CHILD SAFEGUARDING PRACTICE REVIEW

Child Bi

Lead Reviewer: Karen Perry

CONTENTS

INTRODUCTION

1.1. This Child Safeguarding Practice Review is in respect of Child Bi who died aged 6 weeks. This is believed to have been due to being smothered by an adult sharing the same bed (overlay). Post-mortem examination revealed a skull injury which has been reviewed by various medical experts. What was originally believed to be a fracture of the skull was in fact an "accessory suture"[1] showing evidence of acute and, possibly, repeated mild local traumatic injury. It is difficult to age the injury but it is consistent with having been caused within 12 hours prior to death. There are also subacute changes that could have occurred over several days or a few weeks. Whilst the post mortem has found the cause of death to be unascertained, a medical expert has assessed that all the injuries are not inconsistent with having occurred as a result of co-sleeping with overlay. An initial criminal investigation led to no further action. A urine sample take from Mother after Child Bi's death showed evidence of drugs in her system and a subsequent hair strand test indicated substance misuse over a 14-month period.

1.2. Northamptonshire Safeguarding Children Partnership (NSCP) will ensure that learning is widely disseminated locally. To avoid unnecessary disclosure of sensitive information, details in this report regarding what happened focus only on the facts required to identify the learning. This Child Safeguarding Practice Review takes into account multi-agency involvement from 1st October 2020 (from when toddler aged sibling was found alone in the street) to Mid November 2021 (when Child Bi died)

1.3. Northamptonshire Safeguarding Children Partnership (NSCP) agreed to undertake this review using a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted as they did at the time and aiming to identify any systems issues[2] which affected this case and may impact in future on other children in the area. Family members are aware of the review. It has not yet been possible to offer them the opportunity to contribute due to the initial criminal investigation.

SUMMARY OF LEARNING

1.4. All learning points are listed in section 3, at the end of each theme. What follows is a summary of the most significant learning from this review. Denied or concealed pregnancies are very rare, the highest estimate nationally is 0.2%. Both mother and baby can be at serious risk if they do not receive antenatal care. The reasons for concealment and denial of pregnancy are varied. They include fear, stigma and shame due to the circumstances of the conception (e.g. incest, rape, adultery, being young or out of wedlock or view of partner about a further pregnancy). They also include a wish to avoid scrutiny by agencies, as seems likely in this case. Midwives should attend Initial Child Protection Conferences (ICPCs)[3] held shortly after children have been born, especially if they made the referral and even if their involvement has ceased.

1.5. Practitioners feel well supported when dealing with parents who are aggressive or intimidating, but systems to share information about incidents are underdeveloped. When parents do not engage with Child in Need (CIN) plans, including not attending meetings, social workers should promptly consider

[1] Skull sutures are the lines formed by the separate plates of bone that make up the skull, as they grow and fuse together. In young children, the sutures have not fully fused and can be seen as dark lines if the skull is X-rayed. An accessory suture is seen when the pattern of bone growth and fusion is different from the normal pattern. This does not usually cause any symptoms but on skull X-ray will show up as an unexpected dark line that can be mistaken for a fracture

[2] E.g Technology, forms and other processes which support or hinder practice, organisational issues cultures, demand and workload pressures, restructuring, professional hierarchies

[3] Initial Child Protection Conferences

either ceasing the Child in Need (CIN) plan or convening a strategy meeting. When parents explicitly state they do not want social work involvement there is no legal basis to continue a CIN plan.

1.6. A challenge for all practitioners is how to share what they observe about children's lived experiences effectively. The risk is that as descriptive information is disseminated, the facts of what happened and what the children saw and how they presented are diluted, for example, by the way this is summarised in records, or described from records by someone who was not there.

1.7. Management oversight when the police share Public Protection Notices with social workers is important to ensure an appropriate and timely response. The prompt arrangement of strategy meetings is necessary to maintain momentum of enquiries and action. In assessments and child protection conferences, it is important to consider all of a parent's history and also to request and share information about a parent's partner, even if they are not part of the family household.

1.8. This family, like others nationally, and in Northamptonshire, was affected by the mother being a repeat victim of domestic abuse by men who were serial perpetrators of domestic abuse. Police have recently put in place arrangements to identify and manage serial perpetrators of domestic violence; these need reviewing for effectiveness. Mother was never considered by a Multi-Agency Risk Assessment Conference (MARAC),[4] it may be relevant that despite the level of concern about Putative Father's history of violence, including domestic abuse, there were no actual reports of domestic abuse against Mother during the period under review.

1.9. Research suggests parents often do not find safe sleeping advice to be meaningful and had often understood the goal to be to follow the advice most of the time, rather than always. Work has been done locally on this issue but it is not an easy one to solve. This case demonstrated the importance of practitioners visiting the parent and child's main home to check the sleeping arrangements, which would also provide opportunities to talk though any barriers which might prevent parents following the safe sleep advice all of the time.

2. DETAILS OF THE FAMILY AND THE CHILD'S STORY

2.1. Family members will be referred to by their family relationship to Child Bi e.g. Mother, Sibling, Putative Father according to Mother, although his name was not on the birth certificate. It is not known if he knows about baby's birth and death. At the time of his death Child Bi was living with Mother and four half siblings (3 primary school age and one toddler). Mother and children are White British. Ex-Partner 1, Father of Siblings 2, 3 and 4, died in 2019.

2.2. Some history prior to the scoping period is relevant. Since 2013 there has been social work involvement with Mother and children due to significant domestic abuse by different partners (which included her having at least one broken bone and allegations of attempted strangulation), association with other risky adults and lack of parental supervision. Mother has several criminal convictions, including for violence and shoplifting, (the latter when she has involved her children). In June 2016 the three siblings born by then were made subject to a child protection plan, category emotional abuse, due to domestic abuse by an ex-partner against Mother. This was later "stepped down" to a Child in Need (CIN) plan in August 2016 as the perpetrator was in prison and Mother had demonstrated an understanding of the risks and given evidence in court.

2.3. In March 2020 the family had to move house due to assault by Ex-partner 2 trying to get in. Mother refused to go to hospital or give details of the children, but the ambulance service gained consent

[4] A MARAC meeting is one where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.

for a referral under her name which went to adult's and children's services. Mother agreed to the children receiving emotional support in school but withdrew consent before the children took it up.

2.4. In October and November 2020 there were three incidents which culminated in a strategy meeting and an Initial Child Protection Conference (ICPC) in December 2020. In October 2020 Sibling 4, then aged 16 months was found alone crying in a car park near his home. During a phone call from the social worker Mother stated she had been taking the children to a friend's house to be taken to school. This person is a risky adult. The social worker advised Mother by telephone that her actions were reckless leaving a toddler alone in the house near a busy road with an unlocked door.

2.5. In early November 2020 the police had information that mother, Putative Father, and another male were using drugs at the home address. Shortly after the incident police attended the house due to an argument between Putative Father and his ex-partner about child maintenance. Also in early November 2020, Police found a partially dressed Putative Father in the home when searching for someone else. Mother was believed to be aware that Putative Father posed a risk of violence. Home conditions were reported as poor, and both individuals were very hostile. The children were present and records describe them as frightened. The social worker made a phone call followed up by a visit four days later. In mid-December 2020 an Initial Child Protection Conference (ICPC) was convened. The outcome was continuation on a CIN plan. This was not a unanimous decision; the social worker and health visitor felt that threshold was met for a child protection plan. Other participants did not agree, the outcome was for a Child in Need plan to continue. The chair directed that a return to a further ICPC should be considered if there was non-compliance with the CIN plan.

2.6. Between Christmas 2020 and New Year police attended the house in response to a third-party report of a male, who is not named, kicking the door. The house was reported to be "unkempt" and smell of cannabis. In Mid-February 2021 Putative Father was recalled to prison for poor behaviour and failing to co-operate with his probation officer. At the end of March 2021 Mother was reported to the police for shoplifting twice on the same day. There were no enquiries about either incident as neither shop completed the crime pack provided by the police**.**

2.7. In Mid-April 2021 social work involvement was transferred to a team "Innovate", which was commissioned to support the addressing of social work caseload pressures and allocated to SW2.[5] At the end of April 2021 Mother sought support from SW2 having been informed that Ex-Partner 2, against whom she had a restraining order, was due to be released from prison; she was fearful as he knew her address.

2.8. In May 2021 there were reports to the police about an Ex-Partner 2 who had breached a restraining order by banging on the door. In June 2021 there was an anonymous referral from the NSPCC that alleged Mother was shoplifting with the children, misusing drugs and pregnant. On the same day the school sent an email to reported concerns from five days earlier when Mother's speech was slurred. When SW2 visited Mother denied she was misusing drugs or being pregnant and being in a relationship with Putative Father.

2.9. At the very end of August 2021 there was a further change of social worker, to SW3. Two weeks before Child Bi's birth in early October 2021, his half siblings told the school that Mother was pregnant. No other agency knew this before Mother presented at hospital in labour. Midwifery services submitted a referral to the Mult-agency Safeguarding Hub (MASH) within a few hours of Child Bi's birth due to the concealed pregnancy and some concerns about Mother's lack of interaction with the baby. In early November 2021 an ICPC was convened due to the circumstances of Child Bi's birth**.** This resulted in a continuation of the CIN plan. The decision of the ICPC, which is

[5] An Ofsted monitoring visit in October 2020 identified that caseloads in the Duty and Assessment teams were still too high – with an average of 26 children per social worker but some staff holding 35 cases

discussed in detail in the "working together theme" was not unanimous; a recently allocated social worker, SW4 had recommended the siblings be made subject to a child protection plan, other participants disagreed. There was no information or representation from midwives because their involvement had ceased before the ICPC. Despite practitioners believing that the pregnancy was concealed, which Mother denied, there was no evidence that anyone had discussed or shared any hypotheses about why the pregnancy was concealed and the potential impact on Child Bi accordingly.

2.10. In mid-November 2021 an ambulance was called as Child Bi was in cardiac arrest. He had been found unresponsive in Mother's bed. Suitable action was taken to ensure the siblings immediate safety; they were placed with Maternal Grandmother pending further assessment, including of her ability to care for them appropriately.

3. THEMATIC ANALYSIS

Response to concealed pregnancy
Safe sleeping
Working together to safeguard the children and decision making about level of intervention, Child Protection or Child in Need
Managing parental non engagement and hostility
Children's voice and lived experience

Response to concealed pregnancy

3.1. As a result of a previous local Serious Case Review in 2015 (Family R) the local safeguarding partnership has a procedure and practice guidance[6] on concealed pregnancies to ensure that agencies make a safeguarding referral, and an assessment is undertaken by a social worker when a concealed pregnancy is suspected. The procedure and guidance defines concealed pregnancies as those of least 24 weeks gestation, where women know they are pregnant, but have either not told any practitioner about the pregnancy, or hide the fact they have not had any antenatal care, or where the woman tells friends or family but not health practitioners, as is suspected for this case. This is different from "denied" pregnancies, where the mother is either unaware of their pregnancies or refuses to accept they are pregnant. Both kinds of pregnancies may come to light late in pregnancy, in labour (as Mother's was), or after birth.

3.2. The procedure and practice guidance for such pregnancies implies, but does not stipulate, that referrals of concealed pregnancies should always prompt a strategy meeting to consider whether S47 inquiries[7] are necessary. Practitioners told this review that strategy meetings could be particularly useful forums for discussions about why the pregnancy might have been concealed or denied and how best and by whom this could be explored. They felt strategy meetings should always be considered for concealed or denied pregnancies and that they should be always held when these have been discovered late in pregnancy or after birth i.e. at or after 36 weeks. This review was told that the partnership intends to review their guidance and procedure on concealed pregnancies, which needs updating with more recent research and case reviews, with more focus on why the parent might have concealed the pregnancy and how to ensure hypotheses are shared and recorded, even if parents deny that the pregnancy was concealed, as Mother did in this case.

[6] https://www.proceduresonline.com/northamptonshire/scb/p_concealed_preg.html and http://www.northamptonshirescb.org.uk/policies/local-protocols

[7] S47of the Children ACT 1989 is the local authority's duty to investigate where there is reasonable cause to believe a child may have suffered or be at risk of significant harm

3.3. Nationally, numbers of concealed and denied pregnancies are very small, the highest estimate being 0.2%.[8] Research regarding concealed and denied pregnancy is sparse, and has some limitations, for example that the sample group tends to be children who have come to significant harm rather than understanding the outcomes for all children who were born of concealed pregnancies. The reasons for concealment and denial of pregnancy are varied. They include fear, stigma and shame due to the circumstances of the conception (e.g., incest, rape, adultery, being young or out of wedlock or view of partner about a further pregnancy). They also include a wish to avoid scrutiny by agencies as seems likely in this case.

3.4. Records show Mother told midwives at the time of Child Bi's birth that social workers had not been involved since 2016. Mother may have said this and concealed her pregnancy to evade scrutiny from practitioners, in particular social workers. As discussed later Mother had consistently wanted social work involvement to cease during the period of the CIN plan. Records also show some evidence, through comments to the police, that she had a fear not uncommon to many service users, irrespective of how likely that it is, that social workers would take her children away. In this case Mother might have been motivated to conceal her pregnancy because she knew that agencies were concerned about her relationship with Putative Father. Also we know now, due to the hair strand test after Child Bi's death, that mother had been misusing drugs for over 12 months, including throughout pregnancy. This may have been why she refused blood tests for herself and the baby when Child Bi appeared "jittery"[9] after birth; this can be a sign of withdrawal from drugs in new-born babies. SW4 told this review that she was suspicious of Mother's refusal to have the blood test when hospital staff suggested one and wondered whether this might be to conceal drug use. Records suggest Mother was aware of the potential implications of Child Bi being "jittery" and denied taking drugs. Her drug use during pregnancy could have been a reason for concealing the pregnancy/not taking up antenatal care. She will have been aware that urine and blood tests are offered during pregnancy and, although midwives told this review that a mother's drug use would not show up in routine tests, she might not have known that.

3.5. There is no evidence that anyone considered in detail the potential reasons for the pregnancy being concealed either individually, or with another practitioner, despite practitioners believing this was a concealed birth. Whilst it is challenging to do this when parents deny the pregnancy is a concealed one, as Mother did, both to a range of individual practitioners and at the Initial Child Protection Conference, it is important to identify hypotheses to assess whether there might be future risk to the child. SW4 told this review that she had included detail of the refusal of the blood test in her report to the ICPC as a risk factor but did not spell out the implications in terms of potential drug use being a reason to conceal the pregnancy. This is hard to do without any evidence of previous drug misuse by Mother.

3.6. In the UK there is no legal requirement that mothers seek ante natal care or assistance to give birth. Unborn children do not have a legal existence separate to that of their mother, whose choices must therefore be respected unless it is believed she does not have the mental capacity to make an informed choice. However, concealed or denied pregnancy can pose very significant potential risks to children during pregnancy and after birth. During the antenatal period the lack of antenatal care means that dietary advice and implications of smoking, drugs misuse and drinking and any medication being taken will not be discussed. Potential problems with the baby's development will not be identified, nor any health concerns about the mother e.g. high blood pressure, which could harm her and the baby. Nor will there have been opportunities for midwives to have conversations

[8]Estimates range from 1 in 500 to 1 in 2,500 in studies cited in the concealed pregnancy partnership guidance http://www.northamptonshirescb.org.uk/policies/local-protocols Op cit

[9] Involuntary jerking movements

about future care of the baby, including safe sleeping advice. In extreme cases a lack of antenatal care or help during labour could lead to the death of either or both baby and mother. In addition, health visitors will not have been able to make an antenatal visit to begin building a rapport with the mother, check preparedness for the baby practically and emotionally and provide advice. Whilst some women who unexpectedly become mothers can quickly adjust to parenthood and bond well with their babies, concealed or denied pregnancies may indicate an immature coping style or tendency to disassociate which can impact of bonding and ability to parent. Concealed or denied pregnancies feature disproportionately in cases of infanticide and other forms of significant harm.[10]

3.7. At the end of June 2021 Mother had denied being pregnant to social worker 2. Between then and Child Bi's birth she was not seen by the health visitor because she had not been engaging and because the health visitor thought the CIN plan had ceased. This was not the case, although there appear to have been no social work visits until after Child Bi was born, for reasons that are not known. It may be relevant that there had been a change of social worker at the very end of August 2021 and the new SW (SW3) had a high caseload and was holding the case pending reallocation to another social worker. This level of contact with Mother limited opportunities for the discovery or disclosure of the pregnancy. However, signs may not have been easy to detect; Mother was being seen regularly by school staff who told SW3 in September 2021 that they had seen no signs of pregnancy.

3.8. During enquiries after Child Bi had been born, Mother denied knowing she was pregnant until about two weeks before the birth, when she booked a private scan which confirmed the pregnancy two days before Child Bi was born. Practitioners were sceptical about her not knowing she was pregnant given that Mother had four older children. For all but one of those pregnancies she had booked in with midwifery services by 12 weeks gestation. Even for Sibling 4, when she said she was not aware of the pregnancy, she had booked in by 20 weeks. In addition, something, perhaps a disclosure from Mother, made someone make the anonymous referral about her being pregnant in June 2021.

3.9. About two weeks before the baby was born the siblings were overheard at school discussing potential names for the new baby. It is unclear whether this was recent news for them, or that they had known previously, but they had been told not to talk about it in front of practitioners. School staff told this review they were uncertain about how to respond, they had thought their relationship with Mother had improved and they were surprised she had not told them this herself. They knew about the previous suspicion and her denial to the social worker that she was pregnant and did not feel able to ask mother about this. However, they have reflected since that school staff were the ones with the best relationship with Mother, and that if there were a similar situation in future they would share with a parent what the children had said and ask whether they needed any support. This might mean mothers would then access antenatal care. The local safeguarding partnership procedure on concealed pregnancies states that agencies should talk to other practitioners involved if suspected concealed or denied and make a referral to the MASH.

3.10. It seems more likely than not that this was a concealed pregnancy. However, even if practitioners had accepted at face value that Mother only knew a couple of weeks before the birth (which they didn't), this also has potential implications for attachment. In this case midwives did note concerning behaviour as initially after birth Mother did not acknowledge the baby or hold Child Bi in hospital. Midwives told his review that Mother had had a difficult birth of a kind that can temporarily impact on an individual's ability to function. Therefore, Mother citing this as an explanation might have been

[10] concealed pregnancy partnership guidance Op cit

partly or wholly true, and evidence was seen later by midwives and the health visitor of Mother appropriately tending to Child Bi.

3.11. Midwives did consider the quality of interaction between Mother and Child Bi and signs of bonding. There is no evidence they used any formal screening tools; however, the context was Mother being uncommunicative in hospital, and they would usually leave discussions about mental health until post-natal home visits, rather than in hospital, unless there were obvious signs of concerns. In line with NICE guidelines[11], the health visitor used two screening tools to assess Mother's mental health after birth, this raised no concerns. These were standard tools used for all new mothers. Had there been any concerns about her mental health in general, or about bonding, practitioners told this review they would have moved on to using more specialist screening tools or, if necessary, making a referral for a mental health assessment.

3.12. Records show Mother declined to give midwives Putative Father's name, and stated that she did not have a proper relationship with him, and he was in prison. She told health visitors the relationship with Child Bi's Putative Father was short lived and over. The first evidence of discussion about whether he knew about the pregnancy or any implications if he got back into contact, as ex-partners often do, was at the ICPC where Mother stated she did not want him to know as she was fearful of repercussions. The recent "Myth of Invisible men" report published as part of a suite of national reports into non accidental deaths of babies under 12 months old[12] found that men are too frequently overlooked and are poorly engaged by universal services, such as midwives or health visitors which is then replicated by targeted and specialist services. In this case, given Mother's history of involvement with risky males who have a history of domestic abuse there should have been more reflection by all agencies on who the Putative Father was and whether this could be relevant to the reasons for the concealed pregnancy, and any implications for Child Bi. The CIN Plan following ICPC then focuses on risk assessment of Putative Father and the impact on the family, rather than mother's repeat involvement with risky partners.

3.13. Child Bi was born on a Sunday. Due to the concealed pregnancy, and some concerns about Mother's lack of interaction with the baby midwifery services submitted a MASH referral to the out of hours service as promptly as was possible given the difficult delivery had prevented midwives to discussing the circumstances of the pregnancy with Mother immediately after birth. After reviewing the case the next day, the named midwife contacted the MASH to enquire about the response to the referral and shared it with the GP and the health visitor. The team manager of the allocated social worker received the referral by 10.30 on the Monday, however the strategy meeting was not held until the following day. It is not clear whether this was due to delays by the social worker completing the request form or availability of the police.[13] By the time of the strategy meeting Mother and Child Bi had been discharged; Mother was not engaging with the midwives in hospital declined some recommended health checks. There was no medical reason to delay Child Bi's discharge, and a conversation between a midwife and the MASH team manager established that there was no known other reasons to prevent discharge. Nonetheless it would have been better practice to have held the strategy meeting before discharge, to ensure that all information by agencies about risks and protective factors could have been assessed, and plans confirmed in advance for monitoring, support

[11] NICE guidelines are evidence-based recommendations for health and care in England. They set out the care and services suitable for most people with a specific condition or need, and people in particular circumstances or settings.
[12] Child Safeguarding Practice Review Panel (Sept 2021) The myth of invisible men; safeguarding children under 1 from non-accidental injury caused by male carers **and** Walters A et al (2021) Fieldwork report: National Review of Non-Accidental Injury in under 1s **both** Child Safeguarding Practice Review Panel
[13] This review was told that, From Feb 2023, the police will reserve the 9am slot specifically for urgent cases. Any other urgent cases come in the that need a same day response can be discussed with the open cases team and if there is insufficient capacity, they will ask colleagues in the police Child Protection Unit to assist.

and assessment. When the strategy meeting was convened the following day, the attendance was in line with best practice.[14]

3.14. Pre-birth assessments late in pregnancy, or assessments after birth, are particularly challenging for social workers because of the tight timescales. Those for concealed or denied pregnancies are likely to be particularly sensitive. These challenges in this case were amplified by a change in social worker part way through the S47 enquiries. Managers told this review that they would always seek to avoid this; the circumstance in this case were that SW2 had moved teams within the service and SW3 was allocated in the interim period awaiting the arrival of SW4. Whilst SW3 had contacted the school and health visitor in September 2021 to ascertain whether there were any concerns about the children (there weren't) and got actively engaged in the S47 enquiries the level of her caseload meant it was necessary to transfer involvement as soon as the newly recruited SW4 had capacity to take the case.

3.15. There is evidence that some practitioners kept a possible pregnancy in mind, which is good practice. One of the social workers told this review that her key learning was to reflect on what Mothers who had concealed pregnancies might not want practitioners to find out, for example via antenatal care. This is a useful tip for reflection for all practitioners who suspect someone might be pregnant but not disclosing it, as well as for those who have concealed pregnancies.

Learning points; concealed pregnancy

- Denied or concealed pregnancies are very rare, the highest estimate nationally is 0.2%
- Both mother and baby can be at serious risk if they do not receive antenatal care
- The reasons for concealment and denial of pregnancy are varied. They include fear, stigma and shame due to the circumstances of the conception (e.g. incest, rape, adultery, being young or out of wedlock or view of partner about a further pregnancy). They also include a wish to avoid scrutiny by agencies.
- Practitioners identifying the reasons for concealed pregnancies is more difficult when Mothers deny that the pregnancy was concealed. Nonetheless it is important that practitioners develop and share hypotheses and draw conclusions about the potential reasons during assessments and at ICPCs
- When pupils who are on a CIN plan disclose at school that their mother is pregnant staff should make further enquiries with the mother about this and consider contacting other agencies

See Recommendation A

Safe sleeping.

3.16. The Lullaby Trust charity cites unsafe sleeping environments (unsafe sleeping position, loose/soft bedding or beds and overheating) as being one of the maternal/infant care factors most associated with Sudden Unexpected Death of Infants (SUDI).[15] The others are: smoking; co-sleeping on a sofa or in a bed after drinking alcohol and/or taking drugs, and poor antenatal care and use of alcohol or drugs during pregnancy. The presence of more than one of these circumstances increases the risk. Provision of advice verbally and in written form (often a leaflet) at key points during antenatal and postnatal care is expected practice nationally.

3.17. Midwives had conversations with Mother in hospital about safe sleeping. No practitioner was able to visit antenatally and the visits made postnatally by health practitioners were to Maternal

[14] Attendees included police, social worker, midwife, and representatives from 0-19 community health service and education.
[15] https://www.lullabytrust.org.uk/research/evidence-base/

Grandmother's address where mother was staying with the other children for support after the baby's birth**.** The health visitor visited Child Bi there twice. As is standard practice she viewed the sleeping arrangements and informed mother about the dangers of co-sleeping after use of alcohol or drugs, despite her denying use of either. Health practitioners told this review that they would continue to do this at every visit, explaining that it is important for parents to know in case they change their minds, (or lie about their use of drugs, as in Mother's case). Advice about smoking was given, Mother told the health visitor in detail about the appropriate precautions she said she took to reduce smoke exposure for the children.[16] SW3 also had conversations with Mother about safe sleeping and SW4 told this review she visited the family home a few days before Child Bi died the children were allowed to show her the bedrooms and Child Bi's Moses basket in Mother's bedroom.

3.18. A recent report[17] by the national Child Safeguarding Practice Review Panel involving a sample of 40 cases of SUDI found that safe sleeping advice had been given to all the parents in their sample at least once, as in this case, but that research and evidence from Serious Case Reviews suggested that parents do not find these interactions meaningful and had often understood the goal to be to follow the advice most of the time, rather than always. A local public health campaign to promote safe sleeping has included campaigns on Facebook at Christmas/New year 2020-21, and 2021/22 and the summer of 2021, with messages aimed at parents/carers. Training on safer sleeping has been offered to all practitioners and the series of partnership two page "tea break" guides has a useful one on safe sleeping, which covers the key messages and how to overcome some of the challenges in delivering them effectively. The guide reminds practitioners that shock messages (or threats of prosecution if something goes wrong) are not successful, and that if parents' reluctance to disclose co-sleeping for fear of criticism cannot be overcome, it is not possible to provide advice that could mitigate the potential harm. In this case it would have been useful for a home visit to be made to the Mother's home address to check the sleeping, which might have given a further opportunity for practitioners to talk though any barriers which might prevent Mother following the safe sleep advice all of the time

3.19.

Learning points; Safe sleeping.

- Research suggests parents often do not find safe sleeping advice to be meaningful and had often understood the goal to be to follow the advice most of the time, rather than always
- Shock messages (or threats of prosecution if something goes wrong) are not successful. If parents' reluctance to disclose co-sleeping for fear of criticism cannot be overcome, it is not possible to provide advice that could mitigate the potential harm
- Practitioners should always child's main home to check the sleeping arrangements, which would also provide opportunities to talk though any barriers which might prevent parents following the safe sleep advice all of the time.

Working together to safeguard the children and decision making about level of intervention; Child Protection or Child in Need, including consideration of history

[16] She stated she was smoking outside the family home, wash her face and hands after smoking and not to handle baby for 20-30 minutes and to wearing a specific coat for smoking which needs to be taken off when returning into the home

[17] Sidebotham P et al 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 Child Safeguarding Review Panel

3.20. There are several examples of insufficiently robust or delayed responses and insufficient or ineffective management oversight by in this case. Sibling 4 being found alone in October 2020 was not recorded as a crime of neglect despite Mother telling police officers that she had left the child alone,[18] and the social worker made a phone call, rather than a home visit that day, as they should have done. There is evidence of a discussion of this incident at supervision a few days later but, rather than convening a strategy meeting immediately, as would have been warranted by the seriousness of the incident and Mother's lack of insight into it, the decision was to review whether the case needed escalation at the next CIN meeting, including considering Mother's non engagement. It is unclear whether the incident was discussed at the CIN meeting almost two weeks later. However, as school attendance had improved, and practitioners had no other concerns the decision was to cease the CIN plan at the next CIN meeting. Mother was present and clear that she did not want further social work involvement so there should have been discussion with a team manager about whether there was justification for a strategy meeting or whether involvement should cease at that point or been escalated to a strategy meeting.

3.21. Between Christmas 2020 and New Year police officers attended the house in response to a report of a male kicking the door. The house was reported to be "unkempt" and smell of drugs. No social work visit was made for over a week. One reason for this, and the previous delay in visiting, could be the lack of a system at the time to ensure team managers were aware of PPNs (Public Protection Notifications) on open cases**.** This is being addressed because of this review. Practitioners also told this review that, although the situation had improved recently, PPNs were not always being shared in a timely way. In June 2021, despite the team manager asking for a visit within 24 hours in response to the anonymous referral from the NSPCC that alleged Mother was shoplifting with the children, misusing drugs and being pregnant, no visit by a social worker was made until nearly a week later. There is also at least one occasion where delays in a social worker in response to an incident are due to Mother not being co-operative. For example, cancelling two appointments in February 2021 after Mother had reported a threat from Putative Father, due to staying with Maternal Grandmother. There is no evidence of any consideration of whether making a visit to her there was appropriate. There was some discussion about these cancellations in supervision soon afterwards. Records indicate that a consideration was that at the last ICPC the threshold for a child protection plan was not considered to be met. This does not mean that this would still be the case, and if there were insufficient grounds for a Child Protection conference, social work involvement should have ceased as Mother had been clear in a phone call that she did not want social work involvement.

3.22. Arguably the seriousness of Sibling 4 being left alone should have prompted a strategy meeting in early October 2020. In mid-November 2020 SW1 told agencies that a strategy meeting would be convened because of recent incidents of risky people being found in Mother's home. This did not happen until two weeks later, instead of immediately as it should have done. Although the reason is unknown for this case, at the time there were difficulties with police availability to attend strategy meetings. Practitioners told this review that a specific team of police officers has been created to attend strategy meetings to overcome delays holding these on open cases. This review was told that waits on open cases due to police availability have reduced to a couple of days and that there is capacity to respond to urgent requests for a strategy meeting. Although the subsequent ICPC was held within 15 working days of the strategy meeting, as it should have been, the cumulative effect of the delays was a loss of momentum because the first CIN meeting after the ICPC was not held until January 2021.This could have given Mother the impression that the concerns were not that serious. The second ICPC was not held within 15 working days of the strategy meeting as it should have been[19], for reasons that are not known.

[18] The importance of this has been included in safeguarding training for police
[19] http://northamptonshirescb.proceduresonline.com/p_ch_protection_enq.html

3.23. There were three incidents that mirror the learning from another recent local case review about the need for more work about when to share and how to respond to information about involvement in criminal activity by parents/adults linked to households which could post risks to children. The first example is when no PPN was raised in November 2020 when the police had information that mother, ex-partner/Putative Father and another male were taking drugs at the home address. The second example is no PPN being raised in July 2021 when the police received intelligence that Mother was dealing drugs, because the children were not linked to the incident. In the third example, when officer found a partially dressed Putative Father at the home in November 2020, police did submit a PPN but this did not include the risks posed by the wanted male that they were searching for. In addition, when police officers attended incidents they were not consistently adding children names to reports nor recording who has parental responsibility. This review was told that the police have done a lot of internal awareness raising via their vulnerability strategy and have been pleased to see a consequent 50% increase in PPNs between 2019/20 and those submitted in 2022.[20] In addition because of this review, PPN training is being rolled out to all new police officers and sergeants.

3.24. The outcome of each ICPC in this case was for the children not to be made subject to a child protection plan but to continue to be subject to CIN plans, although neither ICPC was unanimous. Both chairs of the ICPCs contributed to this review. They explained to this review that the chair will make the final decision where practitioners are not unanimous, they will usually go with a majority but, especially where views are finally balanced, they will give more weight to the views of the practitioners who know the family best. Accordingly, they seek to understand the perspectives of each practitioner and identify the level of significant harm and any unassessed risks for the children. Thresholds and criteria for a child protection plan are the last thing discussed at conferences, after information by agencies is shared and a plan has been developed based on the risks and protective factors. Both chairs' assessment of the information available at the time was that there was not enough evidence of potential or actual significant harm presented to each ICPC to place the children on a child protection plan.

3.25. Local data for 2020-21 shows that 80% of ICPCs resulted in a child protection plan. Current data during 2022-23 shows the figure has reduced to 77%. A detailed breakdown of the reasons for these outcomes, including the proportion which result in Child in Need plans or no plan is not available. Conference chairs told this review that there are several reasons why children discussed at ICPC are not made subject to a child protection plan. Sometimes this will be because their circumstances have changed e.g. they have come into care. Sometimes more information which has increased the children's safety has become available since the request for an ICPC, including other family members stepping in to provide support. Nationally it would be normal for a small proportion of ICPCs to not result in a child protection plan. However, the chairs also told this review that they are seeing cases like this one that do not meet threshold, including where there were potential risk factors but no evidence of actual or potential significant harm. Perhaps some of these could have been managed in a different way rather than being brought to ICPC, which is stressful for parents and can adversely affect relationships between families and practitioners, as well as being resource intensive for all agencies. Practitioners agreed that work needs to be done to better understand the numbers and reasons for ICPC outcomes that do not result in a child protection plan. Work by managers from the Duty And Assessment Teams and the Safeguarding and Quality Assurance service (SQAS) is ongoing to reflect together on which cases come to child protection conferences, including promoting the use of duty Child Protection Chair to provide consultation and thinking space for referring SW's and their managers.

[20] 2019-20 16322 PPNs, during 2022, 25227 PPNs

3.26. Child Bi being made subject to a child protection plan in 2021 would not have prevented his death as it was so soon after the ICPC. The siblings being made subject to a child protection plan in 2020 should have improved their care and would likely have been still in place when Mother was pregnant with Child Bi. The pregnancy would have been more likely to have been discovered by practitioners although Mother may still have tried to hide it. Whether or not it would have prevented his death is not possible to say, however for the benefit of other children in future similar circumstances it is still important to consider gaps in information and reflection at the ICPCs that might have influenced the type of plan.

3.27. There were some gaps in information for both ICPCs. The information provided did not include a chronology which might have provided a better understanding of the history of the family, including the repetitive nature of concerns, as well as focusing more attention on the children as a sibling group as well as individually, and on the potential cumulative impact of concerns and incidents. In addition, ppolice reports for Child Protection conferences only include incidents which have occurred since the previous review; this approach does not give the whole background. The GP provided reports for both conferences, for the second there was no new information to provide about the children, and Mother had not been to the surgery for herself since 2019.

3.28. At the first ICPC in 2020 there was insufficient information to identify what level of risk Putative Father might pose. This was due to his name not being on the ICPC invite as he was not a member of the household. Had the social worker or chair specifically contacted the police to ask for information to be brought to conference about him, or the attending police safeguarding officer (SGO1) noted a link to the household in advance in police records and enquired if this was correct, SGO1 would have shared information that he posed significant potential risk given his history of violent offences including domestic abuse, drug use and dealing. On this occasion SGO1 incorrectly believed they could not disclose information without the name being on the invitation and advised that a Clare's law[21] application should be made by Mother. A recommendation of the ICPC was that a risk assessment should be conducted regarding Putative Father, and that a ICPC should be reconvened if the risks warranted it. This does not appear to have been done, for reasons that are not known. The police officer who attended the house looking for the wanted male was not involved in this ICPC. Therefore, SGO1 was not well placed to remind attendees at the ICPC that although home conditions might have improved at the time of the ICPC, they had been concerning in November 2020 with walls having stains and holes, the floor being cluttered, rubbish in kitchen, and food left out. Also, although SGO1 shared the concerns about the aggressive behaviour and abusive language of Mother and Putative Father towards police officers and that the children were frightened, they were not well placed to give the more evocative kind of account a transcript of the police body camera of the visit would have provided or challenge Mother's minimisation of this incident. Some practitioners advocated sharing body camera footage of such incidents at ICPC. Others had practical concerns about how feasible this was. In addition, whilst it is very important to have information which clearly conveys the impact of any incident on the children, at the same time it is important to do this in a way that would not re-traumatise any children present or create an imbalance. In a seminal article[22] considering common errors of reasoning in child protect work, Eileen Munro describes how memory is biased towards more vivid tangible things, especially if they arouse emotion or are encountered first, or most recently. One way of capturing and sharing the information on police body cams could be to ensure the social worker providing a report to the ICPC has an opportunity to see it and includes a summary, including the impact on the children, in their report to child protection conferences.

[21] Clare's Law, or the Domestic Violence Disclosure Scheme (DVDS), means that anyone can ask the police about a partner. Also, a member of the public can ask about the partner of a close friend or family member. If the police decide to share the information it will usually be with the person at risk.

[22] Munro, E (1999) Common errors of reasoning in child protection work. Child Abuse and Neglect, 23(8) August: pp745–758

3.29. The police have identified that the role of the police safeguarding officer (SGO) was affected by some organisational issues. Firstly, the team had had frequent changes of line manager, who each had other responsibilities. Lack of administrative capacity within the team meant the SGOs had to help in managing conference invitations. Despite the team having insufficient capacity to manage the core elements of the SGO role, there was additional pressure from an expectation that they should provide investigation assistance to detectives in the Child Abuse Investigation Unit. In addition, preparation, and training for the SGO role was insufficient. SGO2 who attended the second ICPC had only commenced the role a few months previously. SGO2 had had limited training on safeguarding, which did not include lack of engagement/disguised compliance. Preparation for the role had centred on shadowing a peer, which is valuable, but should be backed up by formal safeguarding training to enable new recruits to ask better questions and challenge. SGO2 also had some Signs of Safety input from her manager, but SGO2 found it difficult to weigh up the positives against the concerns and did not fully understand the scoring. In practice SGO2 felt it did not seem to match up with each practitioner's expressed views. The conference chairs told this review that that element of the conference can be difficult to manage when participants explain their scores by repeating their concerns about risk and vulnerabilities without these being balanced by any protective factors in the case. SGO1 was an experienced and long serving SGO, but the incorrect belief about sharing information about partners suggests that training about information sharing needs improvement. This review was told that these issues are being addressed by a review of the police role in the Multi-Agency Safeguarding Hub.

3.30. The social work assessment prepared for the ICPC in 2021 contained limited information with little analysis and no clear recommendation for either a CIN or CP plan. It may be a relevant context that during the resultant S47 enquiry there was a change of social worker to SW4. Timescales for ICPC are already tight and SW4 will have been under significant pressure of time to understand the case and produce a report for ICPC**.** SW4 told this review she benefitted from some conversations with SW3 and undertook a joint visit during the S47 enquiry. She also read the file but at the time she had not realised the seriousness of the domestic abuse suffered by Mother in terms of severity and number of partners. Minutes of the ICPC show some information about the history of both Mother and Putative Father and a recognition that there was a pattern of historical concerns. However, they do not consider her level of insight into the concerns about choice of partners or possible reasons for concealing the pregnancy (which Mother denied), or her failure to engage previously and her recently expressed view that she did not want any support, nor therefore the potential impact of these on risk to the children.

3.31. Records show midwives had thought a child protection plan was a likely outcome of their referral. Midwives declined the ICPC invitation having discharged Mother and baby from their care and handed over to the health visitor. They did not supply a report, which would have been good practice. Therefore, there was no direct input to the ICPC from the midwives. The health visitor had had more recent contact with the family and she had positive observations about the care of Child Bi. The health visitor believed Mother's care of the children was satisfactory when she had no partner, and she had no safeguarding concerns about Sibling 4 or Child Bi and had observed good interaction by Mother with Child Bi who was gaining weight satisfactorily. The school had noted a very significant improvement in the children's attendance during the autumn term from the low level of 58% in the spring term. They also noted an improvement in their presentation. Although they were still often late, more regular and more punctual attendance had improved their attitude to learning, they appeared to enjoy school more, they had friends and they appeared more confident. Mother was supporting them better by ensuring they had the correct uniform and equipment (e.g. PE kit) and noticing their achievements.

3.32. The historical lack of engagement was not highlighted as a risk factor at either ICPC. This alone would not be enough to warrant a child protection plan (or a further ICPC as recommended in 2020) unless the children were already considered to be at risk of significant harm, which would be amplified by a parent's lack of co-operation with a plan. Neither ICPC had information which suggested the children were at risk of significant harm. On both occasions Mother assured participants that she would co-operate with a CIN plan and, at the time of the 2021 ICPC, Mother was engaging well with both the health visitor and the school.

3.33. The reliance at ICPC on information sharing between midwives and health visitors is not as effective as a direct contribution especially as there was no system to ensure that midwifery information and assessments was consistently effectively transferred to health visiting services. Midwives share copies of MASH referrals as in this case, and discharge summaries. However, discharge summaries do not always contain full details of all relevant interactions between the midwives and parents and the discharge summaries may not contain full details about concerns that have been resolved by the time the mother and child has been discharged from the service. Midwives also add comments to the personal child health record ("red book") for the health visitor to see. However, these records are held by the parent so the effectiveness of this way of communicating depends on the parent keeping the record safe and sharing it. During 2022 a new communication tool for 0-19 health services[23] to highlight circumstances during pregnancy the perinatal period where information should be shared is being implemented. This includes specific expectations of what information midwives should share with health visitors when according to the level of concern about the mother/baby and how the health visitor should respond.

3.34. The Covid pandemic necessitated Child Protection conferences being held virtually, via video technology, with anyone who could not access this dialling in by phone. This system had been established for some months before the ICPC in December 2020, so the chairs were very experienced in having conferences this way and practitioners were familiar with it, unless they were new to their roles. Some practitioners from a range of agencies felt that ICPCs not being held in person have impacted on their effectiveness. Whilst virtual meetings might have advantages in terms of enabling attendance without travelling, they described difficulties from the use of telephone/video technology for practitioners and parents. These include technological difficulties and challenges developing a rapport with parents and *"get a feel for people"* through observing body language especially, but not only, for those who were had not met parents before. They also felt it was hard to "*jump in to ask questions".* In addition, it is not possible to tell who else might be present with the parent. Mother joined the ICPCs by telephone. Some practitioners described her as not feeling comfortable in a virtual setting but observed that both Chairs were able to make her feel more at ease and join in the discussion.

3.35. A survey and follow-up interviews with more than 500 practitioners and parents published by Nuffield Family Justice in December 2020,[24] showed a disconnect between the experiences of practitioners involved (social workers, police, teachers, GPs and other health practitioners) and those of parents and families. While nearly half of professionals thought remote Child Protection conferences were better, all the parents interviewed said they would have preferred a face-to-face meeting if one had been possible. Most of the parents surveyed said they had joined by phone even when practitioners joined by video. Three quarters of parents thought that the way the conference had been conducted had adversely affected their ability to contribute. Just over half felt that they had been able to express their views and comment on what was being said even if it was difficult to do so. However, the rest believed they had been denied that opportunity or were not able to comment. Since September 2022

[23] Maternity / 0-19/ FNP / Tiny Steps/ Perinatal Mental Health Service Information Sharing
[24] https://www.nuffieldfjo.org.uk/news/concerns-parents-families-virtual-child-protection-conferences

ICPCs in Northamptonshire have returned to being face to face, currently[25] Review Child Protection conferences remain virtual, unless a parent, practitioner or the chair requests that they be face to face. Whilst this is positive, it could be hard for parents to request face to face meetings if they believe, rightly or wrongly, that practitioners would rather they were held virtually.

3.36. An ongoing risk factor in this case were the risky males that Mother had relationships with; she had repeatedly been a victim of serious incidents of domestic abuse. For all victims the usual service is the Freedom programme.[26] Locally delivery was affected by Covid, although, given a combination of Mother's lack of insight into her vulnerability, it is doubtful she would have taken this up even had it been available. Her partners were men with a significant history of criminal behaviour, including offences involving drugs and weapons. These men had also had previous relationships where they were the perpetrators of domestic abuse. Practitioners told this review that they were aware of several local men who were serial perpetrators of domestic abuse who had moved from relationship to relationship affecting the lives of a lot of children. They identified two areas where they thought services could work more effectively together to support these families. One was having more detail from the police of the nature and seriousness of the previous domestic violence with previous partners so they could better assess risk to the children. The other was a multi-agency approach which identified and monitored serial perpetrators so that intervention could be offered at an earlier stage of relationships.

3.37. The police told this review that since the time that Child Bi died Northamptonshire Police have developed a system managed by their Domestic Abuse Investigation Unit (DAIU) in liaison with Neighbourhood Police Teams (NPT) to identify and track and monitor the top 10 domestic abuse perpetrators in the county by recentness, frequency and gravity of offences. One gap in the use of these criteria is that people in prison, including for domestic abuse offences, would not appear after release until they had re-offended. Awareness of their release is dependant on notification from probation and/or intelligence from local neighbourhood policing teams. Oversight by the DAIU and the NPT means the top 10 offenders are aware that their behaviour is under scrutiny and ensures prompt involvement of the DAIU should they reoffend. However the expectations are not clear about who might intervene in what way in terms of communicating with the new partner or other agencies if the DAIU/NPT received intelligence about a new relationship. Northamptonshire Police Crime and Fire commissioner has also funded a project Preventing Intimate Partner Abuse (PIPA)[27] to deliver weekly groups work sessions as an out of court disposal for low or medium risk perpetrators of domestic abuse who have admitted the offence and accepted a conditional caution.

3.38. On the occasions that Mother did ask for help with protection from domestic abuse from Ex partner between January 2021 and the summer of 2021 when he came out of prison, this does not seem to have been effectively provided. The only evidence of contact with either the housing office or probation was an email from SW2 in April 2022 asking for information about whether the family are to be moved/when he was due for release. For reasons that are not known there is no evidence that this was followed up in any way even despite SW's suspicions that fear of him might be why Mother was staying with MGM in June 2021. The police told this review that on occasion they had advocated with housing to support vulnerable women get re-housed but that in this case there was a restraining order in place and they would have need to see that not being sufficient protection first. It does not seem to have been effective given the reports of him banging on the door in June 2021. However, this was the occasion when the police were unable to attend sufficiently promptly to catch him and subsequently Mother did not engage.

[25] This review was told this is being kept under review
[26] *http://www.freedomprogramme.co.uk/*
[27] https://risemutual.org/domestic-abuse-awareness/

3.39. There is no evidence of Mother, Putative Father or Ex-partner being discussed at a Multi-Agency Risk Assessment Conference (MARAC)[28] during the period under review. There are three main criteria for referral to MARAC[29]; Visible High Risk, for example as evidenced by a DASH tool assessment (Domestic Abuse, Stalking, Harassment and Honour Based Violence Assessment); Potential Escalation (the number of callouts to the victim as a result of domestic abuse in the past 12 months) and Professional Judgement (if a professional has serious concerns about a victim's situation). It is relatively unusual to refer a victim if they do not want to be referred, practitioners should assess whether it is proportionate and appropriate to share information, depending on the level of risk which the victim is facing. There is no evidence in social work records of any consideration of referral to MARAC nor of any discussion about this with Mother. Police told this review that they would not have referred Mother regarding Ex-partner without evidence of the restraining order not being effective. It may be relevant that despite the level of concern about Putative Father's history of violence, including domestic abuse, there were no actual reports of domestic abuse against Mother.

3.40. Records show limited and conflicting information about the role of Maternal Grandmother, rather than a robust analysis of risk and protective factors. GP records note Mother spent much of her time at Maternal Grandmother's home as a protective factor. Social work records also use the phrase "protective factor" without also weighing up the risks and with no detail of what that meant other than that she had offered support and temporary accommodation when Mother needed to be rehoused to get away from a previous partner. She was also Mother's birthing partner for the birth of Child Bi, and Mother and children stayed with her for a few days after Mother and Child Bi's discharge from hospital. However, midwifery records show she vociferously supported Mother in her refusal of some of the tests and treatment offered and shared Mother's view that a referral to the MASH was unnecessary. Social work records also show she allowed a relative who was a risky adult to visit while Mother and children were living with her, neither she nor Mother recognised social workers concerns about this.

Learning points; Working together to safeguard the children and decision making about level of intervention; Child Protection or Child in Need, including consideration of history

- When sharing information about the child's voice and/or lived experience, the importance of using detailed descriptive language about what children say, how they present and the circumstances in which they are living, including adult behaviour.
- The importance of management oversight when the police share Public Protection Notices with social workers
- The importance of timely strategy meetings to maintain momentum of enquiries and action
- The importance of requesting and sharing information about a parent's partner, even if they are not part of the family household.
- The importance of Child Protection conferences having information about all offences and incidents reported to the police, not just those since the last case conference.

[28] A MARAC meeting is one where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.
[29] MARAC – NADASA

- Midwives should attend ICPC held shortly after children have been born, especially if they made the referral, and even if their involvement has ceased.
- The importance of all practitioners understanding Signs of Safety scoring at Child Protection conferences
- The importance of keeping under review holding some Child Protection conferences virtually and ability of both parents and practitioner to participate effectively
- Police have recently put in place arrangements to identify and manage serial perpetrators of domestic violence; these need reviewing for effectiveness
- The risk that an extended family member who is supportive in a crisis becomes to be seen as a "protective factor" without considering whether there are any risks

See Recommendations B, C & D

Managing parental non engagement and hostility

3.41. It is well known that parents tend to engage better with universal services, partly because they are offered to everyone and partly because they tend to see them as less threatening than involvement by social workers. Notes of CIN meetings show Mother engaged intermittently with health visitor1 prior to Child Bi's birth. Co-operation with health visitor 2 in the run up to the ICPC after Child Bi's birth was better; Mother contacted the health visitor to enquire when she was visiting and to share a new phone number and she received three out of the four visits which had been offered to provide additional monitoring. This could have been genuine engagement (Mother told school staff and stated at the ICPC that she had a good relationship with HV2) or "disguised compliance". Disguised compliance[30] was a term first used by researchers in 1993. This involves parents appearing to co-operate with professionals to allay concerns and stop professional engagement, in this case to reduce the chance of a child protection plan. School staff felt their relationship with Mother had improved during 2021 and attributed their presence at ICPCs as helping her to engage at these meetings. SW4 told this review that she felt Mother tried to use her relationships with the school and health visitor as a reason why she did not need a social worker.

3.42. From their point of view, parents who have previously had difficult experiences of receiving services from children's social care have good reason to feel suspicious and/or anxious and be reluctant to engage with social workers. Mother had been subject to a child protection plan herself as a child and told practitioners she did not trust social workers. Mother told midwives she had "looked online" and believed people were trying to get enough evidence to show she was neglecting her children. She also held the mistaken belief that social workers get a financial bonus if they take children into care. Much of police officers contact was in response to concerns about who was in the household, and police officers thought the occasion when the service had not been able to respond promptly to her reporting an ex-partner in breach of a restraining order banging on the door in May 2021 might not have helped.

3.43. Convening an ICPC reflects the social worker's perception of the potential for significant harm, including having considered information from other agencies, and the potential need for a child protection plan. An ICPC was appropriate on both occasions in this case because of the seriousness of the incidents which prompted the S47 enquiries, plus the lack of engagement with a CIN plan. However, practitioners described how an outcome of a CIN plan can adversely affect a social

[30] Reder, P et al (1993) Beyond blame: child abuse tragedies revisited. London: Routledge.

worker's relationship with parents, who typically feel vindicated that the conference was unnecessary and blame the social worker for convening one.

3.44. Between September 2020 and June 2021 there were seven CIN meetings at intervals of every 6 – 8 weeks. All were held virtually due to the covid pandemic. Mother only attended three of these in September and October 2020 and January 2021. She usually gave a reason for not attending. These included difficulties with the technology or not having been reminded, although there is evidence of social workers sending text and whats app messages for at least some meetings. At the 2020 meeting she was clearly stating that she did not want involvement from social workers and that she was able to look after the children. Leaving aside the lack of insight and challenge (there is no evidence of discussion about the recent incident of Sibling 4 being left alone) this should have prompted consideration by the social worker as to whether involvement should cease, or a strategy discussion be convened. There is no evidence that ether was considered until further incidents a few weeks later prompted a strategy meeting. For the January 2021 meeting it may be relevant that this was after an ICPC and at a time she wanted support regarding the release of ex-partner from prison. However, records still show engagement in that meeting was not wholehearted. For example, she did not want support from the health visitor or immunisations (which is a parent's choice) or to take up vulnerable child places at school and she was reluctant to use Clare's law as had mistakenly been suggested by police at the ICPC. An action was included about repeating elements of the "Freedom Programme", but without further detail about which elements, who was going to support her to achieve this, and within what timescales. All of the actions in the CIN plan, required Mother's consent. She had specifically asked for support to move house because of the release of Ex-partner 2 from prison, who knew her address and to escape from whom she had previously moved house, and actions were included regarding this.

3.45. Practitioners told this review that the level of non-attendance in CIN meetings by Mother was unusual for parents in their experience. As the CIN meetings were not attended by Mother they should not have gone ahead in that format, they should have been held as professionals' meetings, and the lack of attendance should have been considered as lack of engagement.

3.46. There is evidence that the family were discussed in social work supervision several times. Records for January-March 2021 show that, if there were "additional concerns", the social worker should consult with her manager and consider convening another ICPC. There is no evidence then, or in other supervision records, that discussions recognised that, without (new) concerns of potential significant harm, the level of non-engagement meant that social work involvement should cease, certainly on the several occasions when Mother was stating clearly that she did not want social work involvement. Without a parent's consent there is no legal basis to continue a CIN plan

3.47. Social work records show examples of social workers being asked to enquire (again) whether mother wanted social work involvement when there was already clear evidence that she had stated she did not want this, or suggestions of "further assessment" which was not completed. For example, in Mid-April 2021 social work involvement was transferred to the Innovate team. There was no transfer summary or handover, and the case should not have been accepted as Mother had withdrawn consent. Management oversight by the new team manager did not recognise this. The case was allocated to SW2 for visits and assessments without specifying details or timescales. In May 2021 lack of engagement was discussed in supervision. The conclusion was that it was "not safe" to close the case without a further assessment of risk and protective factors, and further discussions with Mother about whether she wanted to engage. At the end of July 2021, because the team manager was off sick, the case was reviewed by the Innovate Head of Service (HOS), who acknowledged that the case had been open for 12 months with no progress and mother not engaging. The HOS recommended that SW2 visit and conduct an assessment within 6 weeks to understand the impact

of cumulative harm to inform next steps (options for which were not specified). Expectations by the team managers or the HOS as to how the assessments requested would be conducted were not specified.

3.48. Any further assessment in May 2021 should have been by way of S47 enquiry as Mother had not co-operated since the ICPC six months previously. There is no evidence of an assessment because of these three requests by managers, including no consideration of use of the Signs of Safety[31] harm analysis matrix, use of the local neglect toolkit or of compiling a multi-agency chronology. Any or all of these would have given insight into what the risks were and the nature and level of the impact on the children. There is also no evidence of any contact with the family or other practitioners to enquire about the children.

3.49. It may be relevant that caseloads were high for all three social workers holding the case in the Innovate team[32] (SW2, 3 and 4) whose operation was also in its infancy having been developed in response to workload pressures in the Duty and Assessment Teams . This review was told that since that time management oversight and support has been strengthened by the additional of an operational manager to manage the team managers. This review was told that current feedback about the teams is positive with evidence of good outcomes for children.

3.50. Practitioners told this review that consideration had been given to using the neglect toolkit with Mother during 2020. However, because of a combination of the Covid pandemic restrictions and lack of engagement by Mother, the Family Support Worker from the school was unable to access the home. In addition, it is quite possible that Mother would have been reluctant to engage as she had told the FSW that she was suspicious that practitioners were trying to gather evidence that she was neglecting her children. Views from practitioners involved in this review about the usefulness of the neglect toolkit varied, partly due to their role, for example midwives find it difficult to use given the short duration of their involvement as they would have to extrapolate from care of the siblings with whom they had no role. Even some of those practitioners who thought it was useful only rated its effectiveness as six out of ten because they found it difficult to use for reasons which included not having had any training in its use, feeling the format wasn't very user friendly or finding it very time-consuming to use. Nonetheless they felt that when it was used correctly it was very useful. This review was told that multi-agency training on the Graded Care Profile 2 neglect assessment tool is being rolled-out to all partners in January 2023

3.51. There was evidence that understanding, and use of the Signs of Safety approach was well developed across agencies and used with enthusiasm by the staff in the MASH. Police officers described how helpful it was when visiting families. Health practitioners told this review that use of Signs of Safety was embedded in supervision. Practitioners also described the approach as being consistently used at Child Protection conferences and being a useful framework in that forum. However, there was no evidence that anyone had used Signs of Safety with Mother. Practitioners felt this was likely due to difficulties engaging her. This is unfortunate as one of its key benefits is its strengths-based approach, which parents usually do respond well to. When parents aren't familiar with Signs of Safety this can have a knock-on effect to their experience of ICPCs. However, the chairs told this review that in their experience parents usually found it easy to understand the "what is working well, what needs to be better" questions. Also, that those parents that understood the concerns, and were prepared to co-operate with the plan, felt able to participate in the scoring discussion. Where this

[31] Signs of safety is a system of working which engages child and parents alongside practitioners to plan and deliver intervention after analysis about "What do you think is going well?" "What are you/we worried about?" "What needs to change?"

[32] Average 24.5 to 31.2

was not the case, or where parents felt a decision they didn't agree with had already been made, they tended to opt out.

3.52. As well as Mother not engaging, there are several examples of outright hostility and threats to practitioners. After the three police visits and social work contact in November 2020 Mother and Putative Father made a threat to put a tracker on the social worker's car and harm her if the children were taken into care. Police records around the same time contain information that Mother was going to "throw boiling water" over the next police officer that visited her home. When police found a partially dressed Putative Father at the home in November 2020, Mother was reported to be aggressive, and the attending officer found Putative Father to be intimidating. In May 2021 when police officers were being appropriately persistent in attempting contact after a report of an Ex-Partner being in breach of a restraining order and banging on the door, Mother refused to co-operate and used abusive language.

3.53. Practitioners from across the agencies involved in this review generally felt well supported in dealing with intimidating or threatening behaviour by parents. They described how managing this needs to be done on a case-by-case basis. Risk assessments and joint visiting are regularly used, although sometimes workload makes this hard to achieve, and involvement of the police can be beneficial. One member of school staff who had worked in social care and the police felt particularly confident in sharing/seeking information or requesting help from other agencies. This is important for health practitioners where otherwise there would be reliance on children being brought to health clinics as they may not be brought and, if they are, this reduces opportunities to assess the home environment. However, whilst the police officers said they would share information if asked or at a strategy discussion there appeared to be no system to ensure that serious potential risks to practitioners were shared across agencies. In this case the health visiting service was not aware of the threats against social workers and the police. Flags can be put on social work records to indicate "violent person" which facilitates information sharing, however this is not being consistently effectively used, for example there was a flag on Ex partner 2's records but not for Mother or Putative Father.

3.54. There was some evidence of disagreement amongst the practitioners working with the family about the level of risk, which was not always fully resolved. In February 2021 SW1 told attendees at a CIN meeting that they were considering closing the case because Mother was not engaging. The health visitor did not agree with this, and the outcome of the CIN meeting was that a strategy meeting should be convened. This was due to continuing concerns about police call outs, the nature of Mother's relationship with Putative Father and limited access to the children, as Mother was refusing to send the children to school. Mother would not allow the SW to see the children's bedrooms. The CIN plan was authorised by a team manager offering cover for the usual team manager saying they agreed with the CIN plan, which did not refer to the request for a strategy discussion. There is no record of a discussion with a manager about having one, despite the discussion in supervision previously referred to, for reasons that are not known. There is no evidence of the lack of a strategy meeting being raised further by the health visitor. In April 2021 the health visitor was considering withdrawing targeted support due to non-engagement. As there had been no recent contact from SW2 the health visitor emailed SW2 in mid-July 2021, without success, to ask if there was still a CIN plan as there had been no CIN meeting for over two months. The health visitor and school staff told this review that, when contacted by SW3 in September 2021 to introduce themselves as a newly allocated social worker, they believed social work involvement had ceased in 2021 before the easter school holidays. This belief could suggest that the process for stepping down CIN cases was not being consistently applied. After the second ICPC SW4 told this review she discussed her concerns about the outcome with her team manager; they agree the importance of continued monitoring.

3.55. Since February 2021 the siblings have had four different social workers, in his short life Child Bi had two different social workers. This can adversely affect relationships with parents and children,

reducing the likelihood of them investing in making a relationship if they are not confident that worker will remain involved. Sometimes key changes happened at critical moments; the change from SW3 to SW4 occurred in the middle of the S47 enquiry after Child Bi was born. These changes in social worker can mean changes in team managers too, and the lack of a chronology on the files will have made it harder for a new worker/team manager to grasp the case. The ICPCs during the scoping period were chaired by different people, practitioners told this review this is common practice. Chairs described some occasions when a family has been subject to an ICPC after a short period, and the chair or a manager has asked for them to convene the new conference. There is no formal system to support this good practice, but it is heavily reliant on the relationships between staff and availability of those involved. The chair for the 2016 conference was still in post at the time of the later two discussed in this review, this is a large gap where continuity of chair might not add much value to risk management. Having the same chair for the 2020 and 2021 conferences might have added value. The second ICPC was attended by a different safeguarding police officer than the first, and there were two health visitors during the scoping period. Also, although not a feature in this case, ppractitioners need to be alert to the compounding effect of several practitioners changing at the same time and consider collectively how to address this.

3.56. Practitioners had several suggestions for trying to engage with resistant parents. They emphasised the importance of speaking respectfully but being honest about concerns and the value of looking for opportunities to provide positive feedback whenever possible. The school described making the most of incidental informal daily contact on the playground at the beginning and end of the day to build relationships with parents. One practitioner shared feedback from a group of local care experienced adults about the importance of positive relationships with practitioners. They felt these were assisted when there was evidence of shared interests and chat rather than "bombarding" them with questions and that it helped when the practitioner had read the file, or otherwise found out about their history, so there was no need to repeat their story.

Learning points: managing parental non engagement and hostility

- When parents do not engage with CIN plans, including not attending meetings, social workers should promptly consider either ceasing the CIN plan or convening a strategy meeting
- When parents explicitly state they do not want social work involvement there is no legal basis to continue a CIN plan
- Disguised compliance may be less visible when there has previously been outright non-engagement.
- Practitioners usually feel well supported when dealing with parents who are aggressive or intimidating, but systems to share information about incidents are underdeveloped
- Views about the usefulness of the neglect toolkit vary; some practitioners find it difficult to use due to the format or lack of time or training.
- Changes in practitioners, especially at key points, affect relationships with parents and children. Whilst this is often beyond agencies' control it is important to set up systems to avoid this if possible.
- The lack of a chronology on the social work files will have made it harder for a new worker/team manager to grasp the case

See Recommendation E

Childs Voice/lived experience

3.57. To properly understand a child's lived experience, it is important to reflect on what children say (or sometimes, what they don't say), how they look and how they behave. Social workers should see

children alone to build a rapport and gain insight into their views and experiences away from the direct influence of their parents. This is often not easy for practitioners where parents may not agree to this or actively undermine children's view of practitioners, so they are unco-operative and guarded in what they say, as in this case, or even hostile. For school or nursery aged children there is opportunity to seek feedback from those staff, or even visit children in those settings (with parental permission for children on a CIN plan). School and nursery staff will know children well and notice any changes in their behaviour or presentation, as well as being able to provide some insight into the child's home life from any comments they make at school.

3.58. Social work records show that statutory visiting timescales were missed, and the children not always seen. This was due to a combination of reasons. Firstly, Mother was reluctant for social workers to see the children alone, secondly on the occasion (November 2020) when social worker did see Sibling 1 on their own the social worker seems to have considered the other children to be too young to be seen alone. This would have been true of Sibling 4, but not necessarily regarding Siblings 2 and 3, where some of the Signs of Safety tools or other direct work techniques could have been used to engage them. Thirdly there was at least one occasion where the children refused to be seen alone, when SW2 visited the family home in July 2021 in response to the anonymous allegation about misuse of drugs and Mother being pregnant). This was the first time that SW2 had seen the children despite having been allocated the case two months earlier.

3.59. When Sibling 1 had been seen alone by the social worker she was very guarded in her responses. Mother did sometimes allow the social worker to see the children in school, but social work records also show Mother told the children that the social workers "will take them away". Records show that the children been turned against the police and social workers and so it is quite possible they had been encouraged not to speak freely to other professionals. Even when this is the case children can still feel able to be more candid in a school environment where they have developed relationships with the staff. However, the children did not attend school during lockdowns, despite places being offered. The school told this review that this was not unusual if the reason the places were offered was due to social work involvement. The children were also not attending school regularly afterwards. This meant that even had they wanted to, there were limited opportunities to confide in adults.

3.60. Even if social workers are not able to see children alone it is important to record their observations about their presentation and there is limited evidence of this in social work records. What evidence there is suggests some concerns. Records of a home visit in February 2021 show they presented as quiet and subdued and looked scared. Some parts of the home conditions were observed to be dirty. The children were not seen by a social worker at all between June 2021 and September 2021. Whilst this might meet the stipulation in local procedures of a minimum frequency of 12 weeks this was over the summer when they would not be seen at school either. Health visiting records show observations of Sibling 4 and Child Bi in the home. These included specific comments on their development and Mother's interaction with birth children, about which no concerns were noted. Police records include examples of very evocative descriptions of the children, how they are presenting and what they are experiencing. However, a challenge for all practitioners is how to share this information effectively. The risk is that as descriptive information is disseminated the facts of what happened and what the children saw and how they presented are diluted, for example, by the way this is summarised in records, or described from records by someone who was not there. We have seen a good example of that in the discussion about the ICPC in 2020.

3.61. Little is known about Child Bi's lived experience because he was so young. For very young children the presentation and lived experience of older siblings is relevant. School staff were able to give a

very detailed description of the personality behaviour and progress of the three older siblings. They appeared tired and were often late getting to school which upset Sibling 2 and suggested they lacked routines at home. They each had friends but struggled to engage in learning activities. All three appeared subdued, somewhat sad and lacking in confidence. While some positive changes had been seen prior to the ICPC in 2021 further changes once the children were no longer living at home offered a contrast to how they presented when there were living with Mother. This perspective was not available until after Child Bi died. However, participants at the ICPC would have benefitted from being reminded of the way that children had previously presented, and reflection on their likely lived experience and how secure any changes were should Mother get another partner.

Learning Child's voice and lived experience

- Parents can obstruct practitioners gaining children's perspectives either by refusing permission for them to be seen alone, or by making it clear to the children that they should not communicate freely with practitioners
- Children not being consistently in school during the covid pandemic affected opportunities for school staff to observe their presentation and learn about their home life in general conversation
- A challenge for all practitioners is how to share what they observe about children's lived experiences effectively. The risk is that as descriptive information is disseminated the facts of what happened and what the children saw and how they presented are diluted, for example by the way this is summarised in records, or described from records by someone who was not there
- For very young children the presentation and lived experience of older siblings is relevant.

Impact of Covid

3.62. The children were offered places at school, but Mother declined these because of a health condition in the family. The local authority provided the children with ipads and the school uploaded accessible content and provided learning packs. The school attempted daily contact in March and April 2020 because the family were vulnerable having just moved due to Ex-partner 2 trying to get access to their previous home. This was not consistently successful, although the school discovered that Mother was more responsive to texts than phone calls.

3.63. Health visitor's workloads increased due to staff sickness during Covid, this led to out of hours working and feelings of being overwhelmed. However, this did not have a direct impact on this case; HV2 had offered weekly visiting after Child Bi's birth to try to build a relationship with her, given her history of non-engagement.

4. POSITIVE PRACTICE

4.1. When undertaking a review, it is important to also consider the kind of positive practice that might have broader applicability to protecting or supporting other children and families. Examples not previously referred to are listed below.

Positive practice by agencies
The GP surgery knew the family well. Records detail long history of safeguarding concerns due to domestic abuse and there is multi-agency Child Protection information on the children's records. The family was discussions at GP safeguarding meetings
By November 2020 a police officers recognised that Mother and Putative Father were in a relationship and a police officer contacted the social worker directly to suggest a strategy meeting be held
When the health visitor was unable to attend a strategy meeting the school nurse attended in her place
Health visitor was able to have reflective supervision with a health visitor who had previously worked with the family. This gave her a better understanding of the historical concerns and challenges working with the family and the need to invest effort in building a rapport
The health visitor visited Mother at MGMs house despite it being out of her catchment area, and offered weekly visits in the run up to the ICPC.
The school had a positive relationship with Mother at the time of Child Bi's death which helped with gaining the engagement of MGM when the children were placed with her
At an arranged home visit when mother did not answer the door, the midwife spoke with the health visitor, and obtained a different phone number to contact Mother gained assurance that she and Child Bi had been seen by a Health Visitor recently
The ambulance service made an immediate referral to MASH when they received a call stating that Child Bi was not breathing

5. CONCLUSION

5.1. Given the ICPC in 2021 was so close to Child Bi's death the outcome of a child Protection plan would have made no difference as there was insufficient time for it to be put into effect. A direct contribution from the midwives is unlikely to have made any difference to Child Bi. However, it might make a difference in future to other children in his circumstances. The outcome of the conference might have been different had there been more focus on the potential reasons for the concealed pregnancy, and a stronger focus on the history of the case, in particular the likelihood of choice of another risky partner, the children's lived experience, (especially in those circumstances) the consistent previous lack of engagement by Mother, and whether recent engagement amounted to disguised compliance. The outcome of the ICPC in December 2020 might have been a child protection plan if there had been: a chronology which showed the patterns of historical concerns; a more evocative description of how the children presented, how the adults behaved and the state of the house when the police visited in November 2020; and had more information been available about Mother's partner (who became Putative Father). A child protection plan would have ensured the children received more support and may have led to the pregnancy being detected at an earlier stage. However, there is no guarantee this would have prevented Child Bi's death.

5.2. Work has been done locally on the delivery of safe sleeping messages. The research about why parents do not adhere to safe sleeping advice suggests this is not an easy message to convey effectively and work will need to continue to be done to support practitioners in their efforts to overcome the challenges in communicating effectively with parents regarding this.

5.3. The review identifies several systems and resource/demand issues which are addressed by ongoing work and/or the recommendations below. These include; the need to update partnership guidance on concealed pregnancy; management oversight of receipt of Public Protection notices on CIN

cases; arrangements to prioritise and convene strategy meetings for children who already have a social worker; thresholds for decision-making about convening ICPC and making children subject to a child protection plan; how to share information effectively about children's lived experience; the identification and management of serial perpetrators of domestic abuse; the change in policies that mean that midwives only attend child protection conferences for very young babies if they are still involved; the timeframe, nature and level of detail shared by the police about offences or concerning incidents at child protection conferences; arrangements to share and record information about parents whose behaviour is aggressive or intimidatory. All three social workers holding the case in the Innovate team (SW2, 3 and 4) had high caseloads, which makes very hard to manage cases effectively. The most recent Ofsted report[33] for the inspection of the local authority children's services conducted in October 2022 notes that caseloads have reduced.

6. RECOMMENDATIONS

6.1. The individual agency reports have made single agency recommendations. Northamptonshire Safeguarding Children Partnership (NSCP) has accepted these and will ensure their implementation is monitored. To address the multi-agency learning, this Child Safeguarding Practice Review identified the following recommendations for NSCP

A. That the partnership reviews their guidance and procedure on concealed pregnancies, which needs updating with more recent research and case reviews, with more focus on why the parent might have concealed the pregnancy and how to ensure hypotheses are shared and recorded even if parents deny that the pregnancy was concealed.

B. That the partnership commission three multi-agency audits regarding

   I. Public Protection Notices; the timeliness of their receipt and the social work response, including effectiveness of management oversight

   II. The timeliness of strategy meetings after referrals on open cases have raised safeguarding concerns

   III. children not made subject to child protection plans at Initial Child Protection Conferences to include thresholds, completeness of information and outcomes 12 months later

C. That the NSCP convenes a multi-agency task and finish group to consider how best to ensure that detailed descriptive language is used when sharing information about child's voice and lived experience, especially at Child Protection conferences. This work should include how best to convey relevant content from police body worn cameras

D. That the NSCP requires the police to

   I. report back on the effectiveness of their arrangements to identify and manage serial perpetrators of domestic violence

   II. to review the timeframe, nature and level of detail shared with social workers and at Child Protection conferences about incidents of domestic abuse with previous

[33] https://files.ofsted.gov.uk/v1/file/50200024 The local authority children's services were judged as "requires improvement to be good" and recognised the positive impact of the Children's Trust; in the previous full inspection conducted in June 2019 the local authority children's services were judged to be inadequate

partners, to ensure that effective decisions about risks to the children of new partners can be made

E. In order to alert all practitioners who might come into contact with parents making threats or demonstrating other aggressive or intimidatory behaviour, that the NSCP requires individual partner agencies to review, amend and raise awareness about their current guidance on recording and reporting threatening or abusive behaviour to include; a) sharing details about any incidents with statutory partners and relevant education agencies and b) recording information received in a easily visible way.

F. That NSCP seeks assurance from each agency involved in this review that learning points have been identified and action has been/or is being taken to address and disseminate them.