and was in prison
- Living with MGM to ensure remained safe and adhered to safety plan

In terms of decision making, it would appear there was a focus on father being the risk and as he was in prison, that risk had been removed. There appears to be little consideration of mother's extensive history of alcohol misuse, the reasons for the removal of her other children to the care of their father, [the review is aware that this was a private agreement between mother and father. However, the professionals at this meeting were unaware at that time] and any potential implications around Child Ba's low birth weight in terms of cause or

vulnerability. There appears to be little consideration given to whether mother wanted to re-establish her relationship with Child Ba's father when he was released.

Evidence of progress of the CP Plan and subsequent CIN Plan was essentially self-reported by mother (probable disguised compliance) as access to the home, and direct access to Child Ba was very significantly restricted during the COVID-19 lockdown. Given the very long previous history of concerns about domestic abuse and the impact of mother's alcohol use, the review author agrees with the professionals present at the rapid review meeting, who expressed concern that the step down from CP Plan to CIN Plan and then CIN Plan to closure at the beginning of June took place very quickly, within only 40 days of Child Ba's birth.

The Northamptonshire Safeguarding Children Partnership (NSCP), Thresholds Guidance 2018: 'The right support at the right time' states within the document:

> *'Some services described as early help or targeted support are also used by children open to children's social care, e.g., Children in Need (CiN) or children on Child Protection (CP) plans. The following considerations may apply: • Children can and do move from one level of need to another, sometimes very quickly.'*

Although the review author fully understands what the above information is saying, he believes that in this individual case the CIN Plan was closed prematurely. The main reason for believing this is that the actions of the CIN Plan had not been completed prior to the case being closed. It is unclear as to what had changed that had provided confidence that mother could protect Child Ba. The father in prison was due for release relatively soon. CP Plan was only four months old (Three months of which pre-birth). It is also unclear why the CP Plan ended and was stepped down to CIN in the first place given the vulnerabilities such as domestic violence, mother's alcohol abuse and other risk factors listed earlier.

The fact that her other children left her care; father removed them from her care under a private agreement and they remained with him –was not recorded in the CP Plan. In the Rapid Review it also mentions that in 2018 all four of her other children were on Child Protection Plans.

There was an action in the CP Plan for a referral to Substance to Solution (S2S) for alcohol treatment (detox, rehabilitation and 1:1 work, and to Bridge to provide a mentor who had been through the recovery process). It has been confirmed that there was no referral made to S2S and it is unclear why Bridge was chosen as a support service. The rationale for closing the CIN plan when a key referral was not completed is not known.

Considering that Child Ba's father was due for release shortly from prison in early July, there was no discussion with Probation Services to understand how this was going to be managed. From the perspective of the Probation Service records it suggests they were not invited to the meeting. From the perspective of Children's Services, their records indicate Probation Officers

were invited. It is not clear from the records if the Conference Chair queried this non-attendance.

There are unresolved conflicts in the records as to who attended meetings or who was invited e.g., probation. Probation says they only received a call to say the case had been closed. The probation officer re-iterated this strongly at the practitioner event. It is acknowledged that there were identified problems with IT systems during COVID-19 and different agencies used different virtual platforms. There was an understanding within the partnership at this time that if core group or Child in Need meetings were not able to get together the social worker would contact professionals individually by telephone, which may explain discrepancy between different agency records.

The Health Visitor records are not clear if they contributed to decision making on the step down from the CIN plan, but Children Services records show Health Visiting Service as part of CIN Plan meeting on 2nd June 2020 with an input via a WhatsApp message.

The only concern recorded by professionals appears to have been mother's understanding of domestic abuse and impact on children, the report stated, 'that all professionals agreed with the decision making'.

The NSCP have recently (September 2020) updated their guidance 'Case and Conflict Resolution Protocol' which states:

> '*The Partnerships Case and Conflict Resolution Procedure has been updated and re-launched to ensure that all members of the partnership are aware of the process and expectations. Effective safeguarding of children is based on practitioners and front-line staff wanting the very best for children. They need to be ready to stand up in the best interests of children to enable collective responsibility for problem solving, even if this brings them into disagreement with other practitioners, with other organisations or with their own managers and employing bodies.*'

As can be seen by this guidance NSCP agencies are encouraged to challenge any decisions they do not agree with and address these with the Social Worker or the Service Manager, that didn't happen in this case as it should have done because there was not an agreement for the case to be stepped down.

There was an impact of over optimism by professionals, particularly with the step-down process and closure, but there are several comments raised in the information recorded by professionals throughout Child Ba's case that do not provide assurance that risks to child Ba had been mitigated.

There is a frequent expression 'no evidence to suggest' in the key event analysis from the acute hospital involved, which is also included in the rapid review analysis. What there isn't

provided for in meetings was if there was actually any evidence to support that there had been any positive changes? This only relied on what the mother self-reported as positive.

Some examples of the comments that relate to the mother not engaging/non-compliance/disguised compliance/self-reporting

- E.g., Bridge (as detailed in the information earlier in this report).
- E.g., Social Worker 'There has been missed appointments because of the mother being tired. It seems that the mother would only engage when necessary.
- E.g., Health Visitor did attempt to have face to face contact but the family were reluctant, other contact methods were offered.
- Acute hospital involved - father not there so no obstruction to attending appointments.
- Acute hospital involved - high risk pregnancy - not attending appointments - what was happening ? - implications for future lived experience of Child Ba.
- Acute hospital involved - appeared professionals did not have a full understanding of mother's alcohol use, not challenged by professionals that found her intoxicated on two occasions whilst pregnant.
- Acute hospital involved - alcohol use not examined effectively in view of her non-engagement and lack of therapeutic service intervention.

2.5. Safeguarding within East Midlands Ambulance Service (EMAS)

EMAS undertook a Serious Incident review following an attendance to the paternal grandparents' address on the 27th of May 2020. This was to attend paternal grandfather. Whilst in attendance, maternal grandmother, mother and Child Ba were present and it was observed that a pillow had been propped across the Moses basket to block out the early morning light getting into the Moses basket. One of responding paramedics appropriately gave mother safe sleep advice; however, she became verbally aggressive and hostile. The crew considered that mother was significantly intoxicated but that paternal grandfather, although he had had a drink, was able to be protective and they did not assess the situation as requiring immediate protection for Child Ba.

On leaving the property, the crew correctly completed a safeguarding referral which they sent to EMAS' Safeguarding Team; however, the referral did not include Child Ba's details and just gave mother's first name. Due to this the Safeguarding Team were unable to progress the referral and returned it to the attending crew asking for further detail. By the time the crew were able to get the information and return it to EMAS' Safeguarding Team, Child Ba had died.

EMAS, as with all ambulance services, their front line clinicians do not have any access to child protection information about named individuals. Neither were EMAS able to access CPIS (Child Protection Information Sharing) at that time, but which they can now access in a limited

capacity, a phased implementation is in progress to provide further access. They can flag addresses for risk information, but not individuals or public places. This is clearly an issue for EMAS and this issue extends nationally.

The Serious Incident investigation being undertaken by EMAS has scoped its terms of reference which includes looking at improving processes when potential child protection concerns are identified following attendance at an address, including when concerns are identified for a child who is not normally resident at that address.

The CPIS electronic register of child protection and looked after children can be accessed by acute trusts, A & E and maternity services. If EMAS had had access to it at that time it could have influenced the CIN plan step down decision. However, as this was, a call to paternal grandfather CPIS would not have been able to have been accessed for child Ba, who resided elsewhere. Other safeguarding concerns such as mothers alcohol intoxication, unsafe sleeping may have been highlighted though through the referral process.

It is the view of the author that the giving of Safer Sleep Advice by the paramedic was excellent practice, but EMAS in their report to the panel state that with this level of concern the police/social services should have been contacted immediately and attended the address. Safeguarding concerns need to be reported (as they were in this case, albeit with limited information which resulted in a significant delay), but if of this nature then police or social services should have been notified sooner. This would have had the added benefit that those services would have had additional information available to them.

The now completed Serious Incident has made a number of useful recommendations for EMAS. The ones that are relevant to this review are: a) to add in safe sleeping advice to core training b) to separate and clearly add in immobile baby risks c) to give a clear guidance on immediate and urgent referrals. This supports their earlier view that on this occasion they felt the crew should have made an immediate referral. The review author and panel clearly support these recommendations.

2.6 Impact of COVID-19 restrictions

This phrase appears in records "But due to COVID-19 this was not completed" (CSPR minutes) - e.g., in relation to contacting Bridge, substance misuse programme - whilst COVID-19 was a factor it was more so due to the mother's use of it as disguised compliance. Some other examples below where COVID-19 is mentioned but mother appears to have used this as a reason not to interact. Sometimes saying family/MGM did not want visitors at the home because of COVID-19.

Bridge - *"Due to the lack of contact and attendance, support has unfortunately been very limited."*

Health Visitor - the number of contacts with mother via telephone during COVID-19 restrictions were more than the normal number of face-to-face contacts that would have typically taken place. Health Visitor did attempt face-to-face contact but the family were reluctant, so as a result other contact methods were offered (e.g. WhatsApp mentioned and used)

Meetings were affected by COVID-19. Probation say that they only received a call to say that the case had been closed whilst social care records say that probation were invited. Problems with IT and different agencies using different virtual platforms – there was an understanding that if core group in CIN meetings did not meet together the social worker would contact professionals individually by telephone - this may explain discrepancy between different agency records?

3. Conclusions

The main themes to learn from in this CSPR are firstly for professionals to assess the impact of parental behaviour more robustly on the state of the child. This can sometimes be aided by hearing the voice of the child, although in this instance, Child Ba was not yet verbal, it was not a reason not to hear their voice. There is a need for professionals to have a deeper understanding of the impact of parental alcohol misuse on children. The third is unsafe sleeping arrangements. Unsafe sleeping has been a factor in a number of recent child deaths in Northamptonshire, this has triggered a separate review of a refresh to current practice in relation to advice and support given to expectant and new parents around safe sleeping and how this can be further strengthened. Linked to this theme and another recent CSPR in Northamptonshire is co-sleeping.

A further repeated theme running through this review into the death of Child Ba is that practitioners focused too much on the needs of the mother and overlooked the implications for her child and their lived experience. In this case they focused too much on the domestic violence/abuse in relation to the father and overlooked numerous recognised risk factors associated with mother.

- Alcohol abuse
- Neglect of unborn child - continued heavy smoking and drinking alcohol against advice, evidenced by low growth rate and induced labour because of these concerns
- Historic involvement with children services in relation to some of her other children, including being found intoxicated in care of 1-year old daughter, and Child Protection Plans in relation to two of her children where there was domestic abuse between her and her partner. All four of her other children now with their father (SF) and a private agreement where she has supervised access. On one of these visits both her and MGM were drinking.

- Housing issues/homelessness
- Mental health - low mood depression/ADHD
- Unplanned pregnancy
- Committing criminal offences with father of Ba
- Domestic abuse where she might have been considered the perpetrator
- Not keeping appointments
- As well as being general safeguarding risk factors they also, along with low birth weight, premature birth and heavy smoking are important risk factors for SUDI including SIDS.

Another theme was the step-down from CP to CIN to closure. The reasons for these step downs are still not clear, as neither of the plan outcomes had been achieved/ It might be assumed practitioners were over optimistic but there is no specific evidence for this. If any professionals had disagreed at the meetings no challenges are recorded, and although a disputed fact, some key professionals may not have attended.

The Health Visitor at the practitioner event advised that although child Ba may have been stepped down from CIN they were still on her Universal Plus Partnership Level 3 care, which although is a step down from safeguarding still warrants involvement. The HV did not know mum had left MGMs home. Some professionals had been critical of MGM for not notifying professionals that mum had taken Child Ba out of her household, but professionals commented that they felt that she had thought that she had gone back to the paternal grandparents, which was a much less risky environment, than with the friend whom she actually went to stay with. There is in this case, and in other cases, assumptions about the capacity to protect, that professionals make around grandparents with very little consideration to clarify with them what expectations are required of them. In this case, notifying professionals that the mother was misusing alcohol whilst on a CIN plan and then had left with Child Ba very shortly after the CIN plan had closed. Learning is required on how best to support these older family members in their required protective role.

There is no doubt that COVID-19 had an impact in this case, firstly it allowed the mother to avoid any face-to-face contact or intrusive involvement in the home. Secondly, the step-down process was carried out less rigorously due to COVID-19 restrictions.

4. Recommendations

Recommendation 1 The NSCP should ensure that all professionals have a better understanding of the implications and risks associated with parental alcohol misuse including historical alcohol misuse and how this is harmful to children**.**
Recommendation 2 a) The Northamptonshire Public Health and the NSCP Safer Sleeping campaign has been re-launched. In light of the learning from this review and a recent previous review it is

recommended that the campaign ensures parents and carers are aware of Safe Sleeping advice. The campaign is titled 'Every sleep a safe sleep'. b) The partnership to examine the learning from the National Panel, SUDI review and consider implementation of the National Panel's suggested preventing and protect practice model for reducing the risk of SUDI. (Please see Appendix B for details).
Recommendation 3 The NSCP should seek assurance that step down procedures are operating effectively and rigorously.
Recommendation 4 The NSCP and partners should consider what needs to be put in place to support grandparents, and other family members, of whom they have an expectation that they are to act as a protective factor to parental risks to safeguarding children. To help with this consideration The Children's Trust have adopted the 'signs of safety model of practice', within this model it includes all family members that are to be regarded as a protective factor. This is in mid implementation phase. The NSCP Partners should also be trained in the signs of safety practice model and there is training available for them to access.

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 Ba. The Strategic Leads agreed with this recommendation and the CSPR formally started 1st September 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 taken 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:

- Professionals understanding of this family unit in terms of Child Ba's care and safety.
- Professionals understanding of Child Ba's voice and his day-to-day lived experiences.
- Professionals understanding of alcohol misuse; what was professionals' knowledge and perception of mother's historic alcohol misuse, the risk / level of harm this posed to Child Ba and professional understanding of mother's pattern and consumption of alcohol.
- Safeguarding concerns observed by ambulance crews: Further exploration is needed of internal safeguarding processes within EMAS and how these can be / are being improved so that safeguarding information can be shared in a timelier manner.
- Analysis of the impact of children's social care step down processes, how actions from plans were addressed and recommendations for any improvements to these.
- The impact of any over optimism by professionals that, as father was in prison due to domestic violence, the risk to Child Ba had been removed without considering the risk by mother due to her alcohol misuse.
- Unsafe sleeping arrangements.
- The impact of the COVID-19 lockdown circumstances on assessment and decision making in this case.

The time period for this Review is 1 November 2019 – June 2020.

The reason for this time period is the 1 November is when Child Ba was placed on a Child Protection Plan as an unborn to June 2020, the date of Child Ba's death.

Agencies should include historic events with the family relevant to the learning aims of this Review, particularly in terms of:

- *Mother's previous children and her contact with them.*
- *Father's involvement with Child Ba and mother, his current status and contact with mother whilst he was in prison.*

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

Panel members:
Independent Reviewer
Children First Northamptonshire representative
Northamptonshire Clinical Commissioning Groups representative
Independent Consultant, Northamptonshire Police representative
Northamptonshire Probation Service representative
Northamptonshire Safeguarding Children Partnership representative

Chronologies and Key Incident reports are required from:
Acute Hospital involved (to include midwifery)
Children First Northamptonshire
GP, Northamptonshire Clinical Commissioning Groups
National Probation Service
Northamptonshire Police
East Midlands Ambulance Service
Northamptonshire Healthcare Foundation Trust

Parallel Processes
It is acknowledged that East Midlands Ambulance Service are undertaking an internal Serious Incident Review and the findings from that review are requested to feed into this process at the earliest opportunity.

Appendix B

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