Hampshire Safeguarding Children Board

Serious Case Review

Child K

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Contents

1) Rationale for the review and terms of reference

1.1 A Serious Case Review is one of several reviews and audits undertaken within the learning and improvement framework established by a Local Safeguarding Children Board. The purpose of such reviews is to drive developments in work to safeguard and promote the welfare of children (*Working Together 2015 p.72)* - learning about, consolidating and promoting good practice but also learning from situations where the review has been prompted by a serious incident or tragedy.

1.2 A review provides an opportunity to open a 'window on the system' especially at a multi-agency/service level. Any learning, perhaps especially from a situation with the most tragic of outcomes, needs to continue to strengthen the development of the various strands (individual practice, its organisation and management, governance and quality assurance within and between each partner agency) of a 'safety net' comprising the response with and for all children, young people and families.

1.3 A child (to be known as Child K throughout this report), aged 11 weeks and 4 days old, was found unresponsive whilst sharing his parents' bed at the family's home address. An ambulance was called but, tragically, efforts to resuscitate Child K by his parents and paramedics were unsuccessful.

1.4 Hampshire Safeguarding Children Board considered that the criteria had been met for a review (under regulation 5 (2) (a) and (b) (i) of the Local Safeguarding Children Boards' Regulations

2006) as the situation potentially constituted: 'a serious case where abuse is suspected and the child has died.' (Letter to HSCB)

1.5 In this case, the parents were arrested initially on suspicion of committing an offence of neglect by overlaying (under Section 1(2)(b) of the Children & Young Persons Act 1933). To prove this offence the starting point has to be that there is evidence that the death of a child under 3 years of age was caused by suffocation. If the above can be proven, then it also has to be shown that:

1. The child was sharing a bed or other furniture item used for sleeping

2. The sharing was with one or more persons aged 16 years or over

3. That the person(s) sharing were under the influence of drink or a prohibited drug when they went to bed or at any later time before the suffocation

1.6 In this situation, the cause of death was unascertained, therefore suffocation could not be proven and the Crown Prosecution Service (CPS) concluded that there was insufficient evidence to progress past the first element of the offence. It should also be noted that the CPS was also asked to consider whether any offence of neglect under Section 1(1) of the Children & Young Persons Act 1933 had been committed; but the evidential threshold was also not met for any charge under that section.

1.7 Following a preliminary consideration of the possible circumstances of Child K's death and information pertaining to the family's situation and the involvement of various agencies with the family, terms of reference for the review were established. It was recommended that information should be considered dating from December 2014 until late January 2017, the date of Child K's death in order that the review remained proportionate

1.8 The review panel was asked to explore a number of themes and related questions:

1) Engagement with families

1.1 How did agencies engage with the family?

1.2 At points where the family declined a service or started to disengage, how was this assessed by agencies and what did professionals do to engage the family? Did this raise concerns and were these concerns escalated?

1.3 What tools were utilised by frontline professionals to assist in engaging with hard to reach families? What was the impact of using the tools?

1.4 Were professionals considering the family holistically rather than individually; were links made to all the children?

1.5 What was the role of the father?

2) Alcohol associated risks

2.1 What was known by agencies about the previous concerns regarding alcohol misuse and how it impacted on the parenting?

2.2 Was alcohol use considered in light of the pregnancy, what was recorded and what was known about usage?

2.3 Was historical information used effectively? Was the impact of alcohol use and the risk to children considered?

3) Co sleeping

3.1 What co sleeping advice was given to the parents and at what stages?

3.2 Who provided the information and who was this delivered to?

3.3 Was a risk assessment regarding co-sleeping completed? What were the sleeping arrangements within the household?

4) Domestic Abuse

4.1 Was there any consideration given to Domestic Abuse, namely coercive control when considering the withdrawal/ non-engagement with services?

4.2 Was there any evidence of coercive control? How was this assessed?

2) The review process

2.1 A panel was appointed to plan and manage the review comprising named and designated safeguarding professionals from the local authority children's social care service, a range of health services and the police. The panel was led by Phil Heasman who is independent of the case under review and of the organisations whose actions are being reviewed.

2.2 The process of the review included:

- preparation of agency reports by senior staff within each relevant agency including, variously: an indication of the agency's roles and responsibilities; a detailed chronology (a narrative of events outlining the contact, involvement and work with the family); a consideration of emerging key practice issues and an analysis of learning and recommendations;
- compilation of a full, integrated chronology;
- meetings of the panel to review the information provided by relevant agencies; to address the terms of reference; to identify themes and issues; to identify key personnel to meet who could assist with developing an understanding of what practitioners did in their work with the family and the management and systems supporting it; to consider the information and circumstances of the situation and identify learning and recommendations;
- meetings by the lead reviewer and an appropriate panel member with relevant practitioners who had been involved with the family - both individually and then as a full group together - in order to understand the case from their perspective, including factors affecting practice and its organisation and management at the time;
- drafting of a review report for consideration by the Hampshire SCB Learning and Inquiry Group before submission of the report to the Hampshire Safeguarding Children Board.

2.3 It was agreed that on conclusion of the police investigation and other proceedings, a letter would be sent to Child K's parents to inform them of the review and invite their contribution.

3) Names used in the report and agencies in contact with Child K and his family

3.1 For the purpose of the report, the child whose death led to the review will be known as Child K. The report refers additionally to other family members, referred to by their relationship to Child K:

- Child K's mother (referred to as such throughout the report, including prior to Child K's birth)
- Child K's father (referred to as such throughout the report, including prior to Child K's birth)
- Child K's older siblings – ranging from pre-school to primary school age and referred to throughout the report as
    - Older sibling/Child KS1
    - Older sibling/Child KS2
    - Older sibling/Child KS3
    - Older sibling/Child KS4

3.2 Several agencies, services and practitioners had contact with Child K, the older brothers and sisters and parents during the period covered by the review and practitioners and staff from the following services are referred to in the report:

- Health Visiting and Community Nursery Nursing
- GP practice at which all family members were registered
- Schools attended by oldest siblings
- School nursing service
- Child and Adolescent Mental Health Service (CAMHS)
- Children's Social Care Children's Reception Team (CRT Hampshire)
- Children's Services Department – previous local authority
- Maternity services (hospital and community)
- Other health services: paediatrics, ophthalmology, physiotherapy

4) Summary and analysis of involvement with the family and key events

4.1 For the purpose of this report and understanding the involvement of practitioners and services with Child K, his siblings and parents, it seems appropriate to divide the period of time covered by the review into six sections representing:

- early involvement up to March 2015;
- a period covering concerns raised by several practitioners in March 2015;
- contact between Child K's oldest sibling's school and Children's Social Care Children's Reception Team in June 2015;
- the period in 2015/6 until Child K's mother's contact with ante-natal services;
- involvement with ante-natal services;
- the period following Child K's birth until the incident that prompted the review.

4.2 The detail that follows, relating to each of these periods of time or circumstances, has been drawn from the integrated chronology, individual agency reports and the meetings with practitioners.

4.3 Whilst primarily descriptive, some analysis and commentary are included to highlight aspects of involvement with the family that will be explored in greater detail in section five: practice, its organisation and management - issues and themes.

4.4 Initial and early involvement up to March 2015

4.4.1 The review focused on the multi-agency work with the family from December 2014. However, information was provided to the review panel about involvement by the Hampshire health visiting service following notification in May 2014 that the family had moved into the area, summarised below.

4.4.2 Early contact included:

- a routine invitation for a 'transfer in' appointment that was missed by the parents and a second appointment cancelled by them;
- a home visit by a student health visitor for Child KS3's two-year development review and a decision that health visiting services would be offered through the 'universal' health visiting programme which facilitates 5 key contacts from the antenatal period to a child's 2-year health review;
- a further home visit by the student health visitor for Child KS4's one-year development check, a follow-up for weight monitoring and a referral to an ophthalmologist – but with two missed appointments;
- information: from Child K's parents about previous involvement with the Child and Adolescent Mental Health Service (CAMHS) in the area in which they had lived previously as a result of Child KS1's ADHD; from children's centre staff including concerns about the some of the children's behaviour and its management; from Child K's mother about her previous post-natal depression; from health records transferred on request from the health visiting service in the previous area which included:
    - information about a previous 'domestic abuse incident' in 2012 relating to alcohol intake by both parents (when Child KS3 was just over two months old). The student health visitor planned to discuss this information with the children's mother at the next visit;
    - information about mother's history of self-harm, previous domestic abuse related to alcohol use, post-natal depression and the oldest two children having been the subjects of child protection plans in the previous local authority.

4.4.3 'Vulnerabilities' were noted at the time of the children's development checks and meeting with the family, but there does not appear to be a record of what these were considered to be or an assessment of Child K's mother's past or present mental health and any implications for the children. There does not appear to have been a decision to review the designated health visiting service level in the light of the historic information received from the previous service area, or a consideration of the need for liaison with other services who were also currently providing services to the children and family.

4.4.4 From December 2014 the multi-agency involvement focused on Child KS1's behaviour and its management (at home and school) and included, in December 2014, telephone calls, letters, meetings and appointments – with the parents individually but primarily with Child K's father, including:

- an initial CAMHS consultation on moving in to the area, brought forward at Child K's father's request because of difficulties at his school;
- CAMHS risk assessment highlighted information about a history of vulnerability / neglect;
- Child KS1 was excluded from school and then withdrawn for three days during which his parents apparently adapted his diet, exercise and removed his medication;
- the school reported to the CAMHS specialist nurse that Child KS1 had been aggressive to other children and upending furniture when angry, had refused to go into school from the grounds or to any adults including his mother when she was called to the school, was shouting and screaming when his mother took him to the car (it was the class teacher who apparently eventually managed to calm Child KS1 down after about an hour and a half);
- CAMHS staff expressed concern about the risk that Child KS1 might present to others at school and his own vulnerability from other pupils;
- Child K's father's request for a medication review for Child KS1 including a request that medication be discontinued and that Child KS1 should have blood tests to help establish the cause of his behaviour;
- GP making a referral to a paediatrician in relation to Child KS1's medication;
- Child K's mother seeking an urgent appointment with a GP as she was not coping, that Child KS1's behaviour was putting a strain on her and Child K's father's relationship (but that there was no domestic violence), refusing referral to children's services for support because of what she thought Child K's father's reaction would be;
- GP suggesting to Child K's father that a referral to children's services could be made, which Child K's father declined.

4.4.5 Prior to the end of term Child KS1's attendance was increased in a planned way and Child KS1's medication restarted. However, Child KS1 was not brought by his parents to a planned ADHD clinic appointment. The GP was informed of missed ophthalmology appointments for the youngest child.

4.4.6 School staff invited parents, the health visitor and CAMHS staff to a 'multi-agency meeting' planned for the start of the next term (after the Christmas school break) given an understanding that several people were involved with Child KS1 and to try to prevent further exclusions. Child K's parents were concerned about him being bullied. It is not known on what formal basis this meeting was called and the focus would appear to be solely on Child K's oldest brother, with school learning and support staff in attendance also.

4.4.7 There does not seem to have been a consideration of the history of previous social care involvement. Indeed, it is not clear whether school staff were made aware of this information at the time of the meeting although there is a record of the health visitor advising the head teacher later in March that Child KS1 and Child KS2 had previously been subjects of child protection plans. Similarly, there does not seem to have been a consideration of the HSCB

inter-agency 'threshold criteria' for services; of the further consideration of possibility of a referral to children's social care; of whether Child KS1 might be considered a 'child in need' under the Children Act 1989 and related guidance in *Working Together 2013* (the statutory guide to inter-agency work to safeguard and promote the welfare of children, in place at the time) or of an the expectation that the multi-agency work might be co-ordinated at an 'early help' level as set out in *Working Together 2013.* A home visit by parent behaviour support service was arranged, but it is not known whether this went ahead.

4.4.8 During the subsequent two months in early 2015 the situation at school appears to have been stable for Child KS1. One ADHD clinic appointment was kept at which medication was reviewed but Child KS1 was not brought to the planned appointment with the paediatrician. It was decided that CAMHS practitioners would continue to work with the family – a further appointment with the paediatrician was not offered. Child K's parents reported to a GP at the practice (during a telephone call) that the situation was calmer.

4.4.9 There is also a record of the family being included in 'Vulnerable Families' discussions between the GP practice's safeguarding lead and the practice's liaison health visitor. The family were included in discussions at fourteen of these such meetings over the period covered by this review. No concerns were recorded at this time. Neither the safeguarding lead GP nor the liaison health visitor were the practitioners in their services in direct contact with the family and it is not clear under what guidance or requirements these meetings were held, the arrangements for them being informed by colleagues in direct contact with family members, for records to be made, or for the dissemination of decisions. It is also not clear whether families are aware that they are included in the discussions.

4.4.10 The school nursing service received and reviewed records from the previous area which included information about the two oldest children having been subjects of child protection plans for a period of 16 months (including at the time of Child KS2's birth) 'because of the impact of domestic violence, alcohol abuse and mother's mental health problems' (from the integrated chronology). It would appear that this information was not shared with the school by the school nurse.

4.4.11 Another school nurse from the service met with the safeguarding lead in the GP practice approximately two weeks later and was advised by the GP that Child KS1 had ADHD and autistic spectrum disorder, attends CAMHS and has a paediatrician. There would not appear to be evidence that the history of previous child protection planning linked to domestic abuse, alcohol misuse and maternal mental health was shared with the GP. However, the GP reported that Child KS2 was affected by her older sibling's behaviour difficulties, was withdrawn and quiet; she was receiving additional educational support in school.

4.5 March 2015

4.5.1 In March 2015 there were multiple concerns identified by several practitioners in relation to the children and contact with family members by many services and practitioners including, not uncommonly, three different GPs from the practice seeing various members of the family at different times. The concerns included:

- reports by Child K's father that Child K's oldest sibling had headaches as a result of the current medication plan, it was suggested that a review of the medication by a CAMHS psychiatrist would be requested;
- Child K's mother bringing Child K's siblings Child KS3 (now 2 years and 8 months) and Child KS4 (now 1 year and 5 months) to the GP practice with bruising to child KS4's cheek and shin, scratches to her foot and a superficial older scratch to her thigh with bruising explained as occurring in the house which was being renovated; bruising to Child KS3's right eyebrow – he said that he had fallen down steps at home It is reported that Child KS4 became upset whilst being undressed for the examination and was still crying when being re-dressed; child KS3 started to cry also and tried to comfort his sister; he apparently cowered whilst his mother dressed his sister (KS4) (from the integrated chronology);
- Child KS4 had a viral illness and 'in-toeing', for which the GP said a referral to a physiotherapist would be made;
- further concerns that same week again regarding the oldest child's (Child KS1) medication and a request by Child K's father to increase it, with the GP then seeking confirmation of the recommended dosage from the CAMHS team. This was recorded as a safeguarding concern within CAMHS following the information from the GP about the apparent dosage levels being administered by Child K's father;
- a planned review meeting at school was cancelled 'due to parents' hostility to the meeting' (from the integrated chronology). The health visitor reported this information to the GP suggesting that the school staff considered that 'holding the meeting would damage the relationship with the parents', but that Child KS1's behaviour was improving and that Child KS2 was getting one-to-one help in the classroom;
- Child K's father complained that a support worker at the children's centre had apparently had a threatening manner towards the children's mother – allegedly demanding that Child K's mother attend groups with the two younger children; the parents were reported as refusing to attend further meetings and that they felt victimised.

4.5.2 During this period of approximately two weeks it would appear that there was considerable liaison between and within services: at least 15 different contacts (including telephone calls, formal and informal meetings/discussion, a letter and emails) between 14 different professionals (including four different GPs from the practice, two health visitors, the headteachers of both Child KS1's and Child KS2's schools, the children's centre, the consultant paediatrician, the CAMHS psychiatrist and the safeguarding children specialist nurse) and at times with the parents. It is not clear how many times the children were seen or spoken to directly.

4.5.3 Concerns were recorded as being of a 'safeguarding' nature and advice sought from colleagues with specific safeguarding responsibilities. One of the GPs had discussed the safeguarding concerns with a consultant (an acute paediatrician) during an advisory discussion about Child KS 4's 'in-toeing' presentation. It is noted in the integrated chronology that the consultant paediatrician advised that, as several professionals had concerns over a number of issues then there was cause for concern; that if there was any doubt at the point of addressing Child KS1's medication and mother's health then a referral to children's services should be made (from the integrated chronology).

4.5.4 The health visitor sought supervision from the safeguarding children specialist nurse (Single Point of Contact/SPOC arrangement) regarding concerns and possible disengagement by the parents. The health visitor was advised to discuss the current issues with the GP and CAMHS practitioners and to refer to Children's Services Department if they also had concerns. The possibility of a referral to the Early Help Hub (EHH) was discussed between the health visitor and the safeguarding specialist nurse, but the parents did not want this.

4.5.5 There does not appear to be a consideration of the expectation in *Working Together* 2013 (and directly included again also in the updated 2015 version published at this time) that the involvement by the several agencies with the family could or should be managed through a single inter-agency assessment, the designation of a lead professional and a co-ordinated plan of response and service provision (*Working Together 2013* p. 12/13 and *Working Together 2015* p.14). A referral to Children's Services was not made.

4.6 June 2015

4.6.1 In early June 2015 the Children's Reception Team (CRT – the team that acts as the first point of contact for professionals and families who are seeking to make a referral to Children's Services) received a telephone call from Child KS1's headteacher saying that Child KS1 had, the day before, 'disclosed that his parents punished him all the time and hit him on his private parts' and smacked his bottom really hard (from the integrated chronology and CRT records). During this contact the headteacher referred to a previous reference by Child KS1 to hitting, seven months prior to this incident. The status and intention of the contact from the school's perspective is not known.

4.6.2 An Assistant Team Manager (social worker) reviewed the details provided by the school and the analysis from the CRT call taker and decided that there was no role for social care. This contact comprised the only information known about the family. More recent concerns (as outlined in the sections above) had not been referred and there had been no contact from the previous local authority. A decision was made not to progress the contact from the school to a formal referral and associated response.

4.6.3 It would appear that school staff did not provide and were not asked about background/historic information, information about other agencies' involvement or circumstances beyond the immediate concerns. Similarly, it does not appear that there was a discussion about Child KS1's cognitive capacity, the diagnosis and treatment for ADHD or a consideration of how this might specifically impact on the way that he communicated or presented information. It could be suggested that, as Child KS 1 had talked about being hit alongside lots of other subjects, then this may have reduced the school's staff members' and CRT practitioners' sense of the veracity of what Child KS1 was saying and the possibility that this was a disclosure of an assault.

4.6.4 The headteacher was advised that he should discuss the concerns with Child KS1's parents. The response to the contact from the school suggests that the information was not taken to constitute concern that Child KS1 may be 'suffering or likely to suffer significant harm'

warranting a process of investigation as set out in sn.47 of the Children Act 1989, *Working Together 2015* or the HSCB child protection procedures. Consideration does not appear to have been given to the possibility of requesting a child protection medical following what could have been defined as a disclosure of physical abuse or assault.

4.6.5 The school do not now have a record of the incident, the contact with the Children's Reception Team (CRT) or of the information shared by the school at the time. The extant CRT record does not suggest that information (provided by the health visitor to school staff in March: of previous social care involvement; that Child KS1 and Child KS2 had been subjects of child protection plans at one point in the previous local authority; or of more recent concerns) was shared by the headteacher with the CRT call-taker. The school also does not now appear to have a record of the discussion or the advice given by the CRT practitioner or manager (which may have included a view that what was being reported might constitute 'lawful chastisement' - from CRT records).

4.6.6 Unfortunately, there is no record of whether further discussion took place between the headteacher and Child K's parents, or of any other subsequent action taken by school staff. It does not seem that the headteacher was asked to – and did not - re-contact the CRT to report on the outcome of the discussion with Child K's mother.

4.7 The period of time in 2015/6 until Child K's mother's contact with ante-natal services

4.7.1 Over the next few months there was apparently limited contact with the children or parents outside of school provision. A CAMHS appointment was missed in July and the family were informed that, if there was no contact within two weeks then Child KS1's 'file would be closed' (from the integrated chronology). Child K's father contacted the clinic apologising for missing the appointment and a further one was planned and kept in October with continuing discussion with Child K's father about Child KS1's ADHD, its effect on his behaviour and its management – including a review of medication. In December the GP contacted Child K's father by telephone as he had still not been brought for a medication review; the GP noted that this was becoming a safeguarding concern but Child KS1's father clarified information about current circumstances and contact with CAMHS in October.

4.7.2 Child K's youngest sister had her 2-year health review, this was undertaken by a nursery nurse and not a registered/qualified health visitor, though there had been identified vulnerabilities. It is perhaps significant that none of the formal development checks of Child K's older siblings during the time of contact with the health visiting service were undertaken by a registered health visitor. No developmental gaps were highlighted for Child KS4 and it was planned that health visiting services would continue to be offered through the 'universal' level of provision. Child K's mother refused a referral for ophthalmology for Child K's sister regarding the family history of 'lazy eye'.

4.7.3 In November Child K's mother was seen by another GP at the practice because of symptoms of depression. There does not appear to have been a discussion about any impact of mother's current mental health on the children directly or indirectly. Anti-depressants were prescribed but Child K's mother later decided to stop taking these in January as she reported that she was hoping to become pregnant again.

4.7.4 The family continued to be included in 'Vulnerable Families' meetings at the GP practice (held monthly) involving the liaison health visitor and the safeguarding lead GP. No recent concerns were noted.

4.8 Involvement with ante-natal services from March 2016

4.8.1 In March 2016 Child K's mother had an antenatal booking appointment with a community midwife and was asked, as part of the routine assessment, about any experience of domestic abuse, of substance misuse or whether she or Child K's father had ever had a social worker or probation officer. Child K's mother answered negatively to all these questions but did report her experience of depression and that she was currently under the care of the GP and had been prescribed anti-depressants. The maternity services booking form was sent to the health visiting service and it could have been identified from the form that Child K's mother had not disclosed the child protection, alcohol, or domestic abuse history.

4.8.2 Child K's mother kept all routine antenatal appointments with maternity services and staff - and there was discussion between the community midwife and Child K's mother about her 'low mood'. At one point, Child K's mother told the midwife that she was relying on her mother for support but that her mother was finding it difficult to help. The community midwife noted that Child K's mother reported that the behaviour of the oldest child (Child KS1) was impacting on the family, but there does not seem to be a consideration of why or how. At some of the appointments, some of Child K's siblings were seen; no concerns about their presentation or wellbeing were recorded.

4.8.3 The GP liaison health visitor linked with the community midwife as part of routine practice although it is not clear under what policy, guidance or requirements these meetings were held - or of the arrangements for them to be informed by colleagues, for records to be made, or for the dissemination of decisions. It is also not clear whether families are aware that they are included in such cross-service discussions. It does not appear that information was shared with the community midwife by the liaison health visitor regarding previous involvement with the family (including the previous history of social care involvement and that the eldest two children had been subjects of child protection plans at one stage - indeed, this information would not appear to have been shared with or available to the maternity service practitioners at any time) or of any more recent concerns.

4.8.4 In September the health visiting team's administrator contacted Child K's mother to arrange an antenatal appointment but was told that she did not want an appointment and was too busy to speak to the health visitor directly. This is generally considered to be an unusual response to the health visiting service's invitation for early contact during pregnancy. The health visitor also reported to the review that she was not aware of the record of previous concerns (historic and more recent) and vulnerabilities – either through accessing the records held by the service or from other sources.

4.9 Following Child K's birth

4.9.1 Child K was delivered 'in excellent condition' with a 'normal delivery' and with no complications. Following routine observations of recovery from the delivery and with Child K feeding appropriately, he and his mother were discharged the following day. Information about

'safe sleeping' and other health and care matters is provided routinely at the point of a baby's and mother's discharge from hospital but it is not clear whether *both* parents/partners (where appropriate) receive the information.

4.9.2 Routine midwifery visits and appointments were kept and did not identify any difficulties or concerns. Child K's new born hearing screening was also completed. Again, however it would not appear that the maternity service staff were aware of previous concerns, the fact that Child K's older siblings had been subjects of child protection plans or the more recent concerns and involvement by various services and practitioners since the family moved to the area in 2014 – including times when vulnerabilities had been noted or when concerns had been identified as 'safeguarding' and contact with Children's Services considered or suggested.

4.9.3 The health visitor sought to arrange a new birth visit and early feeding review, ringing the home on five occasions. Child K's mother contacted the health visitor (day 17 following the birth of Child K) reporting that Child K was well; a new birth visit was declined. Details were given to Child K's mother by the health visitor of clinic days and times and although Child K's mother indicated she would attend, there is no record that this happened. Again, awareness of previous concerns (historic and more recent) and vulnerabilities as well as the unusual refusal of antenatal contact may have provided a context to assess whether this situation might give cause for concern.

4.9.4 The family continued to be included in discussions of vulnerable families at the GP practice involving the liaison health visitor and safeguarding lead GP. It was noted that the allocated health visitor was not allowed access to the house but that 'the midwife is happy'. Maternity service involvement and visits ended twelve days after Child K's birth.

4.9.5 In addition to the safe sleeping advice given at the point of discharge from hospital, the information is reiterated during postnatal community midwife visits and includes the provision of an accompanying UNICEF leaflet. There is no record of Child K's mother saying that Child K would sleep in the parents' bed. The maternity service practitioners were unaware of the historic information and concerns relating to alcohol use and domestic abuse (including reference in the older children's health visiting records from the previous area - that there had been a domestic abuse incident relating to alcohol intake by both parents when Child KS3 was 10 weeks and 2 days old).

4.9.6 Child K was brought to the GP practice for his 6-week check – at 10 weeks and 3 days old. No concerns about Child K or his mother were recorded. Two days later Child K was brought for his first set of immunisations by the practice nurse.

4.9.7 A week later (Child K was 11 weeks and 4 days old) Child K's parents made an emergency call in the early hours of the morning as Child K was found unresponsive. Tragically, efforts to resuscitate Child K by his parents and paramedics were unsuccessful.

5) Practice, its organisation and management – issues and themes

5.1 This section of the report identifies and explores themes, issues and critical debates that have emerged from the scrutiny that a serious case review both requires and allows: bringing a sharp focus to bear on involvement with one particular child and family over a specific period of time.

5.2 Detailed reports were prepared by senior staff from key agencies and services. These reports were based on a consideration of records, meetings and discussions with practitioners. Information has also been drawn from formal (electronic) recording systems that usually remain separate and, less formally, from practitioners who had contact with Child K, his siblings and parents in the course of their work with many other children and families over the time covered by the review.

5.3 The themes and issues considered in this section have their root in what has appeared significant in *this* particular situation but may also be important in future work to help promote and safeguard the wellbeing of all children and young people. It is acknowledged that a review focusing on work with a particular family cannot ascertain whether the practice and its organisation and management in *that* particular situation was typical or atypical of usual practice. Similarly, where aspects of practice and its organisation and management have been highlighted as areas for development, it is perhaps difficult to say whether there is any connection with the outcome for Child K.

5.4 The analysis below is structured according to the terms of reference that the HSCB Learning and Inquiry Group identified from the initial consideration of Child K's death. The key issues that emerged during the review process seem to fit well within these terms of reference. Many of the agency reports also directly addressed the terms of reference and associated questions and such an approach by all agency report writers is to be encouraged in future reviews as it can help bring a consistency to analysis enabling key themes to be pursued and tracked within and across all reports.

Terms of reference 1: Engagement with families

a) How did the agencies engage with the family?

5.5 It appears that there was limited engagement with the family *as a whole* with just one obvious recorded occasion when all members of the family were seen together by a practitioner (the student health visitor who undertook the two-year development check for Child K's youngest sibling in 2014). It would appear that Child K's father did not attend any antenatal appointments and the community midwife did not meet him. It is not clear whether one or more of the postnatal maternity service's practitioners saw the family together after Child K's and mother's discharge from hospital. It may be the case that the whole family was not seen together by any qualified or registered health, social care or education practitioner during the period covered by the review. No one professional had designated responsibility for the whole family.

5.6 There is no evidence from any of the reports or conversations with practitioners that any practitioner discussed historic information, the circumstances of the previous child protection involvement or details of the past concerns that Child KS1 and Child KS2 had been considered to be at risk of significant harm necessitating child protection plans. None of the practitioners seemed to have details of the child protection plans or of work undertaken with Child K's parents as a result of the plans, nor information about the circumstances of the decision that child protection plans were no longer needed in respect of Child K's eldest siblings. Throughout the review period there does not seem to have been a formal or contemporary assessment of whether the historic concerns might still be current.

5.7 There is a record that Child K's mother and father attended one meeting at the school together in January 2015 and there is a record of a telephone call by one of the GPs during which both parents were each spoken to separately during the conversation. According to the records and agency reports, all other meetings or discussions took place with one or other parent and sometimes with one or more of the children present.

5.8 It could be suggested that the way agencies engaged with the family was as a result of the dynamic and interaction of several factors:

- *as required routinely* e.g: health checks, developmental reviews, immunisations, registering with a service such as the midwifery service;

- *as presenting specific issues or problems arose* e.g: an accident or injury to one of the children sustained in school; particular concerns about child KS1's behaviour; routine health advice either sought for one of Child K's older siblings or for one of the parents;

- *the perception by mother of Child K's father's likely response* to the involvement of services e.g: the question of making a referral to children's social care suggested by a GP;

- *practitioners' perception of likely response from the parents* e.g: the school were concerned that staff members' relationship with Child K's parents needed managing sensitively and therefore agreeing with a parental request not to go ahead with a planned meeting; the suggestion to the GP (who asked the health visitor to visit in March 2015) that the health visitor is fairly sure that if a call was made to the parents, the request for a visit would not be accepted.

- *on terms defined by Child K's parents*, including missed or declined appointments e.g:

    - not agreeing to a 'transfer-in' health visiting service appointment;
    - appointments sometimes taken up or sometimes missed with the ADHD clinic for Child KS1;
    - not wishing to attend children's centre activities;
    - agreement to referral but no attendance at one of the children's ophthalmology appointment;
    - not agreeing to a proposed referral for physiotherapy for one of the children;
    - agreeing only sometimes for information to be shared between CAMHS and Child KS1's school; asking for a change in Child KS1's medication;
    - registering with antenatal service;
    - not seeing the need for a pre-birth health visiting service appointment,
    - not responding to many requests from the health visitor to visit after Child K's birth.

5.9 Given the limited multi-agency co-ordination of involvement with the family by the various key agencies and services and practitioners, it was perhaps unlikely that possible patterns of engagement/non-/disengagement could have been recognised or the potential impact on the children discerned over and above each separate situation. Nor, perhaps, was it possible to

develop a common approach or strategy for effective engagement with the family, especially the parents.

5.10 A further key issue perhaps arises if the question in the terms of reference is re-phrased 'how did the agencies *together* engage with the family?' The picture presented from the integrated chronology, the agency reports and the conversations with practitioners, is perhaps mainly one of individual practitioners, individual agencies and services (and sometimes teams and individuals within services) generally engaging with the family or the parents singly or in time-limited and occasional partnerships and communications – supported and managed by different recording and information management systems.

5.11 There does not appear to be a sense of a 'team around the family' as a whole, or of presenting issues being considered systemically – either with the system defined in terms of the family and all its members, or a wider system that might also include a 'professional dimension': school, health visiting service, GP practice, CAMHs etc.

5.12 There is little evidence that the work with the family was formalised. The somewhat critical mass of concerns in December 2014 and in March 2015 involved consideration of a more formal referral to children's services that might have led to processes of assessment and co-ordination with a whole family/whole professional system emphasis. Similarly, the contact between Child KS1's school headteacher and the Children's Reception Team could have triggered a more formal assessment or investigative process in line with the provisions of *Working Together 2015* and the HSCB procedures at the point of referral.

5.13 The *possible* consequences of the way that agencies (singly and together) seemed to engage with the family were that:

- concerns arising in relation to one child were not necessarily considered as potentially having implications for or an impact on other children. For example: Child KS1's behaviour at one stage was described as being a risk to other pupils in school - this does not appear to have been seen as having relevance for his relationships with his younger siblings or being a potential risk to them. The management of Child KS1's medication and sporadic engagement with services for him may represent a pattern of parental action that could have implications for the other children;
- there may have been a danger of responding to immediate presentations and issues rather than considering wider, underlying or contributory causes (e.g: Child KS1's behaviour linked primarily to medication management – essentially an organic explanation);
- there may have been an emphasis on reacting to current presenting issues alone and not within a larger contextual understanding of the family. For example: the response to the school's contact with the CRT - where a possible understanding and interpretation of Child KS1's ADHD (and the implications for the way he perhaps processed and presented information) may have led to a minimising of what he said about being hit by his parents because this disclosure was mentioned in the course of other comments and topics; when antenatal and postnatal health visiting contact was not possible; when community midwives were involved following Child K's birth but did not have historic information (including about the previous concerns about the risk of significant harm to the eldest two

children, of problematic substance use, of domestic abuse and of mother's longstanding mental health difficulties).

5.14 Another opportunity to formalise and organise the multi-agency work with this family could certainly have been taken through the expectations and provisions in the 4LSCBs' *Maternity and Children's Services Unborn Babies Safeguarding Protocol* 2013 (due for revision in July 2015 but revised in December 2016) when practitioners became aware of Child K's mother's pregnancy. The protocol in use at the time advises that where there are 'low level known risk factors' (p.9) there should be: liaison between the GP and health visitor and all other relevant professionals; a meeting between involved professional and the family; a joint professional assessment; and a care plan agreed. If there is a 'medium to high level of known risk factors' then practitioners should consider undertaking a CAF (Common Assessment Framework assessment, the process and structure in use at the time that the protocol was established in 2013) and consider referring to Children's Services Department. The listed concerns that may trigger the protocol include (section 4.1): 'mental health support needs', 'known domestic abuse by any member of the family' and 'historical concerns such as previous neglect, other children subject to a child protection plan'. Section 5.2 suggests that 'a referral should always be made if:

- A parent or other adult in the household is a person identified as presenting a risk, or potential risk to children. This may be due to domestic abuse, substance/alcohol abuse, mental health or learning disability
- Children in the household/family are currently subject to a Child Protection Plan or previous Child Protection concerns.

5.15 It seems significant that in meetings with practitioners and other information considered by the review, that there was little reference to national or local policies and procedures or guidance for practice and its management including: the HSCB *Procedures Manual*, related *Hampshire Safeguarding Children Board and Children's Trust Thresholds Chart/* 'threshold guidance', the *Information Sharing and Confidentiality Policy* (Hampshire Children's Trust) and policies in relation to response to a child or young person presenting with bruising, or not being brought to appointments or (as above) the 4LSCBs' *Maternity and Children's Services Unborn Babies Safeguarding Protocol*.

5.16 In particular there does not seem to be overt reference to the provisions and guidance (and associated responsibilities and practice arrangements) set out in *Working Together 2013/2015* (versions in use during the period of this review but with identical guidance and language in the relevant and respective sections drawn out below).

5.17 *Working Together 2013/2015* refers to 'a continuum of help and support to respond to the different levels of need of individual children and families' (*WT 2015 p. 15 para 14)* with four main elements within the continuum and thresholds defined:

a) 'where need is relatively low';

b) 'other emerging needs';

c) 'where there are more complex needs';

d) 'where there are child protection concerns'.

Each of these elements are linked with expectations of responses by services which are defined as: 'universal', 'early help', 'child in need', 'child protection' and have related and formally defined expectations of roles, responsibilities, powers duties and rights and associated management processes.

5.18 At various times there certainly may have been a question of where on this broad differentiated continuum of need/service response the children might have been located. For example, could the concerns about all or some of the children in March 2015 or Child KS1's disclosure at school in June 2015 meet threshold criteria for 'child protection concerns'; could Child KS1's needs relating to his diagnosis of ADHD meet the criteria for services without whose provision he would be 'unlikely to achieve or maintain a reasonable level of health and development, or whose health and development is likely to be significantly or further impaired' (definition of 'a child in need' in sn. 17 of the Children Act and included in *Working Together 2015* p. 18)?

5.19 However, *Working Together 2013/2015* is clear that at the 'early help' level of concern and need (where 'children and families may need support from a wide range of local agencies') – then: 'Where a child and family would benefit from coordinated support from more than one agency (e.g. education, health, housing, police) there should be an inter-agency assessment.' This is to be undertaken by a 'lead professional who should provide support to the child and family, act as an advocate on their behalf and coordinate the delivery of support services.'

5.20 There is reference to the importance of services being 'co-ordinated and not delivered in a piecemeal way' *(WT 2015 p.14)*; that the 'early help assessment carried out for an individual child and their family should be clear about the action to be taken and services to be provided…. And aim to ensure that early help services are coordinated…' (*Working Together 2015 p.14).*

5.21 Referral to Children's Service 'Early Help' was considered at times but this seemed to imply a process of accessing services provided through the Early Help Hubs in place in Hampshire, rather than a sense that the processes identified in *Working Together 2013/2015* might apply to the management of involvement with a family whether or not there is involvement by Early Help Hub practitioners, including, again:

- the designation of *a lead professional* (which *WT 2015* suggests could be 'a General Practitioner, family support worker, teacher, health visitor and/or special needs coordinator');
- *a single multi-agency* assessment undertaken by the lead professional;
- the *coordination* of support services

5.22 In Hampshire, the 'early help' band of the safeguarding and promoting continuum set out in *Working Together 2013/2015* is differentiated into two levels (level 2 and level 3 in the *Hampshire Safeguarding Children Board and Children's Trust Thresholds Chart* in use during the period of the review and currently) with the 'Early Help' subsections defined as:

- 2: Early Help: has additional needs within the setting that can be met within identified resources through a single agency response and partnership working

- 3: Targeted Early Help: Has multiple needs requiring a multi-agency co-ordinated response

However, a more recent Hampshire County Council paper in July 2016 (setting out new proposals in relation to Family Support Services) includes the following definition in relation to the Children's Trust and Hampshire Safeguarding Children's Board's 'threshold of need' chart:

> 'The 'threshold of need' chart therefore identifies 4 levels of need:
>
> - Level 1 (universal) – all families and children where there are no specific needs;
> - Level 2 (early help) – families where there is a need for support, but this can be met within a specific setting e.g. pre-school or school and by one single service or agency, i.e. a speech and language therapist providing advice and help;
> - Level 3 (targeted early help for vulnerable families) – families and children with more needs requiring more than one service or agency to be involved; and
> - Level 4 (children's social care) – families and children with a high level of unmet and complex needs and meeting the threshold for children's social care intervention.'

5.23 Arrangements, processes and services that characterise a 'level 3' level of need or concern for a child or young person or family in Hampshire (according to the *Hampshire Safeguarding Children Board and Children's Trust Thresholds Chart*) and related response, would seem to be well-defined with a clear sense of an assessment process (and accompanying proforma etc.) and the co-ordination of both a single assessment and a subsequent plan and provision of services through the identification and action of a designated lead professional.

5.24 It is perhaps less clear how on-going 'partnership working' (at Hampshire *Thresholds Chart* 'level 2' - but which also accords with *Working Together 2013/2015's* guidance for *all* 'early help' work) by practitioners such as GPs, health visitors, school staff, maternity service staff, CAMHS practitioners and school nurses – and their respective services - is to be managed.

5.25 The current HSCB 'Early Help' website information suggests that 'practitioners need to understand their role both when providing a service as a single agency (emerging additional need) and as part of a multi-agency response (targeted interagency).' However, the practitioners involved with Child K's family do not seem to have considered the expectation that they use the 'Early help checklist' and then potentially 'consider commencing an Early Help Assessment to inform the support that is needed for the child and family from you and other agencies.' (*Early Help and Supporting Families Checklist July 2015*)

5.26 It is not possible to know what could have been the impact on involvement with the family of applying the single category 'early help' level expectations set out in *Working Together 2013/2015* to 'partnership working' (HSCB Level 2). In this case it *may* have:

- led to a single, holistic, systemic assessment using a conceptual model such as the *Assessment Framework* 'triangle' (as proposed in *Working Together 2013/2015/2018)* to identify strengths and difficulties past and present (to assess the particular health, development and wellbeing of each child; to assess whether her/his needs are being met; to assess parenting capacity and the potential impact of wider family and environmental

circumstances) which would then potentially have been available more readily to all GPs, all health visitors, all maternity services staff and have led potentially to the assessment and information being used and shared at key moments - such as the contact with CRT by Child KS 1's school in June 2015;

- at times of more acute specific concern (e.g: March 2015, June 2015), enabling presenting issues to be seen in the context of past safeguarding concerns and information about the previous child protection plans so that an informed judgement could be made about any *current* relevance of historic information and implications for the current wellbeing of the children);
- helped identify one lead professional;
- potentially provided a framework for meetings;
- assisted with information sharing (and a greater transparency about this - for example, it is not clear that the parents were aware that the family was discussed at 'vulnerable families' meetings at the GP practice or at discussions between the liaison health visitor and community midwife);
- increased the opportunity for patterns of parental engagement or of dis-/non-engagement to have been identified;
- helped in considering parental and family dynamics – including issues pertaining to information regarding historic domestic abuse and alcohol use;
- helped coordinate services and work with the family.

Engagement with families b) At points where the family declined a service or started to disengage, how was this assessed by agencies and what did professionals do to engage the family? Did this raise concerns and were these concerns escalated?

5.27 As identified in section 4, there were several occasions when the family either *declined* or were thought likely to decline a service ('transfer-in appointment' with the health visiting service; referral to Early Help Hub; physiotherapy; ophthalmology; referral to children's services); *disengaged* or had a *sporadic* or *selective* pattern of engagement (with CAMHS, with school, with the health visitors, rejection and complaint about the children's centre). It is difficult to discern a clear pattern, but a possible explanation might be that Child K's parents primarily sought assistance and services when it was seen as beneficial or *they* considered that it was in the children's interests. The perception of what was in the children's best interests held by the parents did not perhaps accord at all times with the perception of the practitioners involved.

5.28 The possibility that when Child K's mother declined further help it may have been because of Child K's father's influence does not appear to have been considered by the various practitioners involved or explored with her. Similarly, the possibility that *sporadic* or *selective* engagement was as a result of the differing perceptions of need (parents and practitioners, as above), or the result of the organisation of the parents, or even the result of a strategy to engage with just some services – does not seem to have been considered or tested.

5.29 The children were dependent on adults (primarily their parents) to meet their needs and *Working Together 2015* sets out what children have said they need which includes:

'Vigilance: to have adults notice when things are troubling them. Understanding and action: to understand what is happening; to be heard and understood; and to have that understanding acted upon, Support: to be provided with support in their own right as well as a member of their family.'

This perhaps reinforces the importance of practitioners considering that a parent's/parents' capacity or level of willingness to engage may be inhibiting a child's or children's access or right to services that could promote their wellbeing (e.g: access to physiotherapy, CAMHS appointments, attending ophthalmology services, engagement with ante-natal and post-natal health visiting service, even heeding safe-sleeping advice etc.) - rather than representing a parent exercising parental choice. Such a recognition could lead to a referral of concern or other response. Guidance on countering what has been recognised as disguised non-compliance in some parents seems to highlight the critical need to keep a focus on the child or young person's health and development as a primary indicator of effective engagement and to measure what parents and carers actually do, not what they say they agree to do, will do or are doing. (See NSPCC: *'Disguised compliance: learning from case reviews. Summary of risk factors and learning for improved practice around families and disguised compliance guidance'*, for example)

5.30 Perhaps because of the apparent limitations to partnership working or coordinating multi-agency services, it may not have been possible for issues or patterns of non-engagement, sporadic or selective engagement or disengagement to be recognised, tested or challenged if necessary.

Engagement with families c) What tools were utilised by frontline professionals to assist in engaging with hard to reach families? What was the impact of using the tools?

5.31 It is not clear that any particular tools were identified or referred to but the development of policy and guidance e.g: *Child and Family was not brought and disengagement guideline* is welcomed and is likely to help practitioners respond to this issue effectively and within a well-defined procedure.

Engagement with families d) Were professionals considering the family holistically rather than individually; were links made to all the children?

5.32 As considered above, it could be suggested that a holistic, 'whole family' or 'think family' perspective was not always taken perhaps either in relation to the consideration of difficulties or 'problems' (their cause and potential impact on all the children) *or* in terms of 'solutions' and responses. The one meeting which the parents attended together was at the school in January 2015. Whilst the health visitor and CAMHS practitioners were invited, this meeting was prompted by issues relating to Child K's oldest brother's behaviour – and to prevent any further exclusions. The 14 'vulnerable families' meetings that included discussion of the family by the safeguarding lead GP and the liaison health visitor to the practice were not necessarily informed by a full and integrated picture of the family or each child's situation either from within each of the two services, between the two services or more widely.

5.33 Aside from the suggestion that coordinating *an* assessment and an *integrated* response to the family through the 'early help' process and provisions recommended in *Working Together*

2013/15 might have helped promote a 'whole family' approach, then the more formal involvement of children's services would probably have prompted a whole family assessment and more formal multi-agency coordination of all known information and perhaps services.

Engagement with families e) What was the role of the father?

5.34 Child K's father was active at times in working with CAMHS and to an extent the school in relation to Child K's oldest brother's ADHD, his behaviour and its management especially regarding medication levels. At times, Child K's father was happy for information to be shared with school – but not at other times; it is unclear why that might be the case.

5.35 There was a suggestion raised in the reports that Child K's father may have been concerned at the details of the discussion between the health visitor and Child K's mother during the home visit in Autumn 2014. This was the one obvious time when a practitioner saw the whole family together.

5.36 Child K's father complained about the children's centre staff and Child K's mother was reported as being sensitive to her husband's likely reaction at the suggestion by a GP that a referral to children's services for support could be helpful. When the GP also made this suggestion to Child K's father it was rejected.

5.37 In March 2015 the health visitor informed the GP that a scheduled meeting at school was cancelled due to parents' hostility to the meeting and that the school staff felt that holding the meeting would damage the relationship with the parents.

5.38 Given the absence of school records relating to the contact by the headteacher with the Children's Reception Team in June 2015, it is not known whether the advice given to the headteacher (to talk further with Child K's parents about the information disclosed by Child KS1) was followed and, if not, what informed the decision by school staff. Because this contact was not taken forward as a referral, there does not seem to be an expectation from the CRT that it would follow up further or that school would report back.

Terms of reference theme 2) Alcohol associated risks

Alcohol associated risks a) What was known by agencies about the previous concerns regarding alcohol misuse and how it impacted on the parenting*?*

5.39 Some of the agencies and practitioners were aware of information from counterpart services in the area in which the family had lived previously e.g: eldest two children's health visiting records provided August 2014 and the mother's records received in October 2014 after a request; school nursing service records; request from CAHMS for information from the previous area's service, that was not forthcoming.

5.40 Records received included references to Child K's eldest two siblings having been the subjects of child protection plans and that the associated risk of significant harm was apparently linked to alcohol use and domestic violence. Details do not seem to have been available of an incident or incidents, of assessments made, of plans and the process of work with the parents leading to the decision that child protection plans were first necessary and then no longer necessary. Historic information including concerns about problematic alcohol use was initially known to some services and practitioners but was not apparently always either sought, further shared or

available at the point where other practitioners were involved or became aware of the family e.g: when the headteacher contacted the CRT in June 2015; when the community midwifery service became involved from Child K's mother's registration before his birth; when the new health visitor was allocated for Child K; all GPs in the practice.

Alcohol associated risks b) Was alcohol use considered in light of the pregnancy, what was recorded and what was known about usage?

5.41 Routine questions were asked at the point of Child K's mother's registration with the community midwife and the responses given were unlikely to prompt further detailed exploration (no problematic alcohol use, no issues relating to domestic abuse, no previous involvement with social care), especially without any background information.

Alcohol associated risks c) Was historical information used effectively? Was the impact of alcohol use and the risk to children considered?

5.42 Historical information about the specific issue of alcohol use and associated information relating to domestic abuse, neglect and mother's mental health and previous child protection involvement and plans was not known to all practitioners and therefore did not comprise an aspect of all current assessments including by the community midwife and in relation to a discussion about sleeping arrangements.

5.43 Information about the details of how past parental alcohol use might have impacted on the parents' capacity to meet the children's needs or have affected the children's health, development and wellbeing would not appear to have formed part of any discussion with the parents by the practitioners who were aware of it.

5.44 In relation to all historic information and sharing information more generally, *Working Together 2013/2015* is also clear about the importance of sharing information within and across practitioners and services to promote and safeguard children's health, development and wellbeing:

> 'Effective sharing of information between professionals and local agencies is essential for effective identification, assessment and service provision' (*Working Together 2015* p.16 para 22) across the whole continuum of need/concern/service provision and 'Early information sharing is the key to providing effective early help where there are emerging problems' (*WT 2015* p.16 para 23).

In this situation, information seemed to be shared between some practitioners within and between some services and agencies, but this does not seem to have been coordinated, transparent or always involve consideration of issues of consent by the family.

5.45 It would appear that at the point of contact between school and the Children's Reception Team in June 2015, at the allocation of Child K's health visitor toward the end of 2016 and with the involvement by maternity service staff both before and after Child K's birth - both historic information and full information about more recent concerns, was not shared, sought or available - including *within* a single service such as health visiting, the GP practice or *between* sections of services such as the various branches comprising health services or Hampshire Children's Services e.g: Children's Centres, the Children's Reception Team.

Terms of reference theme 3) Co-sleeping

a) What co sleeping advice was given to the parents and at what stages? b) Who provided the information and who was this delivered to?

5.46 Discussion with the community midwife and information in the agency report suggested that advice about safe-sleeping, including the potential risks that might be associated with 'co-sleeping', would have been given routinely in discussion with Child K's mother before discharging Child K and his mother from hospital and then again as part of the visits once home. There is no specific detail available about these conversations and it would appear generally that advice and discussion is primarily and usually undertaken with babies' mothers.

5.47 Information from the maternity service staff does not indicate whether Child K's father was present during the postnatal midwifery visits or was part of the discussion about care arrangements in general or sleeping arrangements more specifically. It is now understood that co-sleeping was a planned decision by Child K's parents and had been their practice with the older children also.

5.48 The review panel's discussion of the issue of co-sleeping included a consideration of the status, authority and consistency of advice and messages given within and across relevant services. It was suggested that perhaps this might be reviewed further against the best available evidence, both about the messages but also perhaps about the effectiveness of publicity and its related impact on behaviour including what may help parents understand the possibility and probability of risk of harm.

5.49 Perhaps in situations where it is known that there has been problematic alcohol or substance use (including an association with concerns about other children in the family as evidenced in previous child protection plans, for example), then a more formal discussion and risk assessment especially in relation to sleeping arrangements (and especially where co-sleeping is identified as a parental choice) should be carried out with a requirement that this is recorded as having taken place.

5.50 The status of the advice may be important to consider in relation to practitioners' responses if they have concerns, especially about parental reaction to advice. Is the advice a 'guideline', a 'recommendation', a 'summary of generally safe/safest practice' or a 'requirement'? If the latter, then there perhaps needs to be some consideration of what practitioners should do if they have concerns – including recording concerns and discussion with senior or supervising staff. When might a parent's refusal to comply with advice and guidance potentially constitute neglect of a baby's best interests, imply the actual or likelihood of significant harm and therefore potentially suggest further action within statutory guidelines?

Was a risk assessment regarding co-sleeping completed? What were the sleeping arrangements within the household?

5.51 It does not appear that a formal risk assessment was completed or that there was specific discussion about the sleeping arrangements within the household. Enhanced partnership working, the identification of a lead professional, the coordination of multi-agency support based on a single shared assessment and through a shared, agreed and integrated plan could have increased the possibility that the community midwife was aware of the historical

information and assessed whether it still had relevance for the parents' care of Child K. This may have helped inform advice, discussion and parental behaviour relating to care arrangements in general or the potential for alcohol use and co-sleeping arrangements in particular.

Terms of reference theme 4) Domestic Abuse

a) ***Was there any consideration given to Domestic Abuse, namely coercive control when considering the withdrawal/ non-engagement with services? b) Was there any evidence of coercive control? How was this assessed?***

5.52 The records that had been received by some of the services and practitioners referred to domestic abuse but with apparent limited information about the circumstances, nature and severity or the impact on the children - other than to give professionals in the previous area cause for concern meeting the criteria for child protection processes and plans. However, when the health visiting records were received in October 2014 (alongside reference to mother's long-term history of self-harm, post-natal depression, the older children being the subject of child protection plans in the previous local authority) there was also reference to previous domestic abuse with an incident in 2007 which led to Child K's mother seeking a place in a refuge, but no reports of domestic abuse since 2012; yet this is still a period of five years. Child K's mother reported to the GP that while her relationship with Child K's father was strained by their oldest child's behaviour, there was no domestic violence. The community midwife followed standard practice in asking about this issue at the antenatal registration appointment.

5.53 Nothing in the presentation of Child K's brothers and sisters that have been noted in section 4 of this report led any of the practitioners to consider that there might be continuing concerns about domestic abuse, though Child K's father did tell one practitioner that arguments between him and Child K's mother could become 'physical.' No concerns about Child K's health and development or mother's engagement with midwifery services (pre- or post- Child K's birth) prompted any of the midwives to have concerns that might have required further exploration or explanation.

5.54 There does not seem to be evidence that, at the point of withdrawing or non-engagement with services, the possibility of power exercised through coercive control within the parents' relationship was considered or that information was given to suggest that that might be an issue.

5.53 Whether knowledge of the historical information that included reference to domestic abuse, the problematic use of alcohol and mother's psychological wellbeing would have prompted a heightened sense of vulnerability, of risk of harm for the children or more specific and overt discussion of these issues, is difficult to say. Furthermore, whether a heightened sense of potential vulnerability in this process would have necessarily changed anything that practitioners did or said is difficult to say – other than to report that the health visitor and community midwife talked to during the review thought that it would have affected their assessment and actions.

6) Recommendations

6.1 The recommendations below have emerged from a consideration by the panel of the information from the agency reports, the integrated chronology prepared by the agencies, the meetings and conversations with practitioners and a related practitioners' workshop. Unfortunately, at the time of writing the report it has not been possible to include the views, opinions and perspectives of Child K's parents or consider the views of Child K's older brothers and sisters, where this might have been appropriate.

6.2 Several of the agency reports included an analysis of 'lessons learnt' and 'recommendations' of particular relevance to the services, teams and practice within the agency. Examples were provided of changes and developments already implemented based on the agency reviews: the management and recording of health visiting/midwifery liaison meetings; training in the 'Child and Family was not brought..' guidelines; the importance of exploring and confirming the exact circumstances of previous children's services involvement and using that and other information to inform care planning; the importance of sharing historical information; improving the coding and cross-reference access to information about safeguarding risks in GP records; developing the structure of 'Vulnerable Families' meetings; developing a template for maternal postnatal checks; training in relation to professional optimism and updating assessments and reviewing risk in the light of new information.

6.3 The panel are confident that these will help to develop practice and its organisation and management. Many of the recommendations in the individual agency reports accord with the terms of reference and questions that the review was asked to explore and with the recommendations of this overview report to the Safeguarding Board (in section 6.7 below). It is expected that each agency will track and audit the implementation of lessons and recommendations from both the respective agency reports and this overview.

6.4 The practitioner workshop included questions that the participants were asked to consider, including a question to elicit information about learning from their involvement with this situation and any additional recommendations that they might have. The responses included: the ability and importance of consultation and referral with children's services/awareness of the consultation line for advice; requirement to transfer-on information when children move to another area – especially if there has been statutory involvement with a child identified as a child in need or a child in need of protection; collation of significant information within a service that works with several family members separately; guidance to parents about information sharing within and across services; workload review; clear escalation process if historic information is not obtained; summarised records at point of transfer; quality of conversations at point of discussion or referral using a common format e.g: SBAR – situation, background, analysis, recommendation; feedback to referrers; awareness of the local information sharing protocol; raising awareness of a 'think family' perspective.

6.5 'Transformative suggestions' included: transfer and sharing information between local authorities and social care and health services, between schools etc. when families move especially when there has been statutory involvement with a child identified as a 'child in need' or within child protection procedures; guidance/flowchart/prompts for questions to be asked to assist in identifying risk and protective factors in the CRT; integrated health and social care records system; automatic 'opt in' of sharing information between agencies; fathers' and

partners' engagement with maternity services; a public health campaign regarding safe sleeping and alcohol; guidance about parental lack of consent to 'early help' services

6.6 Finally, the panel members and practitioners involved in the review provided information about current and on-going initiatives and developments informed by other recent reviews (at a local and national level) and audits of practice, for example: work to promote awareness, understanding and compliance with national and local policies and procedures e.g: the current HSCB 'spotlight' on the revised *Unborn/Newborn Baby Safeguarding Protocol*; enhanced assessment skills and confidence to challenge at the point of contact or referral; *Child and family not brought…* guidance; access to both clinical and safeguarding supervision; maintaining the primary focus on the child rather than the professional relationship with parents; the work on health information records' alignment; the Early Help Hub/Family Support Service developments; the scrutiny of schools' safeguarding arrangements through sn.175 audits. Some of these also link in to themes, issues and critical debates pertinent to this review and the recommendations below.

6.7 The specific recommendations from this overview report are primarily concerned with multi-agency and inter-agency matters and it is recommended that the Hampshire Safeguarding Children Board (HSCB):

1) invites all partner agencies to promote awareness of responsibilities and expectations for the management of arrangements for sharing information and records set out in the 4LSCB area 'Protocol for Protecting Children who Move Across Local Authority Borders';

2) asks the Early Help Board to review information and guidance to support and promote 'partnership' practice, arrangements and management at the HSCB and Children's Trust Thresholds Chart 'level 2' level of need, concern and response;

3) promotes awareness within partner agencies of the need for all practitioners to:

- ascertain, understand and take into account the 'voice', experience and participation of all children, especially including those with additional communication and learning needs;
- consider all the children and young people in a family and take a 'whole family' perspective when primarily working with or providing services for specific family members;
- identify and liaise with other services and practitioners who have/had contact, who work/have worked with a child, young person or family when undertaking assessments or providing services;
- share historic information about a child, young person or family with relevant practitioners and services (where appropriate) and include this in all assessments;
- act confidently within the current safeguarding arrangements and procedures, including in relation to making a referral to Children's Services, if it is considered that a child or young person is unable to have access to necessary services or may be at risk of harm through actions of parents or carers.

4) reviews the guidance and information about 'safe-sleeping' arrangements (including known risk factors, for example alcohol consumption) provided to *all* prospective and new parents (including fathers or partners) and to the practitioners who may work with them; and consider promoting public awareness through a media campaign.

7) Conclusion

Many people have contributed to this review and their time and expertise is appreciated greatly, not least in the way that it has helped develop a greater understanding of involvement with Child K's family and issues identified following his tragic death. It is acknowledged that developments identified in practice and its organisation and management that: a) have been implemented already; b) that comprise the recommendations within specific agencies; or c) that may follow in line with the recommendations above - may not have changed the outcome for Child K. However, the lessons and recommendations from this review aim to help contribute to the ongoing work to further develop, strengthen and enhance services and response to other children, young people and families.

Appendix

List of agencies providing agency reports and contributing to the review

- Health Foundation NHS Trust
- 5 Clinical Commissioning Groups
- Hospitals NHS Foundation Trust
- Local Constabulary
- CAMHS Partnership NHS Trust
- Local Authority Children's Services