Barnsley Safeguarding Children Partnership

Local Child Safeguarding Practice Review – Child X

1.0 Introduction

1.1 Three weeks old child X died in his family home after apparently being overlayed by his mother who fell asleep whilst breastfeeding. Mother had a history of periodically excessive alcohol use and it appears that she was under the influence of alcohol at the time of child X's death. Child X's death and one of his siblings were being supported by child in need planning and another sibling was subject to child protection planning. Concerns that mother may have been co-sleeping with child X and using alcohol led to the escalation of concerns from midwifery to children's social care management which were under consideration at the time of child X's death.

1.2 Barnsley Safeguarding Children Partnership decided to conduct a local child safeguarding practice review (CSPR). David Mellor was appointed as the independent reviewer. He is a retired police chief officer who has nine years' experience as an independent reviewer of CSPRs and other statutory reviews. He has no connection to services in Barnsley. A description of the process by which the review was conducted is set out in Appendix A.

1.3 An inquest into the death of child X will be held in due course.

1.4 Barnsley Safeguarding Children Partnership wishes to express sincere condolences to child X's family.

2.0 Terms of Reference

2.1 The period on which this review has focussed is from November 2017 when concerns about mother's alcohol use when caring for her children first arose until the death of Child X on 28th June 2020. Significant events which took place prior to November 2017 have also been considered.

2.2 The key lines of enquiry addressed by the review are as follows:

- How effectively did practitioners respond to persistent concerns about mother's alcohol use?
- Was the impact of mother's alcohol use on her parenting capacity fully considered and addressed?
- What support was offered to mother to help her address her alcohol use? Was her alcohol use seen in the context of her risk of domestic violence and abuse from partners and her anxiety and depression?
- When concerns about co-sleeping, mother's alcohol use and her co-operation with practitioners arose in the period following the birth of Child X, how effectively were these concerns escalated and addressed?
- Is there a formal multi-agency escalation procedure? Was the procedure invoked when risk began to escalate following the birth of Child X? If invoked, what was the outcome? Is there a common understanding of the escalation procedure across all agencies?

- How effective was partnership working between midwifery, the Hospital Safeguarding Unit, the Public Health Nursing Service and Children's Social Care?

- How comprehensive was the pre-birth assessment in respect of Child X?

- How effective was the Child in Need Plan for Child X and his sister and the Child Protection Plan for his brother?

- Was there sufficient enquiry into the role of males in the household, particularly the father of Child X and his sister, who was considered to be a high risk perpetrator of domestic violence and abuse and another male who appeared to be involved in the care of the children in the period following the birth of Child X?

- Did restrictions imposed as a result of Covid-19 impact in any way on measures necessary to safeguard Child X?

- Is the learning from this LSCPR consistent with the learning from the National Panel Review of Sudden Unexpected Death in Infancy?

3.0 Glossary

A **Child in Need (CiN)** is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled.

Domestic violence and abuse is any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, psychological, physical, sexual, financial and emotional abuse.

The **Domestic Violence Disclosure Scheme (DVDS)** – often referred to as 'Clare's Law' after domestic homicide victim Clare Wood. The principal aim of the Scheme is for the police to consider the disclosure of information in order to protect a member of the public who may be at risk of harm from domestic violence or abuse. The Scheme recognises two procedures for disclosing information, namely a
'Right to ask' which is triggered by a member of the public applying to the police for a disclosure and a 'Right to know' which is triggered by the police making a proactive decision to disclose information to protect a potential victim.

The term **Early Help** describes the process of taking action early and as soon as possible to tackle problems and issues emerging for children, young people and their families. Effective help may be needed for at any point in a child or young person's life.

Health visiting levels of service. The health visiting service provide four levels of service as follows (1):

- *Community*: health visitors have a broad knowledge of community needs and resources available e.g. Children's Centres and self-help groups and work to develop these and make sure families know about them.

- *Universal*: health visitor teams ensure that every new mother and child have access to a health visitor, receive development checks and receive good information about healthy start issues such as parenting and immunisation.
- *Universal Plus*: families can access timely, expert advice from a health visitor when they need it on specific issues such as postnatal depression, weaning or sleepless children.
- *Universal Partnership Plus*: health visitors provide ongoing support, playing a key role in bringing together relevant local services, to help families with continuing complex needs, for example where a child has a long-term condition or additional concerns such as safeguarding, domestic abuse and mental health problems.

A **Legal Gateway** meeting is an opportunity to discuss a case fully, and to consult with colleagues to ensure that children are the subject of active case management and effective child protection planning and that appropriate legal action is taken when required to promote and safeguard the welfare of the child.

Every local authority has a statutory responsibility to have a **Local Authority Designated Officer (LADO)** who is responsible for co-ordinating the response to concerns that an adult who works with children may have caused them or could cause them harm.

Multi-Agency Risk Assessment Conference (MARAC) is a meeting 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) and other specialists from the statutory and voluntary sectors. A victim/survivor should be referred to the relevant MARAC if they are an adult (16+) who resides in the area and are at high risk of domestic violence from their adult (16+) partner, ex-partner or family member, regardless of gender or sexuality.

The **perinatal period** refers to pregnancy and the first 12 months after childbirth. Specialist community **perinatal mental health teams** offer specialist psychiatric and psychological assessments and care for women with complex or severe mental health problems during the perinatal period.

SafeLives DASH (Domestic Abuse, Stalking and 'Honour'-based violence) is a commonly accepted tool which was designed to help front line practitioners identify high risk cases of domestic abuse, stalking and 'honour'-based violence and to decide which cases should be referred to the Multi-Agency Risk Assessment Conference (MARAC) and what other support might be required.

Section 47 Enquiry is required when children's social care have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm. The enquiry will involve an assessment of the child's needs and the ability of those caring for the child to meet them. The aim is to decide whether any action should be taken to safeguard the child.

A **Strategy Discussion** must be held whenever there is reasonable cause to suspect that a child has suffered or is likely to suffer significant harm. The purpose of the Strategy Discussion is to decide whether a Section 47 Enquiry under the Children Act 1989 is required and if so, to develop a plan of action for the Section 47 Enquiry.

4.0 Synopsis

4.1 Mother is a registered nurse who works in a nursing home. She had three children, child 1 who was born in 2009, child 2 who was born in 2017 and child X who was born on 6th June 2020 and died on 28th June 2020. The father of child 1 is referred to in this case summary as father 1 and the father of child 2 and child X is referred to as father 2.

4.2 Mother suffered domestic violence and abuse in her relationships with both father 1 and father 2, including an assault on her by father 1 when holding two week old child 1 in her arms. During her relationship with father 2, the police were periodically called to domestic abuse incidents by child 1 who disclosed that he was scared by the 'screaming and banging' that father 2 was 'mean' to him 'all the time'. Mother was reluctant to support any prosecution of father 2 but alluded to a history of controlling behaviour and aggression on his part. Concerns began to accumulate over mother's capacity to care for child 1 and about her use of alcohol. There were numerous reports of staff at child 1's school smelling alcohol on mother's breath when bringing the child to, and collecting him from, school.

4.3 From 13th July 2017 until 3rd December 2018 mother received support from an Early Help Family Support worker. The primary focus of this work was on supporting mother to parent child 1 who had issues with anger, agitation, frustration and self-harm. At the time Early Help support began, child 1 was 8 years and child 2 was 4 months old and mother was on maternity leave. During this period a diagnosis of auditory sensory processing disorder was being investigated in respect of child 1 and he was supported through an education, health and care (EHC) plan because of a diagnosis of moderate learning disability. The purpose of an EHC plan is to identify educational, health and social needs and set out the additional support required to meet those needs.

4.4 On 12th November 2017 the police were called by a member of the public after mother appeared drunk whilst taking child 1 and 2 home from a family party. The police went to mother's home where she was found lying on the floor, smelling strongly of intoxicants and slurring her speech. Child 1 was attempting to care for his younger sibling who he had placed on a double bed with pillows either side of her to try and prevent her rolling off. However, child 2 was 'totally covered' in bed clothes on which faeces were noted. Mother was arrested on suspicion of child neglect and detained overnight as she was assessed as too drunk to be interviewed.

4.5 Children's social care were notified of the incident and worked together with the police. The police decided to take no further action was taken as the incident was treated as an 'isolated' incident for which mother appeared very remorseful. Children's social care closed the case in January 2018 on the grounds that mother was not considered to be alcohol dependent and the incident had been a 'one-off'. It was noted that child 1's school had smelled alcohol on her breath, which mother had denied. It was decided that the support provided by the Family Support worker would continue.

4.6 Early Help referred mother to the Local Authority Designated Officer (LADO) as she was employed as a registered nurse in a care home and therefore worked with adults with care and support needs. The LADO's role is limited to cases in which an adult works with children and so it seems likely that the referral would have been considered within the local authority's Person's in a Position of Trust (PIPOT), but the outcome of the referral is unknown.

4.7 Early Help continued to support mother and the children. Mother's relationship with child 1's primary school became strained. The school did not perceive the 12th November 2017 incident as an isolated event. Child 1 disclosed that mother drank at weekends and a strong smell of alcohol was noted when mother and father 1 attended a meeting at school to discuss a disclosure from child 1 that he had been kicked by his mother. Father 1 acknowledged that he had been drinking but it was suspected that mother may also have been drinking.

4.8 During February 2018 child 1 disclosed that his mother picked him up from school and took him to her friend's house where she drank a bottle of wine. Child 1 added that when they got home, mother went to bed leaving him to look after child 2. Child 1 was later seen by a social worker and there were said to have been 'huge gaps' in his account.

4.9 Mother claimed that her relationship with child 1's school had broken down and began looking for an alternative school. The school expressed concern about disguised compliance from mother. Mother began avoiding school because she 'felt judged' by them and began sending relatives to take and collect child 1 from school.

4.10 Child 1 moved to a different primary school in June 2018 although he was excluded from his original primary school shortly before he transferred to the new school.

4.11 Early Help referred mother to IDAS, which supports people affected by domestic abuse, after father 1 was arrested for drugs and violence offences which made her fearful for her safety - although father 1's violence was directed at another family member. Mother declined IDAS support.

4.12 On 25th January 2019 mother reported an incident to the police in which she had invited father 1 into her home to see child 1 and an argument had taken place during which mother feared father 1 was going to head-butt her. The police attended and subsequently arrested father 1 although the Crown Prosecution Service (CPS) decided not to authorise a charge because of 'evidential difficulties'. Mother also reported a mark on child 2's neck which she believed to have happened when father 1 tried to grab her to say goodbye. Child 1 was said to have been very upset by the incident and was frightened of seeing or speaking to his father. A DASH risk assessment identified a medium risk. There is no indication that alcohol played any part in this incident.

4.13 Children's social care were informed and a further period of assessment followed although the case was closed in February 2019 as mother and father 1 'had separated' and mother was to be supported through an Early Help Assessment. Father 1 was documented not to want contact with child 1 and was advised that if he wished to renew contact with child 1, children's social care would need to carry out a risk assessment.

4.14 On 1st June 2019 father 2 attended the family home in a drunken state. Child 1 was home alone and after texting his mother, she told him to contact the police. During the call to the police child 1 said that he was scared because previously when mother and father 2 argued there had been 'blood everywhere'. The police notified children's social care. When the latter service spoke to mother she said that child 1 had lied about the incident, adding that he 'always tells lies.'

4.14 On 15th June 2019 mother reported child 1 as missing to the police who subsequently located him at his maternal grandmother's address. Child 1 disclosed that he had been

assaulted by his mother, not for the first time he said, and maternal grandmother raised concerns about mother's mental health and alcohol consumption.

4.15 A strategy meeting took place on 21st June 2019 at which concerns were expressed about mother's alcohol consumption, the emotional and physical abuse of child 1 and child 2 presenting as unkempt at nursery from which the child was often collected by her aunt. The matter was to be progressed to Initial Child Protection Case Conference (ICPCC). The disclosure of assault by child 1 was treated as 'over chastisement' and no further action was taken.

4.16 The ICPCC was held on 10th July 2019 when both child 1 and 2 were made subject to a Child Protection Planning in respect of concerns about domestic abuse, alcohol use and risks in the community. In particular there was concern that the children continued to be exposed to violent incidents between father 2 and mother; that there was strong evidence that mother was using alcohol to excess in order to manage her low mood and her current relationship with child 1 and there had been reports of mother being 'drunk' whilst pushing child 2 in her pushchair; and that child 1 was often unsupervised in the community during mother's working hours and that she did not accept responsibility for his behaviours and continually requested for him not to be in her care.

4.17 On 26th July 2019 maternal grandmother contacted the police after child 1 arrived at her house after returning home from school to find the front door unlocked and neither his mother or child 2 at home. Maternal grandmother advised the police that she had also contacted children's social care who had agreed that child 1 could stay with her for the night. As children's social care were thought to be aware, no further action was taken by the police. No enquiries were made by the police to locate mother and child 2 and no referrals were submitted. Children's social care had been informed of the situation by maternal grandmother but no further action was taken other than adding the incident to the chronology of concerns about the family. In their chronology of concerns, children's social care documented that mother was reported to have returned home with child 2 whilst 'drunk' later in the evening.

4.18 On 9th August 2019 father 2 contacted the police to express concern that mother was preventing his access to child 2 due to her being in drink. The police contacted children's social care who advised that mother had already informed them that child 2 was unwell and that the family had been engaging well with their service. The police visited mother at home and concluded that she was not 'in drink', having consumed one glass of wine. The police shared this incident with the subsequent Review Child Protection Conference meeting held on 2nd October 2019.

4.19 On 22nd October 2019 mother contacted the police to report that father 2 had falsely informed her employer that when she called in sick it was actually because she was drunk. Mother decided against making a formal complaint about father 2. The police completed a DASH risk assessment which highlighted a standard risk and offered her a referral to IDAS which mother declined. Children's social care were also notified.

4.20 On 6th December 2019 mother attended a booking appointment with midwifery in respect of the unborn child X. When asked about alcohol consumption, mother said that she drank 12 units per week prior to her pregnancy. She said she was prescribed propranolol for anxiety and cyclizine for morning sickness. She said that she was no longer in a relationship with the father of child X (father 2). Safeguarding was discussed and she said that the Child Protection Plan was in place because of drug abuse by father 1 – which was false.

4.21 On 9th December 2019 mother registered with GP practice 2 and during the new patient health check she stated that her weekly alcohol consumption was zero.

4.22 On 4th January 2020 child 1 contacted the police. He said he was not at home but had been texted by mother asking him to call the police because father 2 was at his home address and refusing to leave. He disclosed previous domestic violence incidents which usually involved father 2 punching his mother in the face and that 'sometimes, blood gets all over the place'. The police attended mother's address where she disputed the account provided by child 1. Father 2 was present but had fallen asleep on the sofa after visiting her at her invitation. She said that she believed child 1 had been worried about her because of previous disagreements she had had with father 2 – which she said had not involved violence. The police escorted father 2 from the address but child 1 was not further spoken to or any texts noted. Due to child 1's disclosures, a crime of assault was recorded and a DASH completed (standard risk). The police notified children's social care and maternity services in view of mother's pregnancy. (The account of this incident shared with the review by children's social care adds that father 2 fell asleep having become intoxicated and that mother had gone upstairs 'to stay out of the way').

4.23 One of the previous domestic violence incidents disclosed by child 1 took place in June 2019 when father 2 attended the family home in a drunken state. Child 1 had been home alone. When children's social care later spoke to mother about this incident she said that child 1 had lied about the incident, adding that he 'always tells lies.'

4.24 On 9th January 2020 maternity informed health visiting of mother's estimated date of delivery which was 24th June 2020.

4.25 On 10th January 2020 social worker 1 made a Child Protection visit. It was noted that father 2 was taking some responsibility for child care in respect of child 2 and mother regarded him as reliable in this regard. He looked after child 2 in his caravan which mother said she had visited and found it to be clean and tidy, with appropriate toys for the child to play with.

4.26 On 17th January 2020 midwifery notified children's social care that mother was 16 weeks pregnant with Child X. Mother had not been attending ante-natal appointments which led midwifery to refer her to Grimethorpe Family Centre for ante-natal care, which she began attending from 21st January 2020.

4.27 On 20th January 2020 a core group meeting took place at which continuing concerns about child 1's behaviour at school were discussed. His school stated that they were often unable to contact mother due to her being in work and advising them that she was unable to take breaks due to her role in caring for residents in the care home in which she was employed. Father 2 was said to have been making calls to mother's workplace. The content of these calls was not documented although mother was said to have discussed them with social worker 1 who advised her to contact the police.

4.28 On 29th January 2020 social worker 1 made a Child Protection visit following which it was documented that child 1 was struggling with his behaviour at school which was said to have deteriorated, indicating that 'he had worries that he felt unable to speak about'.

4.29 On 31st January 2020 midwifery responded to the police notification of the 4th January 2020 incident by issuing an instruction that direct questions about domestic abuse should be asked when mother attended appointments.

4.30 On 6th February 2020 social worker 1 made a further Child Protection visit. It was documented that child 1's school had raised concerns that his behaviour had deteriorated significantly since the last core group meeting in that he had been 'hurting himself' at school, spending a lot of time in the community - sometimes until 10pm - and arriving very early at school and without a coat. Mother was said to remain difficult to contact, saying that she was unable to receive calls between 9.30am and 8.30pm on working days. There were said to be no concerns about child 2.

4.31 On 11th March 2020 children's social care arranged a 'pre-planning meeting' in accordance with the Barnsley pre-birth protocol following the referral from maternity in respect of the unborn child X. It was noted that there continued to be concerns in respect of child 1 and his behaviour in the community. He remained subject to child protection planning due to 'extra familial harm and lack of supervision and safety plans by surrounding adults'. Mother was noted to be 25 weeks pregnant, was now attending ante-natal appointments at Grimethorpe Family Centre and there were no concerns about how the pregnancy was progressing. It was also noted that during her previous pregnancy, a friend (friend 1) moved into her property to provide support to enable her to recover and adjust to a new baby being in the household. No concerns were said to have been raised by health agencies. Midwifery had been invited to this meeting but it is unclear if they attended.

4.32 When mother attended hospital after experiencing bleeding on 16th March 2020, direct questions were asked about domestic violence. Mother disclosed no incidents and said that she did not feel unsafe. A DASH risk assessment was completed which identified a 'medium' risk which was increased to 'high' following a conversation with the Named Midwife for Safeguarding. The domestic abuse concerns were documented as follows:

- A previous high-risk event involving strangulation.
- Continued incidents despite mother and father 2 being separated.
- Father 2's continued contact with child 2 with access providing the opportunity for further domestic abuse.
- 'Unpredictable nature' combined with alcohol use – it is unclear whether this referred to father 2, mother or both.
- Mother's apparent lack of acceptance that the risk of domestic abuse remained.
- Child 1's disclosure of previous assaults which were denied by mother.
- Mother had declined specialist support and a referral to IDAS
- Father 2 had previous children who he had no contact with.
- Father 2 identified as a previous high-risk perpetrator of domestic violence with another victim in 2017 - six incidents with that victim in which strangulation involved on four occasions. Restraining order taken out.
- It was questioned whether or not mother was aware of Clare's law (the Domestic Violence Disclosure Scheme).

4.33 On 22nd March 2020 a Review Child Protection Conference took place. The report prepared for this meeting by children's social care noted that when child 1's concerning presentation was discussed with mother, she was visibly frustrated and dismissive of the concerns, stating that none of this is new behaviour and that child 1 is a 'typical boy'. She was said to disagree with the child safeguarding concerns and did not feel there were any additional steps she could take to safeguard child 1 when she was at work. When child 1's safety in the community was discussed with mother, she demonstrated a poor

understanding of risk. Father 2 expressed concern that child 1 was displaying unsafe and dangerous behaviour in the family home and the community, adding that the child had knives in his bedroom and in the community. Father 2 went on to say that child 1's behaviour placed child 2 at risk of harm and he said he was worried about the impact on the unborn child X. Father 2 also said he was worried that mother was not telling professionals the full extent of what was happening and not being honest. Mother disagreed with this and said that father 2's comments were untrue and were the result of them having a disagreement earlier in the week.

4.34 Overall, it was felt that limited progress was being made on the Child Protection Plan because mother was reluctant to engage with services which would aim to increase her understanding, help her implement strategies and build a clear safety plan for child 1. Children's social care wished to make a referral to CAMHS in respect of child 1's behaviour and early life experiences but mother did not agree that this was required. Additionally, children's social care had considered presenting child 1's case to the Contextual Harm Panel but did not yet have an evidence base to support the level of concern held by professionals. It was decided that child 1 was to remain subject to child protection planning on the grounds of emotional abuse and physical harm, but that the threshold for child protection planning was no longer met for child 2 who was said to be thriving in all areas. She was to be supported as a Child in Need for a period to ensure progress was maintained. The plan for the unborn child X was to be discussed by children's social care and midwifery. Child 1 was to be referred for family support and targeted youth support. There was said to be no evidence of mother using alcohol around the children.

4.35 On 26th March 2020 the case was transferred from social worker 1 to social worker 2 due to the former's maternity. The expected joint home visit by both social workers could not take place to due to Covid-19 restrictions.

4.36 On 31st March 2020 a pre-birth assessment was completed in respect of the unborn Child X. The assessment noted that mother had been difficult to engage with. It was noted that mother's pregnancy with child x was unplanned and due to a brief relationship with father 2, with whom she said she did not wish to be in a relationship with as a result of his past behaviour. Father 2 had wanted mother to terminate the pregnancy. Father 2 expressed concern that prior to the pregnancy mother was consuming alcohol excessively, although there was said to be no evidence to support this. He was also concerned that following the arrival of the unborn child, she would return to this behaviour. The assessment found that there continued to be evidence that mother was able to meet the basic needs of a young child, had an appropriate understanding of child development, the importance of routines, hygiene and had the ability to implement boundaries. There was concern that as a child grows and begins to engage in risk taking behaviour, that mother's parenting ability was different in that her understanding of appropriate supervision for child 1 was of concern and needed to be addressed to prevent the unborn child from having similar experiences as they grew. Mother was said to minimise concerns about domestic abuse and was unwilling to undertake any work with IDAS to develop her understanding of domestic abuse. However, she was no longer in a relationship with father 2, which was regarded as a 'protective factor'. Mother had limited family support and was said to rely upon friends and neighbours in the local community. She remained resistant to engagement with children's social care and had declined a referral to parenting and behaviour management. It was noted that the Child Protection plan in respect of child 2 had recently been ended because there was evidence that mother was able to meet the child's basic needs. It was said that there was no evidence that this would not be the case for the unborn child. A child in need plan was recommended in respect of the unborn child X.

4.37 On 31st March 2020 the case was discussed by social worker 2 in supervision and child 1's case was RAG rated as 'amber' as he was attending school and, due to mother's maternity leave, he was no longer unsupervised in the community. Child 2 and the unborn child X were RAG rated 'green'. (RAG rating of cases had been temporarily introduced as a direct result of the impact of Covid-19 restrictions on social work practice in order to afford cases priority on a 'red' (high), 'amber' (medium) and 'green' (standard/low) basis).

4.38 On 1st April 2020 MARAC considered the 16th March 2020 referral from maternity following concerns that mother, who was pregnant, was minimising issues with father 2, including his alcohol consumption. The police shared details of the 15th June 2019 and 22nd October 2019 incidents and domestic abuse incidents involving mother and father 2 and their previous partners. Father 2's alcohol consumption was referred to but there was no mention of mother's consumption of alcohol. The outcome was that partner agencies were asked to ensure that any incident 'tags' were up to date.

4.39 On 2nd April 2020 social worker 2 made a CIN visit and to introduce herself. Given Covid-19 restrictions the social worker stayed at the front door. Mother, child 1 and 2 were present. The home was noted to be cluttered with toys. Mother said she was struggling to attend appointments due to caring for the children and the impact of Covid-19 restrictions which prevented members of the wider family caring for the children. The social worker advised mother that she would share the unborn assessment completed by the previous social worker with her once she was authorised to do so, to which mother responded by saying that she had been told that the likely outcome of that assessment was that the case would be closed. The children engaged well with the social worker.

4.40 Social worker 2 made a further CIN visit on 23rd April 2020. Mother had begun her maternity leave. She also said that she was in the process of moving house but that Covid-19 restrictions had put this on hold. Child 2 was having weekend contact with father 2.

4.41 On 27th April 2020 mother was sent a text message inviting her to contact the infant feeding service which offered advice and support. She subsequently declined this service.

4.42 On the same date a CIN meeting took place which was conducted through updates being provided by email in view of the Covid-19 restrictions. Social worker 2 confirmed that child in need planning had been recommended in respect of the unborn child X, that she had been unable to do any direct work with child 1 as yet as a result of Covid-19 restrictions. There had been no concerns during home visits in that mother had engaged appropriately and the children had presented well. On her next visit the social worker said she planned to speak to mother about child 1 arriving at school early (8am). Midwifery's update was that mother had been changing her mind about which GP she would be seeing and had not attended a recent appointment with the midwife (date given as next day – 28th April). No other email updates were received.

4.43 The case was discussed in supervision by the social worker and her manager on 30th April 2020. There were no concerns about the basic care needs of the children. The previous concerns about mother's supervision of child 1 had diminished as she was now on maternity leave. Mother's ability to sustain change once she returned to work was considered. Child 1 was attending school and said to be disruptive in class. Child 2 was seeing father 2 at the weekends and there had been no recent reported domestic abuse incidents.

4.44 A further CIN visit took place on 12th May 2020. Mother and the children were seen in the rear garden. Mother said she was feeling 'fed up' as the prospective buyers of her house had pulled out. She said that she would need more space once the baby was born. The social worker discussed concerns about the early arrival of child 1 at school – as early as 7.30am. Child 1 said he woke up at 7.30am and set off for school 15 minutes later which mother confirmed, adding that he avoided washing his face and brushing his teeth.

4.45 The birth plan was completed by children's social care and sent to the safeguarding midwives on 14th May 2020.

4.46 Social worker 2 discussed the case with her manager in supervision on 21st May 2020. Mother was now in a position to move house to Grimethorpe which would necessitate child 1 living in a friend's care during the week so that he could continue to attend his junior school before transferring to secondary school in September. A junior school place in Grimethorpe also appeared to be an option. A police check on mother's friend was to be actioned and child 1 would need to be visited at the friend's house. It was planned to work towards case closure but it was noted that a plan would need to be in place for when mother returned to work in terms of supervision of child 1 and the service would need to be satisfied about mother's understanding of concerns about domestic abuse.

4.47 A further CIN visit took place on 2nd June 2020 during which mother was unpacking her belongings, the move to Grimethorpe having taking place. Mother appeared annoyed at the outcome of the pre-birth assessment. She said that she had understood that the case would close for the unborn child X and child 2. When asked about her understanding of the concerns which had led to children's social care involvement she replied that she knew that what had happened shouldn't have happened and referenced the concerns about the fathers in particular father 1's use of substances. She added that both fathers were 'nice to begin with' and then 'things changed'. Mother said that father 2 would be having contact with the unborn child X, adding that he knew where she now lived although father 1 only knew the area to which she had moved. She added that she was happy that she had moved as fathers 1 and 2 wouldn't just be turning up at the house as they had done previously. Mother's alcohol use was discussed and she said that she was not going to lie and say that she would not drink. Mother agreed to ensure that she was capable of caring for the children and know when to stop drinking.

4.48 Child X was born on Saturday 6th June 2020 and she and the baby were discharged the following day. It had not been possible for the health visitor antenatal visit to be completed as the child had been born earlier than the EDD. Child X was allocated to a health visitor from the Partnership Plus team.

4.49 Midwife 2 made a home visit on Monday 8th June 2020 and no concerns were raised about the condition of the bedroom and no alcohol was seen on the premises. Mother was asked about her alcohol intake and said that she was not drinking. It was noted that mother had moved into the address within the last two to three weeks. Mother said that child X would not be co-sleeping with her.

4.50 On Tuesday 9th June 2020 a CIN meeting took place in the form of email updates. Children's social care noted that child 1 was currently staying with maternal grandparents. The primary school update indicated that this was proving a positive move for child 1, that he was enjoying staying with them and appeared more settled in class knowing that he will be dropped off and picked up by his grandparents each day. However, he told the social

worker that he missed his mother and child 2. The health visitor planned to make the new birth visit shortly. There appeared to be no update from maternity.

4.51 On Thursday 18th June 2020 health visitor 1 made a new birth visit. Mother wasn't expecting the visit as she assumed that the visit would be conducted by telephone. The home was extremely cluttered and untidy with old used cutlery and pots lying around on the table but also covering the sink and all the kitchen sides were covered with clutter. The living room was covered with toys and clutter. Mother was asked about her alcohol consumption and said she liked to have a drink at the weekend but was not drinking currently as she was breastfeeding. When the health visitor went upstairs she saw a glass of half-drunk wine, an empty wine glass and a can of cider. The moses basket was full of clutter and dirty nappies were left on the side in the bedroom. The moses basket did not appear to be being used currently which raised co-sleeping concerns. When asked if she had been drinking, mother became very flustered and said 'friends' had been round, identifying one as friend 1. Mother said that whilst child X would sleep in her bed during the day, when mother was awake, she denied that he slept in her bed overnight. During the conversation it emerged that child 2 had moved child X from where mother had left him into his bouncer chair whilst mother was upstairs. Mother said that child 2 was staying with father 2 on alternate weekends. Mother expressed concern that father 2 was living in a caravan which may not be clean and in which the toilet did not work properly.

4.52 Health visitor 1 shared the details of this visit with the duty social worker that day and via email with social worker 2 the following day and asked whether children's social care were aware that child 2 was having unsupervised contact with father 2. She also asked whether a LADO referral should be made as mother was a registered nurse and one of her children was subject to child protection planning. The duty social worker advised that children's social care were aware that mother did drink and that safe drinking levels had been addressed with her. The concerns were also escalated to the midwifery team lead. Health visitor 1 had also carried out a safe sleep risk assessment in respect of the potential increased risk around co-sleeping and alcohol use. The health visitor chronology states that the 'first part of the escalation policy' commenced.

4.53 On Friday 19th June 2020 midwife 1 made a home visit and found the house to be untidy but not unclean. The moses basket was clean and the midwife had no concerns during this visit. Mother commented that she was 'too honest for her own good'.

4.54 Also on Friday 19th June 2020 social worker 2 rang mother who said that because she had not been expecting a visit from the health visitor, she had not tidied up. She denied drinking alcohol and said that it was friend 1, who mother said was known to children's social care, who had been drinking in the house. She denied co-sleeping and also denied that there were dirty nappies in the moses basket, adding that the nappies in the moses basket were clean. Mother largely rejected the health visitor's observations and said that she didn't want the health visitor to visit anymore 'as she could be saying anything'. The social worker reinforced the co-sleeping advice given by the health visitor. Mother again said that she was 'too honest for her own good'.

4.55 The social worker was to check the file in respect of friend 1 and would visit the following week with the health visitor and said that all home visits would be joint social worker/health visitor visits.

4.56 Also on Friday 19th June 2020 the Named Midwife for Safeguarding escalated the following concerns to children's social care:

- **Home conditions** poor, cluttered; baby sleeping area '*dirty nappies and cluttered to the point where a baby was unable to sleep in the moses basket'.*
- **Possible co-sleeping/risk of overlay**: concern that mother says she isn't bed sharing with baby yet the moses basket shows signs that baby can't sleep there. I feel this leads to possible dishonesty and the risk of alcohol combined with co-sleeping is a very high risk of SIDS
- **Indications of on-going alcohol use**: concern about mother's explanation re the alcohol, as it was unlikely that one of the glasses wasn't hers given that it was her bedroom.
- **Domestic Abuse**. It is understood that mother and father 2 are separated and that father 2 had an alcohol problem. The two types of alcohol indicate a second person. If this was father 2 then there was concern that mother was not being honest about the relationship. Father 2 is known as a high-risk perpetrator in a previous relationship which included strangulation on four occasions. (The police have a record of two strangulation incidents involving different partners in 2017 and 2018 – not involving mother). Mother had been advised of Clare's Law (Domestic Violence Disclosure Scheme (DVDS)) but unclear whether she had taken this option.
- **Significant Others:** concern that mother says there were visitors in her bedroom drinking alcohol, which is very inappropriate if this is the case. Given this explanation is in the context of Covid-19, this is an additional significant factor.
- **Context of the past:** There appears to be a long history linked to domestic abuse and excessive alcohol use which led to mother being convicted of child neglect in 2008. The family composition in 2008 was unknown.

Midwifery concluded by stating that, given the past history of a child neglect conviction (there was an arrest but no conviction for child neglect) which included alcohol and domestic abuse as a trigger, concerns are heightened and it is felt that the threshold for risk of significant harm was now met.

4.57 Midwifery also asked the social worker if mother had been asked if father 2 had been staying over and whether alcohol had been drunk in the bedroom. They also asked if the case needed to be reviewed in the light of the current concerns and also asked when the next CIN meeting was due to take place.

4.58 On Sunday 21st June 2020 midwifery made a home visit and noted that child 1 was at home with mother having been in contact with another pupil who had tested positive for Covid-19. Although child 1 had tested negatively for Covid-19 test, his school had advised necessitated isolating for 14 days. Midwifery had been asked by mother whether the rest of the household also needed to isolate and they said that they would get back to her to advise. The midwife acknowledged that this could affect home visits by professionals. She advised social worker 1 of the circumstances via email.

4.59 On Monday 22nd June 2020 social worker 2 and health visitor 1 arranged a joint visit to coincide with the six week check during week commencing 20th July 2020, although it was intended to arrange a prior joint home visit during the current week but this did not take place.

4.60 On Tuesday 23rd June 2020, midwife 1 made a home visit and found child 2 and child X to be clean and dressed appropriately. Child X was alert, gaining weight and being exclusively breast fed. Child 1 was now staying at friend 1's address. Mother said she has had no advice on Covid-19 other than the text from child 1's school advising self-isolation. The family were displaying no symptoms and did not appear to be isolating with mother saying that she planned to visit her solicitor that day. The home environment had improved,

and the living room and mother's bedroom were tidy and no alcohol was visible. The moses basket appeared to have been used as sheets and a blanket were in place. The risks of co-sleeping were reinforced with mother. Mother again denied co-sleeping at night. The kitchen area was cluttered, with unwashed pots in the sink and clothes on the table but the floors were clean and there was no visible food on surfaces. Mother said that she had made an effort to remove the clutter over the weekend.

4.61 Mother had phoned the midwife in advance to ask for the time of the visit, saying that she needed to know as she was visiting her solicitor. The midwife expressed concern that mother had allowed child 1 to go to stay elsewhere against the school's advice. Mother had said that friend 1 had been drinking in the house prior to the health visitor's visit and had used two glasses.

4.62 On the same day (Tuesday 23rd June 2020) social worker 2 also made a (unannounced) home visit. Mother had been visited by a friend from University and did not consent to any concerns being discussed in her friend's presence. The social worker saw child 2, who was asleep on the sofa and child X who was in his car seat as mother said he had just come from the car. The social worker documented that home conditions were safe for the children and that there were no indications of alcohol use. Mother said that child 1 had been taken to maternal grandparents by friend 1 due to a Covid-19 'scare' at the school. The social worker said that she would call back to discuss the concerns.

4.63 Also on Tuesday 23rd June 2020 social worker 2 responded to the Named Midwife for Safeguarding's concerns in an email as follows:

- **Home conditions:**
  These had improved by the time the midwife visited on 21st June 2020 and the social worker planned to continue to visit announced and unannounced in line with CIN planning. She added that during her visits the home conditions were cluttered but not unsafe and noted that mother just moved in to the property and had a baby, hence the clutter.
- **Possible co-sleeping/risk of overlay:**
  This had been discussed with mother and would continue to be discussed with her. The moses basket was empty during the recent midwifery visit and mother states it to have items in only during the day.
- **Indications of on-going alcohol use:**
  The social worker said she shared the concerns about mother's alcohol use however this was the first time it has been observed since she was allocated the case, and mother had stated that the alcohol was not hers. This would be monitored.
- **Domestic Abuse:**
  The social worker said that individual at the property was not father 2.
- **Significant Others:**
  The social worker said that she shared this concern which would be addressed throughout CIN planning.
- **Context of the past:**
  The social worker confirmed that child 1 was in mother's care and was subject to child protection planning due to contextual safeguarding currently. Progress had been made and the child protection plan was to be reviewed.

The social worker concluded the email by saying that unannounced visits would evidence concerns and that she would keep all parties updated in line with CIN planning. The next CIN meeting was scheduled for 29th June 2020.

4.64 On the same date (23rd June 2020) the Named Midwife for Safeguarding escalated further concerns to the Designated Nurse and Children's Social Care management. In her email the Named Midwife wrote that there was a risk of drift in this case which would benefit from 'fresh eyes'. She also expressed disappointment in the response of social worker 2 to the concerns she expressed in her email of 19th June 2020 (Paragraph 4.55). She warned against false reassurance from improvements noted on more recent visits. The Named Midwife went on to express concern that mother was not self-isolating nor ensuring the self-isolation of child 1 following possible exposure to Covid-19.

4.65 The escalation email was received by a Service Manager in Children's Social Care who arranged for the matter to be discussed with social worker 2's team manager. This discussion was planned for Friday 26th June 2020 but did not take place due to action being required to address another case which involved immediate care proceedings.

4.66 On Wednesday 24th June 2020 the health visitor discussed the case in supervision. She outlined the action she had taken so far and it was agreed that the health visitor would raise the increased risk of sudden infant death syndrome (SIDS) arising from mother's alcohol use and her lack of support as a single mother at the forthcoming CIN meeting. It was documented that a CIN meeting had recently taken place but that neither the health visitor nor midwifery had been invited (Paragraph 4.50). Health visiting had been represented at the meeting but maternity had not.

4.67 On Thursday 25th June 2020 midwife 3 made an unannounced home visit. Mother had been visited by a female friend and two children and both adults and all four children were in the garden. Child 1 was said to be 'staying with relatives'. The midwife reminded mother of the Covid-19 restrictions including questioning whether it was appropriate for mother to be having friends visit when she was supposed to be isolating. The midwife described the garden as 'slightly chaotic' with toys all over the long grass. The midwife found the interior of the house to be messy and 'a chaotic house' with lots of old pots piled up in the kitchen sink and the kitchen table with lots of clothes, boxes etc. on top of it, suggesting it was not used as a kitchen table. Mother said she had only moved in a few weeks ago but it looked to the midwife as though the mess was long term mess. Child X had quite inflamed red sticky eyes and so the midwife asked her to ring the GP and the midwife arranged another visit to ensure this was done (Mother had left GP practice 1 in May 2020. It has been confirmed that she had registered with a new GP following her move to Grimethorpe. However, child X was not taken to see the GP as requested by midwife 3.). The midwife checked mother's bedroom and noticed an empty can of cider under the bed.

4.68 Midwife 3 sent an email to social worker 2 at 8.55pm the same day summarising what she had found on her visit. The social worker did not pick up the email the following day (Friday 26th June 2020) because she was out of office. Her automatic out of office reply was activated.

4.69 On Sunday 28th June 2020 the ambulance service contacted the police to notify them that they were transporting child X to hospital following suspected cardiac arrest. The police attended the hospital to find that child X had died and were told by a hospital nurse that they could smell intoxicants on mother's breath. Mother said that she had breast fed child X during the early hours of that morning and woke at around 5am to find the child lifeless.

4.70 When the police searched mother's house, they found an empty wine bottle on the bedside table at the side of mother's bed, unopened cans of cider in the fridge and the wheelie bin was 'full' of empty wine bottles and cans of lager.

5.0 Contribution of family members

5.1 At the time of writing the criminal investigation of child X's death was ongoing. Mother is a suspect and maternal grandmother is a witness and so it has not yet been possible to offer either of them the opportunity to contribute to the review.

6.0 Analysis

6.1 In this part of the report each key line of enquiry will be addressed in turn.

How effectively did practitioners respond to persistent concerns about mother's alcohol use?

6.2 Child X died whilst co-sleeping with mother who was noted to smell strongly of alcohol by a nurse at the hospital to which the child was taken after being found lifeless by mother. When the police searched mother's house following the death of child X, they found an empty wine bottle on the bedside table at the side of mother's bed, unopened cans of cider in the fridge and the wheelie bin was 'full' of empty wine bottles and cans of lager.

6.3 There were longstanding concerns about mother's use of alcohol. The primary school attended by child 1 smelled alcohol on mother's breath on many occasions during the daytime (Paragraph 4.2, 4.5 and 4.7) and it is possible that mother's drinking may have been a factor in her avoiding school and sending relatives to take and collect child 1 from school (Paragraph 4.9). There were several occasions when mother was known or suspected of being drunk whilst caring for her children (Paragraphs 4.4, 4.16 and 4.17). There were several reports of mother being adversely affected by drink which were not accepted at face value; reports from child 1 (Paragraph 4.8) could have been given more weight and this issue will be considered in more detail later in this report. The credibility of reports from father 2 (Paragraphs 4.18, 4.19 and 4.36) were affected by the fact that he was a high risk perpetrator of domestic abuse and there were indications of coercion and control in his relationship with mother. Some of his reports of mother's alcohol use appear to have been perceived by professionals as malicious attempts to apply pressure in order to exert control over her. It is possible that father 2's reports were motivated by malice whilst also being accurate.

6.4 Assessments carried out by children's social care invariably referred to mother's use of alcohol. Her use of alcohol 'to excess' was one of the concerns which justified child 1 and child 2 becoming subject to child protection planning in July 2019 (Paragraph 4.16) although by the time child 2 was stepped down to child in need support on 22nd March 2020, the assessment concluded that there was no evidence of mother using alcohol around the children (Paragraph 4.34). At that time mother may have been abstaining from alcohol as she was pregnant with child X. When the pre-birth assessment was completed in respect of child X on 31st March 2020, there was said to be no evidence to support father 2's concern that mother had been consuming alcohol excessively prior to her pregnancy with child X and he feared that she would resume excessive alcohol consumption following the baby's birth (Paragraph 4.36).

6.5 No concerns arose about mother's use of alcohol arose during the fairly substantial contact which agencies had with her during her pregnancy with child X. All the indications are that she largely or fully abstained from alcohol during this period. However, father 2's concern that mother would begin consuming alcohol again following the birth of child X

appeared to have been borne out by what was noticed by the health visitor during an unannounced visit on 17th June 2020 (Paragraph 4.51) and during a subsequent unannounced visit by midwife 3 on 25th June 2020 (Paragraph 4.67). During a child in need visit 4 days prior to the birth of child X, mother said that 'she was not going to lie and say that she would not drink (Paragraph 4.47).

6.6 It is concluded that longstanding concerns about mother's relationship with alcohol were very visible to professionals at the time that child 1 and child 2 were made subject to child protection planning in July 2019 but received much less attention at the time of the pre-birth assessment for child X eight months later (March 2020), possibly because mother abstained from alcohol during her pregnancy with child X. Although mother was not seen to be under the influence of alcohol whilst caring for the new born child X, there were indications that mother had resumed alcohol consumption which were not treated with sufficient seriousness by all partner agencies.

Was the impact of mother's alcohol use on her parenting capacity fully considered and addressed?

6.7 Most parents who drink alcohol do so in moderation, which doesn't present an increased risk of harm to their children (1). However, learning from serious case reviews about parents who misuse substances indicates that substance misuse by a parent or carer is widely recognised as one of the factors that puts children at risk of greater harm and that the most significant risk to children is that parents, when under the influence of drugs or alcohol, are unable to keep their children safe (2).

6.8 This learning from serious case reviews stresses the importance of timely and thorough assessments which contain a clear picture of the parent's alcohol consumption which is properly analysed to understand the risks that this poses to their children. This should include an assessment of parenting capacity (3).

6.9 There is no indication that any discrete assessment of mother's parenting was carried out. Had this taken place it might have been possible to more fully explore the impact of her alcohol use on her parenting capacity.

What support was offered to mother to help her address her alcohol use? Was her alcohol use seen in the context of her risk of domestic violence and abuse from partners and her anxiety and depression?

6.10 Only limited GP information has been shared with this review. However, a previous GP with whom mother was registered referred her for support in relation to her alcohol use during the period 2013-2015. The outcome of any referral(s) at that time is unknown. Mother's GP records also include a single entry relating to mental health services at the time she was arrested by the police in November 2017, but the CSPR has received no further information about this. In more recent years mother has denied problems with alcohol use when asked about it by her GP. It is not known if her GP discussed her alcohol consumption in connection with her low mood (mother was prescribed propranolol for anxiety (Paragraph 4.20)). However, there is no indication from her contact with other agencies that mother acknowledged that there was anything problematic about her alcohol use although there are strong indications that she was not always honest about the extent of her alcohol use.

6.11 There is no indication that the causes of mother alcohol use were explored with her. The child protection plan drawn up for child 1 and child 2 in July 2019 suggested that

mother may have been using alcohol to excess in order to manage her low mood and her current relationship with child 1 (Paragraph 4.16). Mother had experienced domestic abuse in her relationships with both father 1 and father 2. Domestic abuse is a leading cause of depression and anxiety among women (4) who may use alcohol to manage the resultant distressing thoughts and feelings.

6.12 Additionally, mother's marked reluctance to engage with various offers of support may have dissuaded professionals from suggesting she seek help with this issue. The July 2019 child protection plan represented a prominent opportunity to offer her support in respect of her alcohol issues but the otherwise comprehensive plan made no mention of this.

6.13 The practitioner learning event arranged to inform this review posed the question of whether professionals from the key disciplines involved in this case had sufficient knowledge of approaches to take to identify and advise people at risk from their consumption of alcohol. Government guidance for professionals who are not specialists in preventing alcohol misuse, recommends that health and social care, criminal justice and community and voluntary sector professionals should routinely carry out alcohol risk identification and deliver brief advice as an integral part of practice (5).

When concerns about co-sleeping, mother's alcohol use and her co-operation with practitioners arose in the period following the birth of Child X, how effectively were these concerns escalated and addressed?

6.14 Mother and the new born child X were discharged home on Sunday 7th June 2020 and the child died three weeks later.

6.15 The first home visit – by midwife 2 on Monday 8th June 2020 – was reassuring (Paragraph 4.49).

6.16 The second home visit – by health visitor 1 on Thursday 18th June 2020 – raised concerns about co-sleeping (moses basket full of clutter), alcohol consumption (glass of half-drunk wine, an empty wine glass and a can of cider found upstairs), lack of supervision of child X (child 2 had moved child X from where mother had left him, into his bouncer chair whilst mother was upstairs), extensive clutter and lack of cleanliness and mother's honesty (mother became very flustered when asked if she had been drinking and attributed the alcohol to 'friends' including friend 1) (Paragraph 4.51). Mother claimed that she would not use alcohol whilst breastfeeding. Following the death of child X, mother's home was searched and the presence of formula milk suggested that child X was being fed partly or wholly by formula milk (Paragraph 4.70).

6.17 During this visit the health visitor conducted a safe sleep assessment which disclosed high risk factors associated with unsafe sleeping. The safe sleep assessment, which is informed by national and international evidence of the key characteristics and risk factors associated with sudden infant death syndrome (SIDS). The sleep assessment checklist is a tool to identify vulnerability to SIDS, to promote discussion to reinforce safe sleep messages and to identify any action planning the professional and/or the parent may need to take. The safe sleep pathway is integrated with midwifery service. Key touch points for safe sleeping assessments and messages from the health visitor is at antenatal contact, the new birth contact and the 6-8-week contact. The first safe sleep assessment by health visitor 1 was undertaken at the new birth visit. The safe sleep assessment is left with parents for their reference and is retained in the personal child health record (PCHR), also known as the red book. The PCHR is a national standard health and development record given to parents

when they have a baby, holds information about the child such as vaccines and growth measurements and is maintained by the parent/carer. The PCHR is not intended to be used as the child's health record nor is it used to record personal, sensitive or safeguarding information. Historically the 0-19 Public Health Nursing Service retained the paper duplicate copy of the safe sleep assessment, but due to moving to more paperless systems and the need to mitigate potential data breaches through carrying paper information this ceased and a move towards taking a digital image of the assessment for upload to the child's electronic record was advised as good practice. However, the need to reduce the risk of cross contamination of the Covid-19 virus led to staff not handling items which cannot easily be cleaned such as the PCHR. However, in this case, health visitor 1 recorded a comprehensive account of the safe sleep assessment within child X's electronic health record, which includes a prompt to check that a safe sleep assessment has been completed. The high risk of unsafe sleeping was shared with children's social care but what became apparent at the practitioner learning event is that it is relatively rare for a health visitor to arrive at an assessment of a high risk of unsafe sleeping. Given the small number of cases which attract a high risk assessment, it was felt that these cases could be given more weight by partner agencies.

6.18 Subsequent home visits – by midwife 1 on Friday 19th June 2020 (Paragraph 4.54), Sunday 21st June 2020 (Paragraph 4.58) and Tuesday 23rd June 2020 (Paragraph 4.60) – were more reassuring in that the moses basket appeared to being used for child X and there was no sign of alcohol. However, concerns arose over mother's compliance with Covid-19 restrictions.

6.19 However, mother's management, or possibly manipulation, of home visits could have given rise to concern. In a telephone conversation with social worker 2, mother largely rejected the health visitor's concerns, implied that the health visitor had not been completely truthful and said she didn't want her to visit again (Paragraph 4.54). Mother also rang midwife 1 in advance of the Tuesday 23rd June 2020 visit to request the time of the visit (Paragraph 4.61) although this may have been for a genuine reason as she said she had an appointment with her solicitor.

6.20 There were two further home visits prior to child X's death. Social worker 2 made an unannounced visit on Tuesday 23rd June 2020 which could not be fully completed as a friend of mother was present and mother did not consent to any concerns being discussed in the friend's presence (Paragraph 4.62). Although child 2 and child X were being supported as children in need which therefore necessitated parental consent, a more assertive approach could have been adopted on this occasion.

6.21 The final home visit was conducted by midwife 3 on Thursday 25th June 2020 and documented concerns about the 'messy' and 'chaotic' house and found evidence of alcohol consumption in mother's bedroom (Paragraph 4.67). Unfortunately, children's social care did not become aware of the concerns arising from this visit until after child X's death. Although an email, setting out the concerns, was sent on the day of the visit, it went to the email address of social worker 2, who was not working that day.

6.22 When mother's home was searched following the death of child X, a clean moses basket was found by the door of mother's bedroom but was full of toys, leaving insufficient room for a baby to sleep in it.

6.23 It is concluded that concerns about co-sleeping and mother's alcohol use were well assessed by the health visitor. These and other concerns about child X were thoroughly

articulated by midwifery and appropriately escalated to children's social care and then further escalated to children's social care management. As stated below midwifery and health visiting viewed the indications of unsafe sleeping combined with mother's suspected alcohol use more seriously than did children's social care. The response to concerns about mother's co-operation with professionals could have been more consistently assertive.

Is there a formal multi-agency escalation procedure? Was the procedure invoked when risk began to escalate following the birth of Child X? If invoked, what was the outcome? Is there a common understanding of the escalation procedure across all agencies?

6.24 The Named Midwife for Safeguarding escalated a number of concerns about child X via email to social worker 2 on Friday 19th June 2020 (Paragraph 4.56). These concerns included indications of mother's on-going alcohol use, the possibility that mother was co-sleeping with child X and the risk of overlay. Having listed these and other concerns, the Named Midwife concluded by stating that it was felt that the threshold for risk of significant harm had now been met. At the practitioner learning event colleagues from children's social care expressed the view that it would have been premature to move to 'risk of significant harm' after one suspected incident of alcohol consumption which mother disputed.

6.25 Social worker 2 replied to the Named Midwife's email two working days later (Tuesday 23rd June 2020) after making an unannounced visit to mother earlier the same day (Paragraph 4.63). Her response reflected apparent improvements noted in three home visits carried out since the visit by health visitor 1 which prompted the escalation email from the Named Midwife. Two of these visits had been unannounced although, as stated, social worker 2's unannounced visit on the day she replied to the Named Midwife had been limited in part by the presence of a friend who was visiting mother.

6.26 The Named Midwife was disappointed with the response from social worker 2 and further escalated the matter to a children's social care Service Manager on the same date (Paragraph 4.64). The children's social care chronology does not include this second escalation nor does it include the details of any response. At the practitioner learning event, colleagues from children's social care said that the second escalation was received by the Service Manager who arranged for the matter to be discussed with social worker 2's team manager on Friday 26th June 2020 but this discussion did not take place due to more pressing priorities and child X died before this meeting could be rearranged.

6.27 Whilst many of the key principles necessary to resolve a professional disagreement were evident in this case, Barnsley Safeguarding Children Partnership's then Escalation Policy (for resolving professional disagreements) does not appear to have been formally invoked. This policy has since been revised and in order to identify relevant learning from the manner in which the professional disagreement was handled in this case, the revised policy will be referred to. The revised policy envisages the policy being formally invoked as this is necessary in order for the Barnsley Safeguarding Partnership Manager to be informed so that she or he is able to initiate and update the escalation tracker through which the discussions and outcomes are recorded.

6.28 The response to the first escalation by social worker 2 was rapid and was informed by an unannounced visit to mother. This was good practice. Stage One of the revised escalation policy allows five working days and only two days were taken. However, there is no indication that prior to formulating her response to the first escalation, social worker 2 consulted her Team Manager. Whilst the revised escalation policy envisages that most

disagreements can be resolved 'professional to professional', Stage One of the policy states that both practitioners should discuss the matter with their safeguarding lead/manager. Given that the escalation from the Named Midwife stated that in her opinion the threshold for risk of significant harm had now been met, it would have been appropriate for the social worker to have consulted her Team Manager.

6.29 The second escalation was initiated but not resolved. Had the revised escalation policy been invoked this would have been Stage Two of the process which again should be completed in five working days. The revised policy envisages a discussion at the next tier of management. In the event the Named Midwife escalated from social worker 2 to the Service Manager. It would have been helpful if the Service Manager had advised the Named Midwife of the action she planned to take in response to the escalation and provided timescales for a reply but there was no indication that this was done. Had the revised escalation policy been followed this could have applied a greater degree of structure into the process.

6.30 Whilst this process of escalation was underway, a further unannounced midwifery visit took place which reinforced concerns that mother may be consuming alcohol in the bedroom she shared with child X. The concerns arising from this visit were promptly shared with social worker 2 who by then was away from work until after the death of child X. There is no indication that this email was sent, or re-sent on receipt of an 'out of office' reply from social worker 2, to the duty social worker and it is not known if the email was shared with the Named Midwife for Safeguarding which would have given the latter the opportunity to include it in the ongoing escalation.

6.31 During this brief period of escalation – a period of six working days – the primary method of communication was email. Email is an entirely appropriate method of communication for escalating professional disagreements because the issues of concern are documented and there is a clear audit trail. However, email is often a less successful method of resolving professional disagreements than in-person, video conferencing or telephone communication. It could have been helpful if greater use of telephone communication had been made in addition to email in this case.

6.32 Looking back at the case, it seems clear that midwifery and health visiting viewed the indications of unsafe sleeping combined with mother's suspected alcohol use more seriously than did children's social care. This divergence of view was also apparent in the practitioner learning event. Midwifery also viewed father 2's history as a high risk domestic violence perpetrator as a further risk factor. (Further risk factors which could have been highlighted included mother's long term lack of co-operation with professionals and indications of untruthfulness and manipulation). For the health visitor and the Named Midwife for Safeguarding these factors unquestionably increased the risk of SIDS, whereas the social worker's view was that this was the first time alcohol use had been suspected since she had been allocated the case and that this issue would be monitored (Paragraph 4.63). Given mother's substantial history of alcohol use and at least one incident in which she drank to the point of incapacitation whilst caring for child 1 and child 2 – who was seven months old at that time (Paragraph 4.4), children's social care may have under estimated the risks associated with mother's use of alcohol.

6.33 In this case the escalation process could be perceived to be less like a process for resolving professional disagreements between equals and more like an appeals process in which agencies sought to appeal against the position adopted by children's social care who, because of their statutory responsibilities, retained ultimate decision making authority.

How effective was partnership working between midwifery, the Hospital Safeguarding Unit, the 0-19 Public Health Nursing Service and Children's Social Care?

6.34 Maternity notified children's social care of mother's pregnancy with child X, although there was a delay in over a month in making this notification despite the fact that mother had disclosed that her children were subject to child protection planning at the booking in appointment. Maternity notified health visiting of the correct EDD in good time.

6.35 Although invited to the pre-planning meeting held in accordance with Barnsley's Pre-Birth protocol, the BHFT chronology states that is unclear if maternity attended.

6.36 It is unclear how well sighted midwifery and health visiting were on the decisions being taken - in parallel to the pre-birth assessment for child X - in respect of child protection planning for child 1 and child 2 . The 'Health' sector was represented at the Review Child Protection Conference in March 2020 but it is unclear whether information from the child protection planning process was shared with maternity and health visiting to better inform their antenatal and postnatal care of mother and child X. It is acknowledged that information about child protection planning for child 1 and child 2 was summarised in the pre-birth assessment but this was not shared with health visiting, as was customary at that time. This review has been advised that health visiting are now provided with a copy of the pre-birth assessment.

6.37 The CIN meeting on 27th April 2020 was conducted via email updates. No email update was received from health visiting although they had yet to make contact with mother. The 0-19 Public Health Nursing Service state that the case was being worked jointly by the health visitor and the school nurse and it was the latter service which provided an email update on 31st March 2020. There is no record of this update being considered by the CIN meeting on 27th April 2020. Mother did not receive the nationally mandated visit by a health visitor at 28 weeks or later in the pregnancy (6). It is concerning that this antenatal visit did not take place in a case where the unborn child had been subject to a pre-birth assessment, his siblings were subject to child protection and child in need planning and the highest level of health visiting support – Universal Partnership Plus – was subsequently provided. The 0-19 Public Health Nursing Service state that the antenatal visit was scheduled for 8th June 2020 which was in advance of the estimated date of delivery of 24th June 2020. In the event, child X was born on 6th June 2020. However, the antenatal visit should take place from 28 weeks pregnancy. The 0-19 Public Health Nursing Service point out that there are several difficulties which can impact upon the timeliness of antenatal visits including late presentation of pregnancy, pregnancies booked outside the Barnsley midwifery service, cancelled contacts by parent who may decline the antenatal visits and house moves – which was also a factor in this case. No antenatal health visitor visit took place in a previous CSPR (Child V) although on that occasion the cause was an inaccurate EDD from maternity. In child X's case he was born prematurely but that should not have prevented the antenatal visit taking place. There is no indication that a joint visit to the family by midwifery and the health visitor between 31 and 32 weeks of the pregnancy, in line with Barnsley's Pre-Birth Assessment Pathway took place. This was an omission noted in some of the cases recently included in a multi-agency audit conducted by Barnsley Safeguarding Children Partnership. The 0-19 Public Health Nursing Service state that there is no record of midwifery contacting them to arrange the joint visit, which they state is midwifery's responsibility as lead agency during the pregnancy.

6.38 Between the date of child X's birth and his death 22 days later, there was considerable multi-agency communication and information sharing. The process by which concerns were escalated has been considered earlier in this report. The CIN meeting which took place during this period was conducted via email updates and there appeared to be no update from maternity. The health visitor update was not provided by mother's health visitor as the case was to be allocated to her shortly. Overall, information sharing was generally prompt and complete and nearly always generated a timely response from the recipient. Midwifery visits during this period were completed by three different midwives, which was not ideal, but did not appear to detract from multi-agency working.

6.39 There was no further CIN meeting scheduled until 29th June 2020, the day after child X died. No multi-agency discussion took place during the period between the birth and death of child X. As concerns escalated this would have been helpful. Social worker 2 and the health visitor intended to conduct a joint visit during the week prior to child X's death but appear to have been unable to arrange this.

6.40 It is concluded that, whilst there was much effective partnership working in this case, improvements which could have been made include the sharing of the pre-birth assessment with health visiting, a joint visit by maternity and the health visitor, the antenatal health visitor visit and consideration of a multi-agency discussion when concerns about child X began to escalate.

How comprehensive was the pre-birth assessment in respect of child X?

6.41 Barnsley Pre-Birth procedures state that young babies are particularly vulnerable to abuse, and early assessment, intervention and support work carried out during the antenatal period can help minimise any potential risk of harm (7). The procedures identify a number of risk factors which could indicate that an unborn child may be likely to suffer significant harm, and therefore justify a pre-birth assessment, many of which were present in child X's case, specifically:

- Involvement in risk activities such as substance misuse, including drugs and alcohol (mother's history of alcohol misuse);
- Victims or perpetrators of domestic abuse (the risk of domestic abuse to mother from father 2. Although they were no longer believed to be in a relationship, there was a continuing risk of domestic abuse around child contact arrangements for child 2 and child X);
- Identified as presenting a risk, or potential risk, to children, such as having committed a crime against children (Mother was arrested for a crime of child neglect against child 1 and 2 for which she was not prosecuted);
- Are known because of historical concerns such as previous neglect, other children subject to a child protection plan, subject to legal proceedings or have been removed from parental care (child 1 was subject to child protection planning and child 2 had recently been stepped down from child protection planning to child in need support);
- Recent family break up and social isolation/lack of social support (mother was a single mother who lacked family support and was said to be reliant on friends and neighbours. Her house move and Covid-19 restrictions may have further increased her isolation) (8).

The procedures point out that if there are a number of risk factors present – which there were in the unborn child X's case – then the cumulative impact may well mean an increased risk of significant harm to the child (9).

6.42 Children's social care arranged a pre-planning meeting on 11th March 2020 which maternity do not appear to have attended (Paragraph 4.31), contrary to the Pre-Birth procedures which emphasises that all agencies should be involved in the development of a safeguarding assessment (10).

6.43 The pre-birth assessment was completed on 31st March 2020 (Paragraph 4.36) well before the estimated delivery date on 24th June 2020. The assessment was generally sound although father 2's concern about what he described as mother's excessive alcohol consumption could have been further explored in the light of her history of alcohol use. Additionally, there was an assumption that because mother was able to meet the basic needs of child 2 (then aged 3 years), 'there was no evidence that this would not be the case for the unborn child'. It is concluded that this was a questionable assumption for a number of reasons:

- Until recently both child 1 and child 2 had been subject to child protection planning. Although it was appropriate to take comfort from the improvements in mother's parenting of child 2, minimal progress had been made in child protection planning for child 1, largely as a result of mother's intransigence in rejecting professional's views of the risks to which child 1 was exposed, a failure to accept personal responsibility as a parent and her unwillingness to work with professionals to reduce the risks to which child 1 was exposed.

- Mother's perception of child 1's presentation to be merely that of a 'typical boy' demonstrated a deficit in her appreciation of risk.

- Mother's insight into domestic abuse appeared limited and she had declined the support of IDAS on at least two occasions. Although she was no longer in a relationship with father 2, this could quickly change as had been the case when she became pregnant with father 2 and he would remain in close contact with her as he had regular contact with child 2.

- The concerns about her use of alcohol appear to have receded but greater weight could have been given to the fact that she had drunk alcohol to the point of incapacitation when child 2 was a baby.

- The arrival of a third child would bring pressures which could put at risk the progress achieved by mother in the parenting of child 2 and increase the risk of alcohol consumption which children's social care had previously assesses mother as using to address low mood.

How effective was the Child in Need Plan for child X and child 2 and the Child Protection Plan for child 1?

6.44 The child protection plan for child 1 and child 2 drawn up in July 2019 consisted of 17 actions which addressed a range of issues including the role of father 1 and father 2, although there is no reference to encouraging support from wider family other than the need to arrange a 'family meeting' to look at how to protect the children. In the event, attempts were made to engage the maternal grandparents in the plan which had only limited success. Mother's relationship with the children was to be assessed including her motivation to change. As previously stated there was no reference to encouraging mother to

seek help in respect of what the plan described as 'strong evidence' of mother's use of alcohol 'to excess'.

6.45 When the review child protection conference report was completed in March 2020 it was clear that whilst considerable progress had been made in respect of child 2 and that father 2 had played his part in providing support for the child when mother was working, little progress had been made in respect of child 1 whose presentation had deteriorated and the risks he was exposed to had not abated. Efforts to engage family members in formulating a safety plan for child 1 when not in school remained an outstanding action.

Was there sufficient enquiry into the role of males in the household, particularly the father of Child X and child 2, who was considered to be a high risk perpetrator of domestic violence and abuse and another male who appeared to be involved in the care of the children in the period following the birth of Child X?

6.46 The Barnsley Pre-Birth procedures stress the importance of all agencies involved in pre and post-birth assessment and support, fully considering the significant role of fathers and wider family members in the care of the baby even if the parents are not living together and, where possible, involve them in the assessment (11). This should include the father's attitude towards the pregnancy, the mother and new born child and his thoughts, feelings and expectations about becoming a parent.

6.47 Father 2's attitude to mother's pregnancy appeared quite hostile, initially arguing for a termination and questioning the wisdom of adding a third child to a family in which the two existing children were known to children's social care. He was consulted as part of the pre-birth assessment and as stated earlier, expressed concern about the risk of mother resuming her excessive use of alcohol once the baby was born. Mother said that father 2 would be having contact with the new born child X although she perceived a benefit of her house move just before the birth of child X as preventing father 1 and father 2 'just turning up' at the house as they had previously (Paragraph 4.47).

6.48 As previously stated, maternity were particularly worried about the presence of father 2 in the lives of child 2 and child X and were concerned that mother did not appear to have availed herself of the opportunity to find out about his violent history through the Domestic Violence Disclosure Scheme (DVDS) (Paragraph 4.56). In response to these concerns, social worker 2 pointed out that mother was currently being supported in the household by friend 1 as opposed to father 2. The police have confirmed that they have no record of an application under the DVDS from mother but point out that agencies should not advise domestic abuse victims to make application, but should do so on their behalf.

6.49 This brings us on to friend 1 about whom there was insufficient enquiry, particularly as one child in the household was subject to child protection planning. The Barnsley Pre-Birth procedures refers to the significant role that the father and wider family members can play in caring for the new born baby but doesn't mention the role of friends. This may have been a factor in the lack of curiosity about the role of friend 1.

6.50 A police check on friend 1 was to have been actioned when child 1 was to stay with him so that he could continue to attend his primary school after mother moved home to Grimethorpe (Paragraph 4.46). However, the police check did not take place because child 1 stayed with his maternal grandparents instead.

6.51 Friend 1 appeared to have a pivotal role in the concerns about mother's alcohol consumption following the birth of child X. Mother attributed the two wine glasses and the can of cider found by the health visitor on 17th June 2020 (Paragraph 4.51) to 'friends', including friend 1. There appears to have been no attempt to verify mother's account by speaking to friend 1. Social worker 2 was to check mother's file for information about friend 1, who had supported her following the birth of child 2, but this did not appear to have been actioned prior to the death of child X. This review has received no further information about friend 1's history.

6.52 It is concluded that agencies had a satisfactory knowledge of the role of father 2 in the life of child 2 but were unsighted on whether mother had sufficient knowledge of father 2's history as a high risk perpetrator of domestic violence. The role of friend 1 was insufficiently explored which is an important omission in this case.

Did restrictions imposed as a result of Covid-19 impact in any way on measures necessary to safeguard Child X?

6.53 The restrictions imposed as a result of Covid-19 have had a profound effect on the delivery of in-person services. Child X was born during the first UK 'lockdown' which was not substantially eased until 4th July 2020, which was after the child's death. However, to their credit, professionals from a range of disciplines managed to make home visits and gain access to the family home during this period, although there were some doorstep visits. The home visit by health visitor 1 on 18th June 2020 which highlighted a number of concerns about unsafe sleeping demonstrates the importance of in-person visits and the importance of making appropriate judgements about which families require in-person visits based on vulnerability and risk.

6.54 Multi-agency meetings were adversely affected. In this early stage of the pandemic - prior to the extensive use of video conferencing technology - meetings were held via email updates which obviously limited the opportunity for the exploration of views through discussion.

6.55 Mother appeared to regularly flout Covid-19 restrictions (Paragraphs 4.58, 4.60, 4.62 and 4.67). She was given advice about this by professionals and her lax approach to Covid-19 risks was raised in both of the maternity escalations of concerns to children's social care (Paragraphs 4.56 and 4.64). Her approach to the risks to herself and her children from Covid-19 could have been linked to mother's attitude to other risks, such as the risks to child 1, and her willingness to accept professional advice.

Is the learning from this LSCPR consistent with the learning from the National Panel Review of Sudden Unexpected Death in Infancy?

6.56 This case has many of the features of the cases considered by the National Child Safeguarding Practice Review Panel's review 'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm' (12), hereinafter referred to as 'the SUDI review'. These cases represented one of the largest groups of cases notified to the National Panel and involve parents co-sleeping in unsafe sleep environments with infants, often when the parent had consumed alcohol or drugs. Additionally, there were wider safeguarding concerns – often involving cumulative neglect, domestic violence, parental mental health concerns and substance misuse. The National Panel concluded that whilst there was no evidence to suggest that advice on

reducing the risk of SUDI had not been routinely given, this advice was not clearly received or acted upon by some of those families most at risk.

6.57 Whilst the case of child X has many of the features of those considered by the SUDI review, the key difference is that mother is a registered nurse. Although her area of specialism is nursing older people, she would have been familiar with the general principle of evidence based advice to prevent adverse health outcomes and would have been accustomed to interacting with health professionals. There is a single reference to mother having been 'diagnosed with a learning disability whilst studying to be a nurse at University' in 2015 in the pre-birth assessment.

6.58 However, despite her professional background and training, mother appeared resistant to professional intervention in her life and did not adopt a collaborative approach to working with agencies. When concerns arose about co-sleeping accompanied by suspicions that mother was using alcohol, mother responded defensively with a focus on managing visits to her home by professionals in order to present her parenting of child X in the best possible light, rather than addressing concerns raised by professionals and complying with safe sleeping advice. Additionally her professional background gave mother a knowledge of how agencies worked which may have helped her to manipulate professionals.

6.59 The SUDI review arrived at the following three conclusions:

- Professionals needed to obtain a better understanding of parental perspectives in order to develop a supportive yet challenging relationship which facilitates more effective safer sleep conversations.
- Work to reduce SUDI needs to be embedded in multi-agency working and not just seen as the responsibility of health professionals.
- The use of behavioural insights and models of behaviour change to support interventions to promote safe sleeping need to be explored.

6.60 Applying these conclusions to the case of child X, mother's reluctance to engage with professionals restricted the understanding of her perspective. The review has received no indication that a parenting assessment was completed. With hindsight, this could have been valuable had she been willing to fully engage. This case also indicates that there is further work to be done to embed work to reduce SUDI in multi-agency working. As stated there did not appear to be a shared appreciation of the increased risk of SUDI in this case across midwifery, health visiting and children's social care. In particular the latter service did not appear to give sufficient weight to the 'high' risk of co-sleeping assessed by the health visitor.

6.61 One further point is that the analysis of cases by the SUDI review identified a category of risk they referred to as 'situational risks and out-of-routine incidents' which included factors such as temporary housing, change of partner, altered sleeping arrangements and alcohol or drug use on the night in question. Whilst there is strong evidence of alcohol use on the night in question, it is also worth considering the impact of the recent house move on sleeping arrangements. Moving house in the late stages of pregnancy as a single parent seems likely to have been quite challenging for mother, who appeared to struggle to properly unpack and organise her new household following the move with the moses basket intended for child X seen to be 'full of clutter' (Paragraph 4.51). Discussing how mother could have prioritised organising the house to meet the needs of the children and the support she might need to accomplish this, might have been a valuable conversation to have had.

The 'voice' of child 1

6.62 This was not an issue this review was initially asked to consider but, looking back at the case, there is learning for agencies from how concerns reported by child 1 were responded to.

6.63 He not infrequently reported incidents of domestic abuse to the police, sometimes independently and also when asked to do so by his mother (Paragraphs 4.2 and 4.13). He raised concerns about his mother's alcohol consumption (Paragraphs 4.7 and 4.8) and found himself caring for his sister when his mother was unable to do so through alcohol consumption (Paragraph 4.4). Child 1 was not always believed by professionals (Paragraph 4.8) and mother often contradicted her son's account, on one occasion saying that he 'always tells lies' (Paragraph 4.13).

6.64 It is unclear to what extent professionals fully explored child 1's lived experience. He was noted to be upset by incidents of domestic abuse (Paragraph 4.12, 4.22). He began to take knives and a screwdriver to bed with him (Paragraph 4.33) which may have been connected to his fear of domestic violence. He also began to carry weapons with him in the community. He disclosed physical abuse by his mother which on one occasion was treated as 'over-chastisement' (Paragraph 4.15), he experienced long term parental neglect, specifically being left to fend for himself in the community when his mother was working during the evenings, arriving for school very early and without a coat during the winter months. There were concerns about mother's attachment to him and she asked for him to be removed from her care on more than one occasion (Paragraph 4.16). She appears to have deliberately made herself unavailable for calls from school about him (Paragraph 4.30).

6.65 Opportunities to explore child 1's concerns were sometimes overlooked (Paragraph 4.17, 4.22), partner agencies did not always take action necessary to safeguard him (Paragraph 4.17), he was said to have worries that he was unable to speak about (Paragraph 4.27) and mother was unwilling to consent to a referral to CAMHS (Paragraph 4.34) in which it may have been possible for those worries to be explored.

6.66 His presentation at school had caused concern for a number of years and continued to deteriorate. Whilst it is acknowledged that much positive work was completed with child 1 within his school environment by the schools he attended, Early Help and children's social care, attendees at the practitioner learning event felt that opportunistic encounters with child 1 were handled much less effectively than planned work with the child.

6.67 Looking back, child 1 comes across as a resourceful boy who demonstrated considerable maturity in seeking assistance from services when he and his sister were at risk from his mother's alcohol use and from her partners' domestic violence and abuse. Looking back, he was probably a more reliable witness to events than his mother, but was often not regarded as such.

Good practice

6.68 Mother had not been attending ante-natal appointments which led midwifery to refer her to Grimethorpe Family Centre for ante-natal care, which she began attending from in January 2020 (Paragraph 4.21)

6.69 On 31st January 2020 midwifery responded to the police notification of the 4th January 2020 incident by issuing an instruction that direct questions about domestic abuse should be asked when mother attended appointments, which was actioned (Paragraph 4.22).

6.70 When mother attended hospital after experiencing bleeding on 16th March 2020, direct questions were asked about domestic violence. Although mother disclosed no incidents and said that she did not feel unsafe, an opportunistic DASH risk assessment was completed which identified a 'medium' risk which was increased to 'high' following a conversation with the Named Midwife for Safeguarding. This led to a MARAC referral (Paragraph 4.24).

6.71 Health visitor 1 clearly identified child X to be at high risk of SUDI and promptly escalated her concerns to children's social care and shared them with midwifery. She also informed her manager and undertook case supervision

6.72 The detailed articulation of concerns about child X by midwifery and the escalation of those concerns to children's social care was good practice as was the speed which social worker 2 responded to the escalation.

7.0 Findings and Recommendations

7.1 This is a tragic case in which child X died at the age of three weeks after being overlayed by mother who fell asleep whilst apparently breastfeeding the baby. There is evidence that mother had consumed alcohol before falling asleep. The risks to child X arising from concerns that mother may be co-sleeping with him and using alcohol had been recognised by partner agencies. However, there was a difference of professional view over the level of risk to which child x was exposed. Attempts were being made to informally escalate and resolve this professional disagreement at the time of child X's death.

Mother's alcohol use

7.2 There were longstanding concerns about mother's relationship with alcohol including being under the influence of alcohol whilst caring for her children and on at least one occasion drinking to the point of incapacitation whilst caring for a very young child. These concerns were very visible to professionals at the time that child 1 and child 2 were made subject to child protection planning in July 2019 but received much less attention at the time of the pre-birth assessment for child X eight months later (March 2020), possibly because mother abstained from alcohol during her pregnancy with child X.

7.3 There is little evidence that mother was encouraged to seek support in respect of her alcohol use. Although professionals asked her about her alcohol use and challenged her about her use of alcohol when caring for her children, it could have been helpful for the professionals from a range of disciplines she came into contact with to have greater knowledge of approaches to take to identify problematic alcohol use and give advice to people who are placing themselves and/or others at risk as a result of their alcohol use.

7.4 It is therefore recommended that the Safeguarding Children Partnership promotes the empowering of health, social care, criminal justice, community and voluntary sector professionals with knowledge of alcohol risk identification and the ability to deliver brief advice as an integral part of their practice.

Recommendation 1

That Barnsley Safeguarding Children Partnership promotes the empowering of appropriate staff within health, social care, criminal justice, community and voluntary sector professionals with knowledge of alcohol risk identification and the ability to deliver brief advice to those whose alcohol use is problematic as an integral part of their practice.

Safe Sleep Risk Assessments

7.5 The health visitor carried out a safe sleep assessment which disclosed a high risk of unsafe sleeping. Although the high risk of unsafe sleeping was appropriately shared with children's social care, the relative rarity of an assessment of high risk of unsafe sleeping indicates that this small number of cases could be given more weight by children's social care.

7.6 It is therefore recommended that the Safeguarding Children Partnership seeks assurance that where the risk of unsafe sleeping is assessed as high this is given appropriate weight in decision making about the child concerned.

Recommendation 2

That Barnsley Safeguarding Children Partnership seeks assurance from children's social care that where the risk of unsafe sleeping is assessed as high by the 0-19 Public Health Nursing Service, this is given appropriate weight in decision making about the child concerned.

7.7 The 0-19 Public Health Nursing Service intends to obtain assurance that safe sleep assessments are being undertaken by health visitors and action plans initiated where risks are identified and that this is recorded in the child's electronic health record. To this end, the 0-19 Public Health Nursing Service will be internally auditing SystmOne electronic health records.

Escalation Policy (for resolving professional disagreements)

7.8 Although a significant professional disagreement arose in this case, the principles of the then Barnsley Safeguarding Children Partnership Escalation Policy were followed to an extent. The initial attempt to resolve the disagreement was handled well at a practitioner to practitioner level, although there is no indication that line managers were consulted at this stage, as advised by the Partnership's revised Escalation Policy. When the disagreement was not resolved at the first practitioner to practitioner stage, it was escalated to senior management and appeared to lose impetus at that stage, although child X died before matters could be concluded. The revised Escalation Policy includes a clearer process and a means for monitoring discussions and outcomes which could have prevented this loss of impetus. Additionally it was notable that the majority of communication in the escalation process was by email and at no stage did a telephone conversation or multi- agency discussion take place.

7.9 Whilst the revised Escalation Policy appears sound, it may need to be further promoted so that it is formally invoked when required. Additionally the Policy should extoll the benefits of discussion between people as an alternative to over-reliance on electronic communication. It is therefore recommended that the Safeguarding Children Partnership further promote the revised Escalation Policy and reminds professionals of the benefits of talking through disagreements.

Recommendation 3

That Barnsley Safeguarding Children Partnership further promotes the revised Escalation Policy (for resolving professional disagreements) and reminds professionals of the benefits of talking through disagreements in an effort to resolve them.

7.10 The significant home visit by midwife 3 on Thursday 25th June 2020 was overlooked by decision makers because it was emailed to social worker 2 who was away from work for the rest of the week. It is recommended that the Safeguarding Children Partnership seeks assurance from Barnsley Hospital NHS Foundation Trust that where urgent safeguarding concerns arise they are emailed to the duty social work inbox in addition to the social worker in the case and that the Trust has a system for oversight of urgent safeguarding concerns sent to children's social care from individual midwives.

Recommendation 4

That Barnsley Safeguarding Children Partnership seeks assurance from Barnsley Hospital NHS Foundation Trust that where urgent safeguarding concerns are identified by midwifery they are communicated to the duty social worker in addition to the social worker in the case and that the Trust has a system for oversight of urgent safeguarding concerns sent to children's social care from individual midwives.

Partnership working

7.11 There are a number of improvements which could have been made to partnership working between midwifery, the 0-19 Public Health Nursing Service and children's social care in this case. It was not standard practice for children's social care to share the pre-birth assessment with the 0-19 Public Health Nursing Service at that time, although the review has been advised that this is now done as a matter of course. Mother did not receive the nationally mandated antenatal health visitor visit. The premature delivery of child X reduced the window for this visit to take place but that should not have prevented the visit, particularly as this was a case in which the siblings of child X were subject to child protection and child in need planning.

7.12 It is therefore recommended that the Safeguarding Children Partnership seeks assurance that pre-birth assessments are now routinely shared with the 0-19 Public Health Nursing Service by children's social care and that the 0-19 Public Health Nursing Service schedule antenatal visits in sufficient time to ensure they take place.

Recommendation 5

That Barnsley Safeguarding Children Partnership seeks assurance in that pre-birth assessments are now routinely shared with the 0-19 Public Health Nursing Service by children's social care.

Recommendation 6

That Barnsley Safeguarding Children Partnership seeks assurance that the 0-19 Public Health Nursing Service schedule antenatal visits in sufficient time to ensure they take place.

Pre-Birth Assessments

7.13 The pre-birth assessment in this case contained an assumption that because mother had (only recently) demonstrated that she was able to meet the basic needs of child 2, there was no evidence that this would not be the case for the unborn child X. Paragraph 6.38 sets out the grounds on which that assumption was open to challenge.

7.14 It is therefore recommended that the Safeguarding Children Partnership seeks assurance from children's social care that pre-birth assessments do not contain overly optimistic assumptions.

Recommendation 7

That Barnsley Safeguarding Children Partnership seeks assurance from children's social care that pre-birth assessments do not contain overly optimistic assumptions.

Pre-birth procedures: the role of friends

7.15 The Barnsley Pre-Birth Procedures stress the importance of fully considering the role of fathers and wider family members. The procedures make no reference to the role of friends. In this case friend 1 appears to have played a significant and not altogether positive role in supporting mother following the birth of child X, which appears to have been largely overlooked. It is therefore recommended that the Safeguarding Children Partnership amends the Pre-Birth Procedures to ensure that the role friends as well as fathers and wider family members is considered.

Recommendation 8

That Barnsley Safeguarding Children Partnership amends the Pre-Birth Procedures to advise professionals to consider the role friends as well as fathers and wider family members.

The extent to which the voice of child 1 was listened to.

7.16 Looking back at this case, child 1 comes across as a resourceful boy who demonstrated considerable maturity in seeking assistance from services when he and his sister were at risk from his mother's alcohol use and from her partners' domestic violence and abuse. Despite his young age, he was probably a more reliable witness to events than his mother on several occasions, but was often not regarded as such.

7.17 When the learning from this case is disseminated, it is recommended that the Safeguarding Children Partnership highlights the missed opportunities to listen to child 1's voice and better understand his lived experience.

Recommendation 9

That Barnsley Safeguarding Children Partnership highlights the missed opportunities to listen to child 1's voice and better understand his lived experience.

The National Panel's SUDI Review

7.18 The SUDI review arrived at the following three conclusions:

- Professionals need to obtain a better understanding of parental perspectives in order to develop a supportive yet challenging relationship which facilitates more effective safer sleep conversations.

- Work to reduce SUDI needs to be embedded in multi-agency working and not just seen as the responsibility of health professionals.
- The use of behavioural insights and models of behaviour change to support interventions to promote safe sleeping need to be explored.

7.19 The case of child X indicates that there is further work to be done to embed work to reduce SUDI within multi-agency working. As stated earlier, there did not appear to be a shared appreciation of the increased risk of SUDI in this case across midwifery, health visiting and children's social care. In particular the latter service did not appear to give sufficient weight to the 'high' risk of unsafe sleeping assessed by the health visitor.

7.20 One further point is that the analysis of cases by the SUDI review identified a category of risk the report referred to as 'situational risks and out-of-routine incidents' which included factors such as temporary housing and altered sleeping arrangements. The impact of mother's recent house move on sleeping arrangements could have been given greater consideration in assessing risk and offering support to mother in this case.

7.21 It is therefore recommended that the Safeguarding Children Partnership highlights 'situational risks and out-of-routine incidents' in assessing the risk of SIDS and considering the support needs of new born children and their parents. The CSPR has been advised that a steering group has been established and that training has been provided to social workers in respect of the findings of the national SUDI review and safe sleeping generally.

Recommendation 10

That Barnsley Safeguarding Children Partnership highlights 'situational risks and out-of-routine incidents' in assessing the risk of SIDS and considering the support needs of new born children and their parents.

Domestic Violence Disclosure Scheme

7.22 Partner agencies expressed concern that mother did not appear to have availed herself of the opportunity to find out about father 2's history as a high risk domestic violence perpetrator through the Domestic Violence Disclosure Scheme (DVDS). The police have pointed out that agencies should not advise domestic abuse victims to make application to the DVDS scheme, but should do so on their behalf.

7.23 The Safeguarding Children Partnership may wish to draw this learning to the attention of the Safer Barnsley Partnership so that they can remind professionals accordingly.

Recommendation 11

That Barnsley Safeguarding Children Partnership informs the Safer Barnsley Partnership of the learning from this case that professional awareness of the need to make application to the DVDS scheme on behalf of victims of domestic abuse may need to be enhanced.

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(10) ibid

(11) ibid

(12) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

Appendix A

Process by which the CSPR was conducted

It was decided to adopt a broadly systems approach to conducting this CSPR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Agency reports and chronologies which described and analysed relevant contacts with child X and his family were completed by the following agencies:

- Barnsley Children's Services
- Barnsley Early Start and Families Service

- Barnsley Hospital NHS Foundation Trust
- Barnsley Public Health Nursing Service
- GP Practice
- South Yorkshire Police

The independent reviewer analysed the chronologies and identified issues to explore with practitioners and managers at learning events facilitated by the lead reviewer.

At the time of writing it had not been possible to offer child X's family the opportunity to contribute to the review as a result of the ongoing criminal investigation into the circumstances of child X's death.

The independent reviewer then developed a draft report to reflect the agency reports, chronologies and the contributions of practitioners and managers who had attended the learning event. The report was further developed into a final version and presented to Barnsley Safeguarding Children Partnership.