Sandwell Safeguarding Children Board

Serious Case Review

Child KS

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Lead Reviewer: Mick Brims

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Section One – Introduction

1.1 What this review is about

This serious case review concerns a child known, for the purpose of this review, as KS. The brief circumstances of this case are as follows:

Baby KS was born in April 2017, the second of twins. 8 weeks after the twins were born, both babies were fed and put down to sleep together in a Moses basket in their mother's bedroom. KS's mother (F1) went to bed 4 hours later. S1 (KS's twin) woke at 4am and was taken downstairs for a feed then put back in the Moses basket. F1 then fed KS at 6.30am in bed. At this time KS was reported to be fine and smiling. S1 woke again and was taken downstairs by F1's partner, M1. After the feed, F1 placed KS in bed next to her (on their side) with their head on a pillow and they both fell asleep. There was a light blanket over them and a king-sized quilt folded under the sheet on top of the mattress.

F1 was woken by a telephone call at 1.15pm and found KS still in bed lying on their back, blue and not breathing. Following attempts by M1 to resuscitate KS, they were transferred to Sandwell Hospital Emergency Department by ambulance and sadly declared deceased. A post mortem later stated KS's exact cause of death was *"inconclusive".* M1 and F1 later provided positive drug tests to the police. F1 and M1 were arrested. A police investigation has concluded with no further action.

Sandwell Safeguarding Children Board (SSCB) agreed this case met the criteria laid down in Working Together to Safeguard Children 2015 for a serious case review to be conducted.

The Independent Chair of SSCB agreed with a recommendation of the Serious Case Review Panel that this case should be the subject of a serious case review; under the requirements of the Local Safeguarding Boards Regulations 2006, section 5(1) (e) and (2).

The statutory basis for conducting a serious case review (SCR) and the role and function of a Local Safeguarding Children Board is set out in law by: *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*.

Regulation 5 requires the Local Safeguarding Children Board (LSCB) to undertake a review where –

(a) abuse or neglect of a child is known or suspected; and
(b) either –

(i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Guidance for Local Safeguarding Children Boards (LSCBs) conducting a serious case review (SCR) is contained in Chapter 4 of *Working Together to Safeguard Children 2015*. This version of Working Together was used when deciding upon the serious case review process, as it was the most current at the time decisions were taken around the review process (it was published in March 2015).

The purpose of this serious case review is to establish the role of services and their effectiveness in the care of KS, whether information was fully shared by the professionals

involved and child protection procedures were appropriately followed. This process ensures that any deficiencies in services can be identified and lessons learned, to minimise the risk to other children or young people.

1.2 How this review was conducted

1.2.1 The Review Panel

The author of this report was Stephen Ashley who has extensive experience in the compilation of high-level reports into child protection issues, having been a senior police officer for thirty years and worked for Her Majesty's Inspectorate of Constabulary. He has conducted several serious case reviews and is the independent chair of two safeguarding children boards. The lead reviewer was Mick Brims who is a qualified social worker and has extensive experience in children's social care across a number of areas.

The author and lead reviewer are independent of Sandwell Safeguarding Children Board in accordance with *Working Together to Safeguard Children 2015* chapter 4 (10*).*

In addition, a review panel was established. Meetings were held at regular intervals and the panel was consulted about the progress of the review and provided further information where appropriate. The panel included a senior manager from each of the key agencies.

The Sandwell Safeguarding Children Board (SSCB) business unit supported the panel.

1.2.2 The Terms of Reference

This SCR has been conducted using a methodology adapted to suit the circumstances of this review and is described in more detail in the next section. The methodology established how well systems have worked, and where they can be improved. It is not a criminal or disciplinary review designed to attach blame to individuals. The methodology is based on the 'Welsh Model'[1]

This review looks at the period from August 2015 until the point of KS's death. This period was selected following a Serious Case Review Panel meeting and is of a sufficient range to include all of the key episodes of engagement that KS had with agencies in Sandwell. Whilst this period was the basis for the review, contextual and relevant information falling outside of this period was also included.

The review was conducted in a way which:

- Recognised the complex circumstances in which professionals work together to safeguard children;
- sought to understand precisely who did what, and the underlying reasons that led individuals and organisations to act as they did;
- sought to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- was transparent in the way data is collected and analysed;
- made use of relevant research and case evidence to inform the findings.

[1]**The 'Welsh Model'** - This process consists of several inter-relate parts: Multi-Agency professional Forums to examine case practice, Concise Reviews in order to identify learning for future practice, and an extended review which involves an additional level of scrutiny of the work of the statutory agencies.

Agencies that are involved in child safeguarding are required to follow the statutory guidance laid down by government. The guidance is called *Working Together to Safeguard Children*. It contains all the processes that agencies are required to follow. Working Together has been through several iterations. This review benchmarks against the statutory guidance contained in *Working Together to Safeguard Children 2015*[2]. This is the version that professionals would be working to during the timeframe of this case.

The review worked to terms of reference agreed with the Chair of the SSCB and contained at Appendix A. The terms of reference proposed 5 'lines of enquiry' that are dealt with in Section Five.

The author took full cognisance of the third annual report of the national panel of independent experts on serious case reviews that was published in November 2016.

1.3 Methodology

The methodology agreed by the Sandwell Safeguarding Children Board (SSCB) review panel is based on a model consistent with the requirements of *Working Together to Safeguard Children 2015*. It ensures that:

- A proportionate approach is taken to the SCR;
- it is independently led;
- professionals who were directly involved with the case are fully engaged with the review process;
- families are invited to contribute.

This methodology is based on the Welsh model.

1.3.1 Chronologies and Management Reports

Agencies were asked to compile a report detailing their contacts with the individual involved in this case, resulting in a combined chronology of events. In addition, each agency was asked to highlight areas of concern and good practice. Where appropriate, an action plan, detailing those areas for improvement, and the work being undertaken to address those issues, was included. All the agencies that were asked for a report provided the information requested. In cases where further clarification was required, agencies responded in an open and honest way.

In some cases, where contact with the subjects was minimal, agencies were only asked to provide a chronology. In addition, interviews with front-line staff and managers took place.

1.3.2 Practitioners' Event

The practitioners' event with front-line practitioners is an essential part of the process. In the practitioners' event front-line staff that had had contact with KS and family were brought together for discussions around themes that had been identified from the chronologies and reports. This engagement provided a view of their engagement with KS that enriched the information provided by agencies and ensured that all the relevant facts were recorded. It

[2] ***Working Together to Safeguard Children March 2015*** - https://www.gov.uk/government/.../working-together-to-safeguard-children--2

was the most effective way of triangulating the evidence and ensuring that an accurate picture of KS and the traumatic events is provided.

This review seeks to determine **why** events occurred and not just record the facts of **what** happened. The front-line view is invaluable in achieving this.

Whilst the details of discussions that took place were recorded, the comments made by the staff involved were non-attributable and their comments are not quoted directly in this report.

1.3.3 Family Engagement

A criminal investigation was taking place at the time of this review and as a result there was no direct engagement with the family. Findings of this review are shared with family members prior to publication and they are given an opportunity to comment.

1.3.4 Parallel investigations

Throughout the period covering the review there was a police investigation taking place. This investigation has now concluded with no further action.

1.4 How this report has been structured

Following the introduction, Section Two provides the story of what happened to KS. There is a description of KS and family and then the detail of what happened to KS over the timeframe agreed within the terms of reference.

Section Three analyses the significant issues exposed in Section Two and explains **WHAT** happened and **WHY**. From this analysis, the key themes are discussed in Section Four. Section Five contains the key lines of enquiry raised by the Serious Case Review Panel and Section Six, the key findings. The recommendations in Section Seven have been developed from these findings taking account of the work carried out by agencies since these events occurred. There is a conclusion at Section Eight.

This report has been written so that it can be read by the public without redaction. As a result, the names of the main subjects are not used and there are no dates that might readily identify KS or the family.

In this report, the following initials represent the main subjects:

- KS – the baby who is the subject of the review
- F1 – mother of KS
- M1 - partner of F1
- M2 – biological father of KS and S1
- S1 – sibling - KS's twin
- S2 – half sibling
- S3 – half sibling
- S4 – half sibling
- S5 – half sibling
- S6 – half sibling

Section Two – The Story of KS

2.1 Introduction

This section sets out the facts in this case. It begins with a description of KS's family circumstances and the environment they were born in to.

2.2 The background

This section will provide a background history of the family describing their personal circumstances.

F1 had 7 children including KS and twin. F1 has been in a relationship with M1 for more than 20 years and he is the father of S2, S3, S4, S5 and S6. M2 is the father of KS and S1 and is a relative of M1. When the relationship with M2 finished in 2016, M1 resumed his relationship with F1. At the time of KS's death, M1 lived with F1 for about half of the week and spent the rest of the week at his mother's home. They later described their relationship as being: *"friends with benefits".*

F1 has a long history of drug abuse but stated she had been 'clean' for between 18 months and 2 years prior to the death of KS. F1, M1 and M2 have a significant history of criminal convictions, although F1 has not had a conviction since 2008. None of the family have any known health issues. Following the birth of each of her children, F1 was monitored by Sandwell Children's Social Care (SCSC). S2, S3 and S4 have never lived solely with their mother. S2 lived with relatives and S3 was the subject of a child protection plan and care proceedings that resulted in a residency order to relatives. S4 has lived with a relative from birth.

Information supplied by agencies present a picture of F1 that indicates the concerns over her care for children were justified. F1 had, by her own admission, been a long-term abuser of opiate drugs and also used cocaine and cannabis. F1 also had a record of failing to attend appointments. F1 missed 34 GP appointments in a 3-year period and there were periods of engagement punctuated by periods of no engagement with services. This was a family who were of concern to agencies and yet records demonstrate that little action took place when appointments were missed.

In mid 2015, a child in need (CIN) plan[3] relating to S5 & S6 commenced. Concerns were held that F1 may have been using drugs and neglecting S5 and S6, although a single assessment did not identify significant risk of harm at that time, instead recommending that a child in need plan be put in place to ensure the children's needs.

Concerns about non-attendance at appointments for the children continued throughout the period the CIN plan was in place, although when the CIN plan closed, it appeared that there had been improvement in this regard. Financial issues were also noted, however over time evidence grew of regular repayments regarding housing issues. F1 remained engaged with a family support worker throughout 2015 although, at the final CIN review in November 2015, there was mention of some appointments again being missed. The CIN plan was closed in November 2015 despite the fact that F1 continued to miss key health appointments for the children often appeared in crisis, with problems relating to debt management still evident.

[3] **Child In Need Plan -** A Child in Need Plan (also known as a Child's Plan) should be drawn up for children who are not Looked After but are identified as **Children in Need** who requiring services to meet their needs. It should be completed following an **Assessment** where services are identified as necessary.

At an unknown point in 2016, F1 began a relationship with M2 who had been released from prison in late 2015. There were a number of reports to the police of domestic violence incidents involving the couple. It is understood that M1 may have been in prison at the time the relationship between F1 and M2 commenced and it is also believed M1 and M2 are related.

In mid-2016, there had been a serious house fire at F1's home and as a result she had been required to vacate the premises while it was restored. F1 resided with her mother for several months whilst work took place and she moved back to her home by the end of 2016 (some sources suggest F1 and family returned at the end of summer 2016, others suggest this occurred by Christmas 2016).

In June 2016 F1 attended her GP complaining of asthma. The GP did not take this opportunity to challenge F1 about her previous history of failing to attend appointments. In July 2016 the school nurse had made attempts to contact F1 regarding S4 and S5 but, while messages were left, she received no response from F1. Throughout the summer period of 2016 both F1 and M2 had been to their GP reporting mental health issues.

At some point in 2016 F1 ended her relationship with M2 and resumed the relationship with M1. This followed at least two reported domestic abuse incidents between F1 and M2.

During the summer of 2016, it is clear that F1 was in crisis. There had been a number of reports of domestic abuse involving her and M2, she had had a termination and her home had been gutted by a fire. F1's relationship had broken down with M2 and she had resumed a relationship with M1. F1 had reported having *"suicidal thoughts"*.

2.3 The facts of this case

2.3.1 Phase one – Pre-birth engagement

In October 2016 F1 was pregnant with KS and S1. At the time she provided a positive pregnancy test she believed she was between 4 and 5 months pregnant. F1 was a 'late booker', however she stated to the Community Midwifery Service that she *"did not know"* she was pregnant. Further exploration of this at the practitioner's event suggested that F1 had shared a range of reasons for late presentation, stating that she had: "*had babies before";* and other factors such as "*being busy", "ill" or "having to do the school run".* F1 said these issues had prevented her coming in to book in her pregnancy with the Community Midwifery Service.

F1 was seen by a midwife and disclosed some of her previous history. Whilst this history was not complete, it did include the fact that F1 had previously used methadone. The midwife was also aware of domestic abuse issues and submitted a 'cause for concern' form which was shared with midwifery services, the GP and the safeguarding midwife. The safeguarding midwife made a referral to SCSC to obtain more information. At the beginning of November 2016, M1 attended F1's address and an altercation took place. The police attended but no offences were disclosed and M1 left. Domestic violence notifications were made to all relevant partners including SCSC and health care professionals. Black Country Women's Aid (BCWA) were contacted to offer F1 support, however were unable to contact F1. BCWA have stated that F1 has never engaged with their service around domestic abuse.

In mid-November 2016 F1 missed the first of her ante-natal midwifery appointments. Between this point and the end of March 2017 F1 missed at least 7 midwifery appointments. When F1 missed her first appointment a follow up letter was sent, and the midwife chased up the appointment and booked another appointment for F1.

At the end of November 2016 SCSC provided the midwife with further information about the domestic violence incident that had occurred. They stated that Women's Aid were to be informed but, since none of the children had witnessed the incident, there would be no further action by SCSC. The email received by the midwife from SCSC also stated that they were aware of *"historical"* issues, but there were no current concerns. The midwife was advised to complete a Multi-agency Referral Form (MARF) if she had any further concerns.

In mid-December 2016, SCSC reported to the midwife that M2 had informed his probation officer that F1 was back on drugs and a referral took place. SCSC stated to the midwife that they had conducted an *"assessment"* and F1 had informed them she was not using drugs. They also stated that they had spoken to the school attended by F1's other children and no concerns were raised. As a result, they were taking no further action and considered this to be a malicious referral. It is unclear whether the assessment referred to by SCSC was a formal process such as a MASH assessment or single assessment (no evidence of this has been located) and it is not clear whether this engagement with education professionals and the midwife constituted a formal child protection meeting in terms of a strategy meeting or Section 47 investigation.

At this point, professionals had sufficient information about F1 and her history to raise their concerns. F1 had a history of domestic abuse and drug use and had previously been unable to look after her children. During her pregnancy to this point, F1 had missed several ante-natal appointments and an ex-partner had reported she was using drugs within 6 months of the pregnancy being reported. There had been 3 recent (non-crime) domestic call outs between September and November 2017, some related to M1 being out of prison and presenting as upset that F1 was in a relationship with M2. Events during the early part of her pregnancy raised concerns with the allocated midwife. By the end of December 2016, taking into account both family history and recent events, there were sufficient grounds for SCSC to initiate a pre-birth assessment. Sandwell would be expected to follow pre-birth procedures as outlined in the *West Midlands Safeguarding Procedures*[4]*.*

In mid-January 2017, F1 missed 2 further midwifery appointments. As a result, the midwife instigated a 'call and report' protocol and went in person to F1's home. The midwife made this visit in late January 2017. It took 2 further visits before she was able to see F1 at home. At the practitioners' event, the midwife reported that F1 did not give her any real cause for concern and F1 was open with the midwife in explaining that with her previous pregnancies she had been using opiates and she wanted: *"to do things properly this time".* The midwife made an appointment for F1 to attend for a scan a week later. F1 failed to attend her next 2 appointments and, as a result, a second 'call and report' visit took place at the end of February.

In mid-March 2017 the midwife again attended F1's home and discussed safe sleeping with her. It was noted that F1 was a smoker but did not want to stop. The GP reviewed F1's case on 15 March when F1 failed to attend an ante-natal appointment. It was noted that the midwife made checks with other health partners and established that F1 had missed numerous appointments including those for scans. An appointment was made for F1 to attend for an urgent scan and it was agreed there should be a MARF submitted and a further 'call and report' visit. Several attempts to visit F1 were made over the next 3 days without success and F1 failed to attend for her scan. On 21 March 2017 the midwife submitted a MARF.

On 27 March 2017 the referral from midwifery was assessed by the Multi-agency Safeguarding Hub (MASH)[5]. This was 6 days after the form had been submitted which is, in itself, a concern. The MASH noted that Health services had engaged with F1 in February and

[4] **West Midlands Safeguarding Procedures -** http://westmidlands.procedures.org.uk/ykpqq/statutory-child-protection-procedures/assessment

[5] **Multi-agency Safeguarding Hub (MASH) –** a multi-agency team responsible for assessing referrals regarding child protection and deciding appropriate action

March 2017. They concluded that she may have missed appointments because of a house fire (this had occurred in mid- 2016 and F1 and her family are understood to have returned to the house by December 2016 at the latest). The MASH took the decision that health services would provide support to F1 on a universal services basis going forward. Health services could consider completing an early help assessment (EHA) if future concerns arose. This was an inappropriate response given the history of F1 and her children and the evidence of concern provided by midwifery in the MARF.

As noted elsewhere, the MASH Assessment of 27 March 2017 cites feedback from the health visitor that she had seen the family recently and had no concerns about the home environment or preparation for the arrival of the twins. It is noted in the MASH Assessment that: *"Mother reports she moved out of the home for a short while to reside with her mother due to a fire. This may be why she has missed appointments however mother does have a history of not attending appointments".* The source of this information in the MASH Assessment is not explicitly clear, however this appears to be from the health visitor.

The conversation between the MASH and the health visitor is significant as it appears to have influenced MASH decision-making. There may have been some misunderstanding in the MASH as to the health visitor's feedback regarding this family. When the health visitor spoke to the midwife the next day she stated that she had spoken to the MASH team the previous day. She informed them that she had seen F1 at home and not identified any concerns and, further, that the home environment was good and F1 was reported to be attending the twin clinic. The health visitor noted that she did not appreciate, when she spoke to the MASH on 27 March, the level of missed ante-natal appointments and that this was an ongoing concern. However, this suggests that the MASH assessment gave greater weight to the health visitor's positive comments (made before she was aware of the ante-natal non-engagement concerns) over the midwife's written MARF outlining several months of ante-natal non-attendance.

The health visitor also noted to the midwife that she had previously seen F1 at her own mother's address, prior to the house fire (in 2016). The health visitor passed on F1's mother's address. The reviewers understand this to mean that the health visitor gave the midwife this address as another possible place to try and find F1, not that the house fire was relevant to current concerns in any way.

On 30 March 2017, the community midwife visited F1, who stated that she had been unwell and that was why she had missed appointments. The midwife reported that F1 presented well and had no problems. The midwife referred F1 to the hospital for a further scan.

Throughout the remainder of March 2017, a further 4 appointments were missed or F1 did not respond to calls.

In a Hospital interview on 3 April 2017, staff were concerned about F1's lengthy recent history of non-attendance at hospital and midwifery appointments. As a result, a further MARF referral was made to SCSC by the hospital around these issues, however they did not speak to community midwifery before submitting the MARF form.

Finally, a further MARF was sent by the hospital on 6 April 2017, noting concern that the case had been closed despite the history of concern regarding non-attendance at ante-natal appointments. As with contact made on 3 April 2017, SCSC informed the referrer that the MASH had considered these concerns, as they were similar to those sent in the first MARF on 21 March 2017, and that no further action would be taken at this time; with health services to follow up.

The failure by the MASH to consider the MARFs in the light of all the available evidence provided and to predominantly rely heavily upon (and misinterpret) the feedback of one

professional resulted in poor decision making and an increase of risk for KS and S1. This issue is analysed in detail at Section 3.3.

2.3.2 Phase two – April 2017 to June 2017

In April 2017 F1 gave birth to twins KS and S1. F1 received a primary visit by the health visitor. The health visitor established that F1 was generally well but fed up with her ex-partner (M2) who she was no longer in a relationship with. The health visitor noted that M2 was: *"bombarding her with text messages and calls".* F1 reported that M2 had had no contact with her during her pregnancy but had attended the hospital and abused F1 in front of patients and staff and threatened to assault her. F1 reported that M1 was going to support her and the children for at least 6 weeks, but he was presently at work. Health advice was given including the importance of getting rest. Smoking cessation advice and risks to babies were discussed as F1 and M1 both smoked and had no desire to give up. Safe sleeping was also discussed and F1 reported to be sleeping on the settee because her bedroom was being decorated. A Moses basket was seen downstairs which was in good condition, with clean linen. F1 was informed by the health visitor that as soon as the Moses basket went upstairs she would review the upstairs bedroom. The living room was reported to be tidy and at an appropriate temperature. The health visitor said she would conduct a review in one week. The health professionals involved in the review were satisfied that the discharge from hospital was appropriate and proportionate.

The midwife at the hospital had also made a referral to SCSC following the birth of KS and S1. This was based on the fact that M2 had attended the ward and threatened F1 and was escorted out of the hospital by security personnel.

Later in April 2017, the health visitor met a social worker by chance outside F1's home prior to a visit being conducted. The social worker stated that a Single Agency Assessment had been carried out and there were currently no concerns. They were considering Early Help[6].

A further two visits took place and in late April 2017 community midwifery discharged the twin's case to the health visiting service.

In early May 2017, a health visitor conducted a follow up visit. F1 and all 4 children were present at the house. F1 stated she did not go to a wedding as she was too tired and her physical and emotional wellbeing were discussed. F1 disclosed that she had changed her mobile number and the text messages and calls from M2 had ceased, although M2 had confronted her in public whilst she was in a queue and was verbally abusive to her. This altercation occurred the previous week and there had been no further incidents since. KS was dressed in a white baby grow and cardigan, was alert and had good tone and colour. KS was taking 3.5 ounces of formula and feeding at least every 4 hours. S1 was reported to be a very long thin baby, dressed in white baby grow. S1 was alert and of good colour and tone. S1 was taking 3.5 ounces of formula every 3 hours and was not left for longer than 4 hours at night. The living room was reported to be tidy.

On 15 May 2017, the health visitor spoke to a social worker by phone. The social worker stated that SCSC were happy with the care the twins were receiving and have no further concerns. They believed that F1 had taken appropriate actions to safeguard the children and so the case was closed.

[6] **Early Help -** Providing early help is more effective in promoting the welfare of children than reacting later. Early help means providing support as soon as a problem emerges, at any point in a child's life, from the foundation years through to the teenage years.

On 16 May 2017 the single assessment was completed. F1 had stated to social workers that she was not aware that M2 was still using drugs and denied advising the hospital midwife she thought M2 was: *"going to hit her".* F1 stated she did not intend to allow any further contact between M2 and KS and S1 until he changed his behaviour. The single assessment states that there had been a further incident whereby M2 had verbally abused F1. F1 also stated she had told M2 he should arrange a DNA test on KS and S1. M1 was now living with F1 most of the time. One of the children had told the social worker that F1 had "*smacked [them] in the face"* when they were naughty and M1 had shouted at them. F1 denied the allegations stating there were current concerns with the child being untruthful. It was the social worker's opinion that F1 was genuine. Observations of KS and S1, including F1's care of them, had raised no concerns. The case was closed to SCSC the following day.

An analysis of the assessment process conducted at this point is contained at section 3.5 below.

In early June 2017, a 6-week check was made by the health visitor. F1 was reported to be well, happy and that she was: *"clean at present".* F1 stated to the health visitor that she would not take drugs again. F1 said that although she smokes she does this outside and away from the children. A postnatal depression and NICE questionnaire was undertaken and F1 stated she felt she had recovered from the birth. M2 had not contacted or approached her. S1 was seen and was appropriately dressed, smiling and looking around. S1 weighed 6lb 10oz and plotted below 0.4 centile. KS was dressed in a baby grow and made lots of eye contact and was looking around. KS was stated to take 5oz formula regularly and would sleep for 6 hours through the night. KS weighed 6lb 8oz. F1 stated KS liked to be in a cot with S1. The living room was tidy with a clothes airer in the corner of the room with washed clothes on. F1 reported that she would be getting support from family and friends. As a result F1 would now receive universal services, as it was considered there were no further concerns to warrant additional intervention.

F1 stated to the police that the night before KS died, at approximately 10pm, KS and S1 were fed and put together in a Moses basket in F1's bedroom. F1 and M1 watched a film and had a meal and went to bed at approximately 2am. S1 woke at 4am and was fed. F1 fed KS in her bed at approximately 6.30am and then fell asleep. M1 took S1 and the other children downstairs and went to sleep. F1 woke up at 1.15pm and found KS unresponsive. KS was taken to hospital and was declared deceased.

A post mortem was conducted which concluded that KS was a small baby who showed signs of dehydration consistent with the fact that they had been suffering from diarrhoea prior to their death. The pathologist found no evidence of overlay and could not ascertain a cause of death but was able to state that there was no suspicion of non-natural causes of death. The cause of death is stated as *"Unascertained SUDI* [Sudden Unexplained Death in Infancy]*."*

The police interviewed both F1 and M1 and initiated a criminal investigation having established that both F1 and M1 had tested positive for opiates, cannabis and cocaine. This police investigation has concluded with no further action.

Section Three – Analysis of Significant Issues

3.1 Significant Issue One

There was a significant family history of agency engagement in this case which should have alerted professionals to potential risks to KS and siblings and resulted in more structured protection and support.

There is a considerable history of agency involvement with F1 and her children over a number of years. F1 had a number police records regarding recorded crimes committed by her (although none since 2008), and there are a number of records regarding F1 being a victim of domestic abuse together with a history of drug abuse and mental health issues.

Regarding the children:

- S2 and S3 have always resided in the care of relatives. When S2 was born, F1 resided in the home with relatives and was involved in S2's care for some time, until her heroin use caused concern in 1998;
- S3 also lived with relatives soon after birth, and S3 was subject to care proceedings with a residency order to live with relatives;
- S4 went to reside in the care of a relative from a young age, after an assessment by SCSC;
- prior to the scoping period for this serious case review, S5 and S6, who were in the care of F1 at the time of KS's death, had previously been subject to child protection plans and a child in need plan due to parental drug use and neglect concerns.

In addition to the involvement of services with F1's children, information provided suggests that F1 has had several additional pregnancies that were not carried to term. Sadly, F1 is known to have had a miscarriage, a reported miscarriage, a possible miscarriage and four terminations of pregnancy in addition to the birth of 5 children over a 20-year period between the mid-1990s and 2016.

Taking into account F1's experiences of pregnancy and motherhood, she is likely to have been managing many periods of substantial grief and loss, when pregnancies have not progressed to term, or when, due to statutory intervention, her children have gone into the care of her extended family.

F1 gave birth to her first child at approximately 17 years old and appears to have had documented issues with substance misuse soon after – the first available information to the reviewers indicating concerns were highlighted in 1998 regarding heroin use. This suggests that F1 had, in many ways, had to manage experiences of ongoing loss as a parent whilst also going through periods of drug use combined with possible periods of abstinence from drugs for up to 20 years. The emotional impact of these losses as a parent must have had a significant impact on F1's psychological well-being. Furthermore, whilst acknowledging disguised compliance concerns in this review, it must be remembered that F1 and M1 are likely to have had little trust in many partner agencies; not only had they suffered the loss of children but both had significant involvement with criminal justice services.

The degree of engagement summarised above is further exacerbated when looking at the detail of the contacts over that 20-year period.

When S5 was born, despite being placed on a pre-birth child protection plan a few weeks before birth (due to concerns about domestic abuse, drug misuse and neglect), this child remained in the care of F1, with the child protection plan ceasing in November 2010.

A pre-birth single assessment was completed during S6's pregnancy due to F1 not engaging with ante-natal care. Whilst this assessment is well before the scoping period of this review, the reviewer notes that: *"case was closed due to both parents complying with methadone programme and engaging with CAF [Common Assessment Framework]"* (now known as Team Around the Family (TAF)) process]. The outcome of this single assessment was that the case was 'stepped down' to the Early Help Service to work with F1 and M1 under the CAF

framework. The health visitor at this time had no concerns for the children's development and described the family as well presented and well-nourished. In 2013 the Early Help Service referred the case back to SCSC due to: *"F1 not engaging; the police raising concerns regarding the state of the property; lack of food in the house; and empty methadone bottles accessible to the children".* A single assessment was completed, however concerns were not substantiated and F1 was noted to have *"abstained from drugs"*. The outcome of this single assessment was *"universal services to monitor"*.

Further referrals were received in 2015. The first anonymous referral initially raising concerns that F1 was using drugs (crack cocaine and alcohol) and *"leaving the children"*. A further referral was then received from a family friend raising concerns that S6 had been left in the care of an adult friend who had been drinking alcohol. The outcome of the subsequent single assessment was for a child in need plan to commence; this plan was open for several months to November 2015.

The plan seems to have had a degree of success. The minutes of the last CIN review in November 2015 suggests substantial progress by F1 in engaging with IRIS (substance misuse service) to commence and eventually complete a methadone reduction program. IRIS noted that whilst *"contact was sporadic"* a *"planned reduction from substitute prescribing was completed"*. This is significant, as in addition to being a real achievement, F1 appears to reference her abstinence from substances in future contact with professionals from this time onward. The CIN review also noted improvements in F1's ability to set boundaries with the children, better management of family finances/outstanding debts, improved conditions within the family home and that S5 was now attending school regularly. It is of note however that F1 refused any after care support from IRIS and November 2015 is the last recorded contact between F1 and IRIS.

It is also significant that at the time that the multi-agency network and F1 agreed that the CIN plan should cease, S6's school attendance was at approximately 65%, although there is reference to S6 spending some days in hospital and subsequent days at home, which may have lowered the attendance rate in what was the first term of that school year. The CIN review minutes also focus on the work and achievements of F1 in improving outcomes for the children without any real mention or focus on the role of M1 in the parenting of S5 and S6.

Despite all of these historical issues, F1 had cared for S5 and S6 since their birth until the death of their sibling KS. S5 and S6 did spend a period of time subject to child protection plans **(**between December 2009 and October 2010) due to ongoing concerns about drug misuse by F1 and M1, domestic violence and neglect.

In 2016, F1 entered into a relationship with M2; her long-term partner (and father of all children to this point) M1 having received a custodial prison sentence. A succession of domestic abuse referrals were made in late 2016, when it became apparent that M1 had been released from prison and was concerned that F1 may have been in a relationship with M2.

In October 2016, F1 attended an appointment with the midwifery service for a 'late booking' whilst 4-5 months pregnant. Information supplied suggests that a cause for concern form was sent to SCSC to obtain information as to previous SCSC involvement with the family – it was clarified by the community midwife at the practitioners' event that unless there is a specific 'obstetrics' issue, then midwives have to access family history via SCSC. It is unclear what information was shared with midwifery at that time.

So throughout 2016, there were concerns as to missed health appointments for S5 and S6, concerns about domestic abuse and potential mental health concerns for F1, who on one occasion was reported, in a 111 call by another person, to be feeling suicidal whilst suffering abdominal pain and bleeding. It was noted by health services that F1 had had a recent

termination and that these symptoms – a potential further miscarriage - were not followed up and engagement at that time could have led to a potentially helpful assessment of F1's emotional well-being.

As noted elsewhere, between September and November 2016, there were a range of non-crime domestic incidents coinciding with M1's release from prison and concern about F1 being in a relationship with M2. The last of these incidents occurred shortly after the booking appointment noted above. Community midwifery sent in a further 'cause for concern' form to SCSC, which according to file information led to no further action at that time.

An anonymous referral was received by SCSC in December 2016 that F1 was using drugs. SCSC information notes that in December 2016: "*enquiries by MASH concluded - no concern. No further action taken"*.

Additional information later in December 2016 indicated that SCSC contacted community midwifery, noting a recent referral after M2 told his probation officer that F1 was: *"back on drugs"*. Midwifery were informed by SCSC that they had carried out an assessment, F1 denied drug use and no concerns raised by school regarding F1's children. SCSC indicated that they would be taking no further action, believing this to be a malicious referral and were told to submit a MARF if there were any further concerns. As noted above, this information does not appear to have been recorded within a formal contact process, such as a MASH assessment.

This was a family with a significant history of engagement with agencies. The use of a child in need plan in 2015 demonstrated that agencies were able to support F1 to create positive change for her and her children in a positive way when a meaningful plan was put in place. When the CIN plan was closed at the end of 2015 there were no further child protection interventions and all support thereafter was provided as part of universal services. There were numerous opportunities to put in place more formal support once F1 became pregnant with KS and S1.

Ultimately, a number of professionals were engaged with the family from a number of agencies. When F1 became pregnant with the twins in 2016 they should have pooled their knowledge of the family to develop a support programme. There was no record of a child safeguarding multi-agency meeting conducted by the hospital. It is common practice in many hospital trusts for the lead safeguarding nurse to conduct a monthly meeting where all pre-birth cases that have been a cause of concern are discussed. It would be usual for children's services to attend this meeting along with the full range of health providers. It would also be useful for drug and alcohol and mental health service providers to attend. In some cases this meeting is chaired by the safeguarding lead from the Clinical Commissioning Group. A meeting of this type would have ensured that all elements of health services were aware of this family and provided SCSC with better information.

Professionals described how at Russells Hall Hospital, Dudley, an 'Unborn Baby Network' meeting has just been established that fulfils this function. It should be considered as a potential model by health services in Sandwell.

This review concludes that:

Insufficient work was conducted to ensure that all of the professionals working with F1 and her family were aware of the full history of drug abuse, missed appointments and potential child neglect that had been apparent over the previous 20 years. Whilst family history is not the only predictor of future risk, in this case it would have provided professionals with a good indication of likely future risks to F1's children. Services had previously provided periods of support that had proved successful. When F1

became pregnant with KS and S1, professionals should have shared all of the information they had, initially via the MASH process, and provided a comprehensive support package.

3.2 Significant Issue Two

F1 had a history of failing to attend appointments for herself and her children. Agencies did not fully consider the implications of these continued missed appointments.

F1 had a history of failing to attend appointments over a number of years which had, on a previous occasion, resulted in a child in need plan to provide her with support.

However, F1 continued to miss appointments and the list below shows the extent to which she avoided contact with professionals during the pregnancies of KS and S1:

- **February 2016** – S6 discharged from a health service due to 3 missed appointments;
- **June/July 2016** – School Nursing made several attempts to contact F1 by telephone without success;
- **August 2016** – S6 missed immunisation appointments with GP;
- **October 2016** – S6 missed immunisations appointment with GP;
- **November 2016** - S6 missed immunisations appointment with GP;
- **November 2016** – S6 again not taken for vaccination (despite mother attending GP just six days earlier when unwell herself);
- **November 2016 –** Did not attend (DNA) – Community Midwife (CMW) Appointment;
- **January 2017 -** DNA – CMW appointment (two records);
- **January 2017** - Call and report visit by CMW to home address due to repeated DNAs. Partner answered said mother was out and would not be back until late afternoon, CMW stated she would return tomorrow and the partner stated mother would be in all day;
- **January 2017** - Home visit made CMW – no reply;
- **February 2017** DNA – CMW appointment (two records);
- **February 2017** Call and report carried out due to repeated DNA, mother advised to attend appointments;
- **March 2017** DNA – CMW;
- **March 2017** - Call and report carried out by CMW – No answer, unable to contact via phone (two records);
- **March 2017** - Call and report carried out by CMW – No answer, unable to contact via phone. Both upstairs and downstairs windows open;
- **March 2017** - Call and report carried out by CMW – No answer, unable to contact via phone (two records);
- **March 2017** - DNA – CMW appointment.

This list represents a significant and sustained pattern of avoiding ante-natal care. There are also patterns in the way F1 explains these missed appointments. On a number of occasions, F1 stated this was due to family illness and some professionals and F1 linked the problem with the house fire the family had suffered in 2016.

At the practitioner's event the community midwife was clear that there was concern amongst midwives around the number of appointments that were being missed. Community Midwifery Service had a policy whereby 3 missed appointments resulted in 'contact and report' visit to the home address and a MARF to SCSC.

In response, 3 multi-agency referral forms (MARF) were submitted by health professionals between 21 March 2017 and early April 2017.

SCSC received a MARF on 21 March 2017 from the community midwife raising concerns about F1's attendance at her ante-natal appointments. Considering the previous family history, she considered a referral was required. The referral went to the Multi-agency Safeguarding Hub (MASH). The MASH checks revealed that F1 had been seen in February and March 2017 by health professionals and that there was a house fire which could have been the cause of the missed appointments. It is noted that the house fire had occurred 10 months earlier. The MASH established that information provided by school and other health professionals was positive and there was no evidence of any current concerns in relation to drugs. MASH agreed a single agency follow up by health services and stated health services could consider an early help assessment if further concerns arose.

On 28 March 2017 the community midwife (CMW) was informed by a health visitor that the MASH had made contact with the health visitor who informed them she had visited F1 in February and March and there were no concerns. When the issue about the missed appointments was raised and the concerns that hospital appointments for scans had also been missed, the health visitor acknowledged she had not been aware of this concern prior to giving feedback to the MASH. The CMW contacted MASH regarding the MARF referral and was informed that no further action was being taken and that the health visitor was going to contact F1 to ensure she attends all of her appointments.

On 30 March 2017 the CMW made another home visit and discussed the missed appointments with F1. F1 reported that she had been unwell. The importance of attending appointments was discussed and the CMW arranged for F1 to be seen the next day at hospital for a scan and to be seen by a consultant.

In February 2017 a home visit was carried out by the CMW. When asked about missed appointments F1 stated she had been to a hospital appointment. There was no evidence she had attended.

In summary:

- Between 16 November 2016 and 29 March 2017, F1 did not attend 7 offered midwifery appointments;
- F1 did not actually successfully attend any midwifery appointment at ante-natal clinic Whilst she missed 7 appointments, there were no additional appointments that she attended at the clinic after the initial booking appointment in October 2016;
- community midwifery managed to see F1 on 3 out of a further 9 'call and report' visits carried out by the Community Midwifery Service as concerns about the lack of attendance at ante-natal appointments grew;
- it is clear from the information provided that at some of these call and report visits there was some concern about avoidance, including one visit where there was no answer despite open windows (upstairs and downstairs). F1 would often state that she was unwell and consequently did not attend;
- during this pregnancy, F1 did not attend 5 appointments at Hospital for ante-natal scans or attend consultant's appointments;
- F1 did attend hospital a few days prior to delivery when concern was held that the twins were quite small and that one twin was: *"severely growth restricted".* Inducement was planned a few days thereafter.

When F1 was found to be pregnant with twins, it may have been anticipated that any significant level of missed appointments, in conjunction with a previous history of similar concerns, would be sufficient to trigger a single assessment and potentially a strategy meeting. Health visitors had gained sufficient access to conclude they were not concerned (prior to learning of the non-engagement issues) and SCSC decided that the missed appointments did not warrant further action. This was despite the fact they had received 3 MARFs from health professionals. Midwives invoked their 'call and report' procedure, but when they raised further concerns were reassured by SCSC that there was no requirement for further formal child protection procedures to be considered.

F1 had also missed appointments with the GP over time and there had been several missed appointments for immunisations for S6. The surgery could have considered calling a multi-agency meeting given the F1's history of non-attendance.

This review considers that professionals in children's social care and health failed to properly review the issue of missed appointments and recognise this as a potential indicator of neglect. When midwives raised the issue as a risk with children's social care, their views were not properly considered.

3.3 Significant Issue Three

F1 had a history of not attending appointments, drug use and being subjected to domestic abuse. SCSC had used formal child protection procedures to protect F1's first 3 children. In October 2016, when F1 was 4-5 months pregnant, SCSC should have considered a pre-birth single assessment and strategy meeting.

This review has already considered issues relating to non-attendance at meetings, a significant family history of potential neglect, domestic abuse and drug use by F1.

In October 2016 F1 had presented as 4 to 5 months pregnant. This late booking was, in itself, an issue of concern and the midwife made a referral to SCSC based on F1's admissions around her previous drug taking. The referral provided the opportunity to hold a strategy meeting and invoke pre-birth procedures. In March and April 2017, 3 further MARFs were submitted which again provided an opportunity for intervention. The first of these MARFs is the most significant and is analysed below:

The first MARF was submitted by Community Midwifery to SCSC on 21 March 2017. At this time, 6 scheduled appointments with the community midwife had been missed by F1. A further 8 'call and report' home visits had been made by the community midwife due to non-attendance at appointments, with a successful unannounced home visit occurring only once, in February 2017.

At the practitioners' event, the community midwifery noted that there is a policy in place of referring cases to SCSC if they are unable to access a mother after the third missed appointment; community midwifery agreed that the MARF to SCSC could have been sent at an earlier stage.

The MARF clearly referenced:

- Previous concerns re: substance misuse, domestic abuse and housing issues;
- recent domestic abuse in late 2016 and M2's claim in December 2016 that F1 was using drugs;

- that F1 was 35 weeks pregnant with twins, had not been accessing ante-natal care with community midwifery, hospital scans or consultant appointments;
- in addition to difficulties seeing F1 and appointments at home or at hospital, community midwifery are unable to reach F1 by phone;
- concern that F1 may not be prioritising the health and well-being of the unborn children.

In response to this MARF, the MASH worker attempted to contact F1, however, was unsuccessful in doing so on 23 and 24 March 2017. It is noted that this may be an example of the difficulties other professionals were having in engaging with F1. Thus, the case was put out to MASH partners (consent overridden) for multi-agency information gathering. The reviewers note a timeliness issue at this point – the MARF was dated 21 March 2017, however attempts to contact F1 were not made until 48 and 72 hours thereafter. With a weekend in between, the decision to 'MASH' the case with multi-agency partners in effect took 6 days (4 working days). This is well outside of accepted MASH timescales to make initial decisions on 'referrals' (24hours) and the reason for this delay is not referenced in the MASH decision. Given that this MARF arrived just a few weeks before the child's birth in April 2017, this delay could have been crucial in terms of available planning and intervention time.

The MASH information responses from partner agencies are crucial and raise varying levels of concern for the welfare of the unborn children. Police noted that there had been 4 domestic abuse reports between 2010 and 2016 (presumably including the three acknowledged reports in late 2016 as outlined above) and F1's criminal history (no convictions since 2008). Police recommended: *"Single Assessment. There have been previous DV, CA (child abuse) and drug issues, however the concerns are now (F1's) lack of antenatal care and the effect this may have on the unborn children".*

The SCSC MASH worker provided a detailed case history but did not provide a recommendation. The Early Help Service however indicated that the case should be passed on for single assessment: *"There are concerns that mother is expecting twins therefore it is a riskier pregnancy yet she is still not attending ante-natal appointments. The health and wellbeing of the twins is at risk. Mother has also done this with previous pregnancies. There is a history of non-engagement, DV, drugs and neglect. It needs to be ascertained what is happening within the family environment, how the children are being looked after, if their medical needs are being met and if mother is prepared for the babies. SA recommended."*

Education did not explicitly recommend an assessment, noting that: *"MASH discussion is required due to the family history, but that F1 appears to be managing the needs of S5 and S6 and getting them to school. Education does not however [note] that ..this could be hampered when the twins arrive so mum's parenting ability may need assessing".*

Housing noted that there had been a report of anti-social behaviour in September 2016 where concerns regarding: *"nightly drop offs to property and reports of the smell of weed coming from the property, F1 is not attending ante-natal appointments and what the effect may be on the unborn twins if F1 is using drugs again, and recommends that 'appropriate assessment to be undertaken"*. The probation service also recommended the same action.

Health noted concerns about F1's lack of engagement with ante-natal services given the expected twins, however goes on to state: *"However, the health visitor information was very positive"*. Details of this health visitor feedback are not included in the multi-agency section of the MASH Assessment document. This health visitor intervention appears to have had considerable weight in the final MASH decision.

The reviewers understand that a 'MASH discussion' may have then taken place, with the MASH decision being recorded afterward. No details of this discussion are available. The MASH decision is brief given the extensive case history and imminent birth of twins. Despite

these issues, the decision states that: *"MASH feel the positives currently outweigh the negatives".*

The MASH decision goes on to note that F1 was seen by the health visitor in February and March 2017 and no concerns noted regarding drug misuse and that health would monitor concerns about smoking. The MASH decision goes on to state that F1: *"moved out of home for a short while due to a house fire and that this may be why she missed appointments, although there is a history of missed appointments."*

The MASH decision notes that the health visitor reports that F1 is prepared for the twins and has no concerns about the family property, that Education have not expressed concerns for the children and that Housing report rent arrears that F1 is paying off. The MASH decision also states that police note no criminal activity for F1 since 2008 and that whilst there had been recent domestic abuse incidents, F1 was not in a relationship with the suspect. What is not outlined is that the health visitor gave the positive feedback before she was aware of the midwifery concerns regarding non-attendance at ante-natal appointments. It is also noted that at least one of the non-crime domestic incidents involved M1 coming to the home to seek out M2, out of concern that he was in a relationship with F1.

The final decision is that: *"MASH agree single agency to support mother and consider EHA if required, Health to visit mother again and advise she attend all hospital appointments. MASH health rep to action."*

The reviewers acknowledge that this MASH decision appears to be the agreed multi-agency approach to this case from a MASH discussion. However, based on what is recorded in the decision itself, the reviewers note the following issues:

Professional Over-Optimism

Despite the range of potential concerns outlined by agencies (at least prior to a MASH discussion) with regards to family history, potential impact of non-engagement with ante-natal appointments and previous history of missed appointments, the final MASH decision does not address why or how these identified risks are mitigated. Furthermore, the MASH decision does not directly mention community midwifery or address the specific concerns raised in the MARF around the pattern of non-attendance at ante-natal appointments over the previous 3-4 months. Instead, the decision seems to select the positive aspects of agency feedback (e.g. no criminal involvement with F1 for 9 years; no education concerns raised by the school) without providing a rationale for how initial concerns held by the same MASH partner agencies may have been alleviated in a subsequent MASH discussion.

The MASH decision does not provide a clear rationale as to why a single assessment will not be completed here, whether all partner agencies have come to agree with the position that a single assessment is not completed and, if there were dissenting views, why these were overruled. Finally, the MASH decision also seems to attach considerable weight to the positive feedback of the health visitor, which are not recorded in the decision record.

In this case, there was clear evidence of professional over optimism. In some cases professionals need to understand how to ask difficult questions.

Disguised Compliance

The MASH decision does not locate the decision to essentially signpost this case to Health services within the context of family history and previous documented instances of F1's non-attendance at ante-natal appointments and non-engagement with services. The MASH itself was unable to make contact with F1 during the MASH process, potentially an example of F1's

previous pattern of engagement with professionals and current pattern of non-engagement with the Community Midwifery Service.

The possibility of disguised compliance is also not directly referenced in the MASH decision. Key potential characteristics of this behaviour, such as avoidance of appointments or professionals, allowing access to one professional over another and avoidance of contact with professionals by phone, were not located within the context of possible disguised compliance. Finally, a house fire is mentioned as a potential reason for missing appointments that is accepted by the MASH service, however file information suggests that this fire occurred approximately 10 months prior to the MARF on 21 March 2017 and that F1 and the children were back in the family home by the end of 2016 at the latest. How this house fire came for part of the MASH decision is referenced elsewhere in this document.

Early Help Assessment

Bearing in mind these issues, no rationale is given as to why an early help assessment (EHA) would not have been immediately completed as health services had already expressed concern for the welfare of the children in future. Given that the Early Help Service had indicated in MASH feedback that in its last period of engagement with this family (in 2013), when the episode was closed due to non-engagement with the TAF process, it is surprising that the EHA was not undertaken immediately.

Health Visiting Feedback

The feedback noted in the MASH decision, that the health visitor had gained access to F1's home in February and March 2017, is given significant weight, although detail of this feedback is not recorded in the MASH assessment at any point. To the reviewers, it would appear that this feedback has been given greater precedence than the information provided by of the community midwife, who at this point had attempted to access F1 at 7 scheduled appointments and a further 9 unscheduled 'call and report' home visits. In addition, there were missed appointments at the hospital for F1 and the unborn twins. No rationale is provided in the MASH decision as to why the health visitors input has allayed concerns to the point where a single assessment may not be required.

As noted above, it seems that this health visiting feedback was been given to the MASH before the health visitor was aware of the non-attendance concerns raised by midwifery. This has significant ramifications, given that the MASH appeared to give primacy to the positive health visiting feedback in taking the decision not to assess at that time.

Voice of the Child

Despite reaching a course of action that the health services would continue to support F1 and consider an early help assessment as required, the MASH decision does not directly reference the perspective of the children (born or unborn). The MASH decision does not weigh up the potential impact upon these children of either commencing an assessment or what the potential outcomes could be if SCSC did not become involved at that time. No further rationale is provided as to the potential impact of this multi-agency decision.

There appears to have been little consideration of the allegation made by one of the children on 2 occasions that they had been slapped around the face by one of their parents.

It is also noted that no child's name is actually referenced in the MASH decision at any point.

The Role of M1

The MASH decision does not reference the role of M1 in the family home or whether his own history may be significant in terms of risk assessment or whether this may contribute to a need for assessment.

Risk Management Protocols

The MASH decision does not locate the case concerns and recommended action within Sandwell's Multi-Agency Threshold Document, thus this opportunity to clarify how risk has been assessed and an outcome reached has not been utilised.

The MASH decision does not locate the concerns or recommended action within Sandwell's Pre-Birth Procedures, as found at the West Midlands Safeguarding Procedures website. How the family history, recent concerns and apparent non-engagement with services did or did not reach the threshold for a pre-birth single assessment is not elucidated.

There is no evidence that at any of these points, the pre-birth procedures were considered and there is no recorded evidence of a rationale as to why it was not considered.

The pre-birth procedures are contained in the West Midlands Safeguarding Online Procedures in which SCSC are a partner. An extract of pre-birth procedures is contained at Appendix Two.

The procedures describes the circumstances in which a pre-birth assessment should be conducted are:

*"A pre-birth assessment should be undertaken on all pre-birth referrals as early as possible, **preferably before 20 weeks**, where:*

- *a parent or other adult in the household, or regular visitor, has been identified as posing a risk to children*
- *a sibling in the household is subject of a child protection plan*
- *a sibling has previously been removed from the household either temporarily or by court order*
- *the parent is a looked after child*
- *there are significant domestic violence issues*
- *the degree of parental substance misuse is likely to impact significantly on the baby's safety or development*
- *there are significant concerns about parental ability to self-care and/or to care for the child e.g. unsupported, young or learning disabled mother*
- *any other concern exists that the baby may have suffered, or is likely to suffer, significant harm including a parent previously suspected of fabricating or inducing illness in a child or harming a child*
- *a child aged under 13 is found to be pregnant."*

Whilst it might be considered understandable that SCSC had reached a point where they considered previous family issues as historical, that seems an over optimistic view in the circumstances. There was sufficient evidence that a number of these points were apparent in this case.

If the assessment had been completed it would have resolved a number of issues including the fact that all of the agencies would have become aware of the family history. An assessment may also have resulted in a strategy discussion or network meeting and at the very least a child in need plan could have been developed. This would have ensured that plans were in place to mitigate any risk and an effective support package could be developed for this family.

Assessment As A Positive Intervention

Risk assessment issues aside, if a single assessment is commenced, it can be utilised as a positive method of intervention within which to fully understand and support a family expecting a new baby whilst also managing risk.

As noted by some professionals, F1 had shown the ability to provide basic care and meet key aspects of S5 and S6's needs over time and had in 2015, demonstrated some ability to enact change and improve outcomes for the children on a CIN plan. A single assessment may have assisted in bringing the network together to consider the likely impact of having new-born twins, in addition to managing the needs of two older children and develop plans to support the family before the twins were born. This could have included collaborative discharge planning and support from the first day that the twins left hospital, in addition to the support provided routinely by universal services.

The second and third MARFs were submitted by the Hospital on 3 April 2017 and a Sandwell e-CAF was received from health services on 6 April 2017. In both instances, it appears that health professionals making the referral had not been in contact with midwifery colleagues, with SCSC not progressing these referrals given that presenting concerns had ostensibly been addressed in the MASH assessment document of 27 March 2017. However, in both instances, no further action was taken on these MARFs, citing the outcome of the MASH assessment on 28 March 2017.

Taking into account the family history, recent concerns and presenting concerns in the first MARF dated 21 March 2017, it is the view of the reviewers that this case did meet the criteria for a pre-birth assessment both under Sandwell's Multi-Agency Threshold Document and Pre-Birth Procedures. There are a wide range of factors, including children historically coming into care/care of others, domestic abuse, drug use, neglect concerns, recent domestic abuse issues, potential allegations of drug-taking and over three months of very limited engagement with ante-natal services after a late-booking when F1 was pregnant with twins.

The reviewers are clear that opportunities were missed to engage with the family and assess risk at a pre-birth stage, which may have enabled a longer period to plan and support F1 with her upcoming twins, whilst also being able to make contingency plans if concerns did arise. An assessment at an earlier stage would also have assisted in understanding whether any risks present met the threshold for child protection procedures. Despite the lengthy case history, KS and S1 were not subject to an assessment until after they were born, when domestic abuse concerns in Hospital arose regarding M2's behaviour.

This review has established that there were sufficient grounds to utilise the pre-birth procedures, but this was not considered in the case of KS and S1. As a result, an opportunity was missed to reduce risk to KS and S1 and put in place an effective support package for the family. The MASH assessment was not comprehensive and does not outline how it balanced risk and need, given the available evidence. It was a missed opportunity to work with the family.

3.4 Significant Issue Four

Following the birth of KS and S1 a single assessment was conducted. There appeared to be limited consideration and exploration of disguised compliance patterns within the context of family history, recent concerns and potential risk and need for KS, S1, S5 and S6.

A single assessment was commenced in mid- April 2017, after concerns were raised about M2's aggressive behaviour at hospital when he perceived that F1 had left the hospital and spent too much time away from the twins. This appears to have escalated into verbal threats and intimidation, with F1 deciding that no contact would take place between the twins and M2 in the immediate future whilst considering family court options.

The SCSC manager who provided the management summary at the commencement of the assessment highlights a number of areas for the allocated social worker to address, including:

- *"Reviewing all family history;*
- *Assessment of parental safeguarding capacity given domestic abuse concerns, including impact of exposure to domestic abuse upon children;*
- *Consider 'current substance abuse' given long history of concern around this, including understanding whether F1 was involved with drug support services and/or what drugs or substances F1 may be taking at this time;*
- *Obtain feedback from hospital staff as to interaction and care provided to the twins;*
- *Arrange to speak to M2 separately and gather his understanding of impact of domestic abuse upon children;*
- *Complete agency checks, consider family networks and given history of involvement, whether s.47 investigation or Initial Child Protection Case Conference required".*

This single assessment does provide a concise history of several key events in SCSC involvement. Attempts were made to speak with M2, however he refused to engage with the assessment process at all, thus it was not possible to understand his perspective on domestic abuse. F1, however, was noted to have followed the advice of professionals in seeking to distance herself from M2 and create a safe environment for herself and the children at home.

The single assessment notes the historic concerns around drug abuse, but only provides very limited evidence of discussion and exploration around this issue with F1, simply noting that F1 had not used drugs since 2009 and ceased methadone 18 months earlier. There is no evidence of the recording of a discussion to explore this issue in any depth in the assessment document. It is noted that F1 and M1 should obtain support should they relapse. There is also no evidence in this assessment of contact being made with IRIS to clarify if there had been any further involvement since the end of F1's methadone program in late 2015. Finally, there is no evidence of exploration with M1 or IRIS as to his previous or current substance misuse.

Despite the concerns noted only a few weeks earlier, this single assessment does not provide evidence of exploring the non-engagement with ante-natal services any further with F1 or M1. Despite listing this concern in the assessment document, the information provided suggests that F1 stated she: *"admits not attending 4 ante-natal appointments as her ankles had swollen up so much that the health visitor came to her home to do visits"*. This information is not challenged, despite the MARF on 21 March 2017 indicating that a much higher number of appointments and hospital appointments were not kept. The assessment does not evidence any further discussion or exploration of these issues with the allocated community midwife, instead focusing on the positive parenting feedback from midwifery since the twin's birth.

The single assessment does not seek to examine potential patterns of disguised compliance behaviour either currently or over time with F1. There is no evidence of exploration of recent non-attendance issues within the context of the historical non-attendance or engagement with ante-natal services in previous pregnancies or around other times in the past when the family have not always engaged with services. The assessing social worker does not appear to have challenged F1 about her claim of swollen ankles, which may fit into previous patterns of illness for F1, or the children, leading to non-engagement with services.

The single assessment does provide considerable information from professionals such as the community midwife and health visitor about how well F1 was coping with the twins since birth, including positive feedback from the allocated health visitor who had known the family for some time. Observations of the children in the home were positive and direct work undertaken did not raise any specific concerns, with the exception of one of the children stating that their mother had slapped them in the face and that M1 shouted at them. They repeated this during direct work and F1 was confronted over this and denied it. The assessing social worker took the view that F1 was being truthful around this. The other child living with F1 did not indicate or disclose any information regarding being slapped in the face or physically disciplined in any other way.

The single assessment does include multi-agency feedback, although some of this is pulled through from the MASH assessment. It is noted that there does not appear to be evidence of direct contact with the GP to obtain their perspective of this family's circumstances.

Whilst the single assessment analysis does address some risk areas and in particular focuses on the ramifications of the recent domestic abuse incident at the hospital, it does not locate the way the family presents currently within the history to date. When referencing previous family history, the assessment analysis falls back on MASH decision stating that *"the positives currently outweigh the negatives"*, revisits MASH's initial rationale for not opening an assessment on 27 March 2018 and then goes on to outline that signposting needs to take place to support the family.

The assessment analysis does not contain any evidence of exploration or challenge of the patterns emerging from family history, recent concerns just prior to birth and how the assessing social worker sees these factors in terms of risk to these children. The analysis similarly does not (whilst acknowledging that the situation at home was positive at the time of this assessment) consider how over time F1 and M1 will manage the care of two new-born twins alongside two older children and what support the family might need to ensure that the children remain safe at home with their needs met. The analysis does not speak to specific support or signposting beyond universal services for this family, despite the considerable history of poor engagement and neglect concerns at times in the family history.

The assessment analysis does not consider the position of the child, in terms of the potential outcomes for these children if a higher or lower level of support is offered. This decision is also not couched within local threshold documents to help outline how this decision was reached.

Finally, the single assessment is largely silent on the issue of M1. Whilst there is some information about how F1 and M1 see their relationship with each other, there is no evidence of direct discussions with M1 to understand his parenting capacity, how he will assist in keeping the children safe, and an assessment of any issues related to his history of drug misuse and domestic abuse in the home. There is no evidence of observations of M1 with the children. The assessment analysis does not outline whether there were difficulties engaging with M1 or why information about his role within the home, or his views on previous non-engagement with ante-natal services.

The single assessment contains a lengthy management oversight section that speaks initially to the presenting issues of domestic abuse involving M2. However, this then goes onto examine wider concerns, such as the role of M1 (who is only briefly addressed in the single assessment itself). The assessment oversight section notes that there are conflicting views that M1 - who had previously been seen as a concern due to the history of M1 and F1 using drugs and being involved in domestic abuse – was now seen as supportive by professionals.

However, there is no further comment as to why this situation is now justifiably safe and supportive, beyond noting that M1 and F1 have: *"come a long way'*. Given that there were potential domestic abuse concerns about M1 coming around to the house in late 2016 due to concern that M2 may have been there with F1, it is unclear how far this relationship has progressed, although F1 did feel that they were supportive of one another. This analysis is not balanced against the historic domestic abuse concerns and does not provide any evidence of how M1 had changed to become a supportive factor.

The assessment oversight section makes no reference to the previous (yet recent) concerns of midwifery around ongoing non-engagement. It is noted that the family have declined early help support despite now having two children under 12 months of age, but that the family will receive support from universal services. The history of child protection plans and child in need plans are noted, however this does not lead into any analysis of whether this history has any bearing on need or risk going forward, beyond the need to inform agencies of the outcome of this assessment.

The assessment oversight section goes on to note -

"…that this seems to be a family who will always need to be on professionals radars. Whilst parents should be commended for the reported progress to date, it seems there are still situations and decisions such as F1's brief relationship with M2 when knowing he had misused drugs which hark back to the past."

Unfortunately, after acknowledging this view, the assessment oversight section does not go on to outline a plan or intervention that will support this family to work towards not being regularly known or engaged with safeguarding services.

The single assessment in June 2017 commenced in very unfortunate circumstances, following the Sudden Unexplained Death of Infant (SUDI) KS just days earlier. The content of this assessment is understandably coloured by these events and may have influenced how some issues, such as substance misuse, were explored with the family.

By way of counterpoint to the single assessment in April/May 2017, the June document goes into considerable depth with both M1 and F1 around current drug misuse, although when M1 and F1 were interviewed in July 2017, it had become apparent through toxicology testing that they had been using drugs at or around the time of KS's death, which may have led to a more honest account from M1 and F1 about the drugs they had used and how frequently. This assessment also incorporated more information and direct discussion and observation of M1, and also sought information from extended family.

This review concludes the assessment conducted in mid-April 2017 failed to accurately explore or challenge current and previous information regarding the family to adequately inform an assessment of risk to KS and siblings. It was a missed opportunity to initiate a greater level of protection and support to KS and siblings.

3.5 Significant Issue Five

This case drifted, and whilst professionals engaged with the family, there was a lack of leadership to ensure a robust plan was in place to provide protection and support.

There were clearly grounds in this case for a multi-agency meeting and the development of a plan to mitigate any risk to the unborn babies and ensure a plan for providing ongoing support.

Whilst some professionals sought to address concerns within their own safeguarding roles, there was never one person or agency that took a lead and pulled others together to formulate a medium to long-term plan. This was exacerbated by a complete lack of cooperation by F1 with the Community Midwifery Service. She failed to attend appointments and was able to demonstrate a degree of disguised compliance that on occasions led to an overly optimistic view of the family.

More should have been done to deal with the issue of missed appointments and the pre-birth procedures should have been adopted. There was no clear leadership to ensure a holistic approach. Individual team leaders did take a leadership role within their own field, but this did not extend across agencies.

As a result, the lack of any clear leadership resulted in some professionals, who were clearly concerned, not pursuing any escalation when their requests for more intervention were declined. Whilst there was clearly some level of supervision, there is a complete lack of management oversight in this case.

This review has found that there was a lack of leadership shown by professionals and no agency took responsibility for ensuring that this family had a plan in place to protect the children and provide support.

Section Four – Key Themes

4.1 The use of child protection assessments and pre-birth procedures

Pre-birth procedures were not considered by SCSC in this case. These procedures would have provided the framework for a more consistent approach and better partnership working.

Opportunities in October and November 2016, when information was shared with SCSC by the midwifery service, were missed to explore the family circumstances further. Similar opportunities were missed in December 2016, when information was shared with SCSC that F1 could be using drugs again.

The MARFS submitted to SCSC by health professionals immediately prior to the birth of KS and S1 provided sufficient evidence to invoke these procedures. The MASH assessment that resulted from these submissions did not consider all of the evidence and gave disproportionate weight to professionals who had positive feedback regarding the family's circumstances, whilst it appears that some of this feedback from professionals may have been given before knowledge of non-engagement concerns came to the attention of said professionals. The MASH failed to initiate appropriate child protection procedures following these referrals.

The fact that the Sandwell pre-birth procedures are not referred to by any professional in documents, or at the practitioner's event, leads to the conclusion that they are not well understood by those professionals.

The single assessment completed following KS's birth did not reflect the level of potential risk and need for KS and siblings that was apparent in the evidence that had been gathered.

Risk assessment thresholds, pre-birth procedures and the quality of analysis in assessments were not, at times, applied in an appropriate way. This is an issue that needs to be addressed.

4.2 Dealing with non-attendance at appointments

There is a long history of F1 missing appointments. This extends to essential appointments for her children. F1 presented late for a pregnant mother and missed numerous appointments during her pregnancy; including scans at the hospital. Given the previous history of F1 and the fact that she was pregnant with twins, this should have caused more concern for professionals.

Whilst midwifery services had a policy in place to deal with these missed appointments the same does not appear to have applied to other agencies. It is clear that SCSC did not see the missing of appointments as particularly relevant.

There needs to be better training of staff to understand the nature of missed appointments and their significance. This needs to be supported by clear policies and supervision.

4.3 Multi-agency working and information sharing

There is clear evidence that SCSC did not disclose information to health agencies and health did not always share information between themselves. GPs did not receive all of the information they needed and were not involved in the child protection process. GPs should, as best practice, ensure that their surgery holds regular child safeguarding meetings to ensure they understand the needs of all the children registered with them.

A multi-agency monthly review meeting conducted at the hospital, but including SCSC, would provide an opportunity for better information sharing.

Agencies need to consider why information sharing broke down in this case and put in place clear guidelines to improve information flow.

4.4 Disguised compliance

F1 had a long history of engagement with agencies and this was not always in a positive way. As a result, F1 appeared adept at being able to satisfy professionals she was complying with their requests. F1 had considerable help with her drug use over time and had reported periods of abstinence that were accepted by professionals. This transpired to be untrue once drug-testing took place after the death of KS.

F1 avoided appointments but would make promises about attending in future or excuses around family illness, and the fact she had had a house fire. Professionals appeared to accept these excuses or had difficulty in effectively challenging them. This process of challenge may have been enhanced by a multi-agency approach to supporting this family.

Domestic abuse incidents between September and November 2016 resulted in a referral to Black Country Women's Aid but F1 did not engage with the service.

The MASH tended to dismiss disguised compliance concerns (such as not engaging with ante-natal services) on the basis of a relatively low level of reassurance from some professionals despite the lengthy family history. It is entirely reasonable to retain a level of optimism for the future of children in the care of their parents and to wish to support parents, despite their family history. F1 had clearly managed to care for 2 of her children for some years and it may have

been that work with F1 to build trust and to understand what may have been driving her avoidance of midwifery services may have led to an outcome a plan could have been put in place to support and keep the children safe at home.

It is perhaps not surprising that F1 may have avoided booking her pregnancy and then wanted to avoid services further given her previous experiences of carrying children to term and the suffering the loss of them going into the care of other family members. The opportunity to explore this avenue with F1 was lost however when the presenting concerns were not placed within the wider family history, and a pre-birth assessment that could have explored disguised compliance concerns was not conducted. When a single assessment was commenced post-natally, there was insufficient exploration and challenge of these concerns.

Professionals should be aware of the dangers of disguised compliance and this case provides a good case study to consider when engaged in multi-agency training.

The reviewers acknowledge that disguised compliance can be a difficult issue to challenge and work with effectively to safeguard children. Whilst there is no evidence that disguised compliance issues had any role in the death of KS, this case has provided several examples of potential disguised compliance factors.

- F1 had a long history of engagement with agencies and this was not always in a positive way. As a result she was clearly adept at being able to satisfy professionals she was complying with their requests. F1 had considerable help with her drug issues and was able to convince professionals she was “clean”. This transpired to be untrue;

- F1 avoided appointments but would make promises about attending in future or excuses around family illness and the fact she had had a house fire. Again, professionals often believed these excuses or at least were prepared to accept them;

- domestic abuse incidents between September and November 2016, resulted in a referral to Black Country Women’s Aid but she did not engage with the service;

- the MASH tended to dismiss disguised compliance concerns (such as not engaging with ante-natal services) on the basis of a relatively low level of reassurance from some professionals despite the lengthy family history. It is entirely reasonable to retain a level of optimism for the future of children in the care of their parents and to wish to support parents, despite their family history. F1 had clearly managed to care for 2 of her children for some years. It may have been that work with F1 to build trust and to understand what may have been driving her avoidance of midwifery services may have led to an outcome where a plan could have been put in place to support and keep the children safe at home;

- It is perhaps not surprising that F1 may have avoided booking her pregnancy and then wanted to avoid services given her previous experiences of carrying children to term. The opportunity to explore this avenue with F1 was lost however when the presenting concerns were not placed within the wider family history, and an assessment of disguised compliance concerns was not conducted.

Professionals should be aware of the dangers of disguised compliance and this case provides a good case study to consider when engaged in multi-agency training.

The NSPCC website[7] contains a range of risk factors and areas to recognise around disguised compliance. In this case, the following have been identified:

Professional Over-optimism

The reviewers believe that there was an element of professional over-optimism at times in working with this family and that had some of the risks identified in the time prior to the birth of KS and S1 been located within threshold and pre-birth protocol documents, this may have led to an assessment of need at an earlier stage. Given the extensive family history and immediate concerns about non-engagement, it is felt that a level of optimism was applied and that other, positive feedback about the family's circumstances was given primacy despite the likely impact of caring for an additional two infant children in the near future.

Parents Deflecting Attention

Information provided suggests that, in this case, F1 did engage with one group of professionals whilst disengaging with another. Just prior to birth, F1 engaged with the health visitor in February and March 2017. This decision to engage with the health visitor at the expense of midwifery, who had attempted to engage with F1 over a period of months, suggests deflecting of attention.

Failure To Engage With Services

Information provided suggests that this has been a longstanding issue across several years, with instances of not engaging with services and not attending appointments going back at least to the pregnancy of S6, where there were issues around non-attendance at ante-natal appointments. In the interim, prior to the birth of KS and S1, there have been reported instances of non-attendance with agencies such as the family GP, Orthoptist, vaccination appointments, Speech & Language Therapy Appointments, some missed appointments with a Family Support Worker, some missed appointments with IRIS and, most recently, a considerable history of missed appointments with community midwifery and the Hospital prior to the birth of KS and S1.

Furthermore, there appear to have been a range of reasons given for non-attendance, such as illness and child illness, coupled with instances where concerns regarding evasion may have arisen due to midwifery attending a property that has clear signs of occupancy but there has been no response at the door.

Avoiding Contact with Professionals

In addition to non-attendance, there appears to have been issues over time with being unable to get hold of F1 by telephone. At times, this may have been due to changing telephone numbers around domestic abuse issues, however there appear to be other periods where this may not necessarily have been applicable when professionals have not been able to get in touch with F1 directly.

Effective Work With Disguised Compliance

Regarding working effectively with disguised compliance, the NSPCC note a range of factors, all of which are applicable to this case, such as establishing facts, not accepting presenting behaviour or reasons for non-engagement, understanding exactly what is occurring, recording the child's perspective and identifying positive outcomes to be achieved to assist families in

[7] **NSPCC risk factors -** https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/disguised-compliance/

moving on from disguised compliance behaviour. Completing this type of work with families would have been assisted by a multi-agency approach in this case.

The reviewers also note the issue of chronologies in addressing disguised compliance.

Chronologies are widely recognised as an effective tool in conveying knowledge and assisting effective risk assessment around a wide range of safeguarding issues. Regarding disguised compliance, a complete chronology can provide clear, easily identifiable patterns of disguised compliance behaviour and can assist professionals in placing current behaviour within the context of family history.

Reviewing the SCSC chronology provided for this case, this appears to have been developed to cover the scoping period of this review from the beginning of 2015. The document notes some key events, however does not highlight disguised compliance concerns or history of non-attendance at appointments, although SCSC may not have been fully aware of this behaviour happening within other agencies (such as health) over time.

The combined chronology put together for this serious case review – where examples of these instances appear across the safeguarding partnership in one document – highlights the importance of multi-agency collaboration and information-sharing to build a clear picture of issues such as disguised compliance across the safeguarding network when working with families.

Section Five – Key Lines of Enquiry

The terms of reference asked 5 key questions that were to form the lines of enquiry for this review. They were:

5.1. Was support offered to the family appropriate, timely and adequate?

F1 had received support in a period that extended over 20 years. When her children were born SCSC made interventions that were appropriate and proportionate. This ensured F1's first 3 children were living in a safe environment. F1 was given support and help with her drug use issues over this period. This support was assessed as part of the Early Help programme.

When F1 became pregnant with KS and S1 she received universal services. SCSC did not, despite 4 MARFs from health professionals and earlier cause for concern notifications, put in place any specific assessment processes or support and made a decision that F1 would receive universal health services. This was not sufficient, and the invocation of pre-birth procedures would have provided the opportunity to put in place more timely and supportive services.

5.2 Was sufficient scrutiny of drug use by parents provided?

Prior to F1 becoming pregnant she had received significant support for her drug issues. Neither health professionals nor SCSC were given any reason to believe that this had not been successful.

F1 avoided appointments and did not readily seek further help; it is noted that drug testing does occur periodically throughout pregnancy as a matter of course and one hypothesis may be that F1 (and M1) may have avoided ante-natal care so as to avoid drug-testing

Given none of the children resident with F1 were on any form of child protection plan and, without further evidence of drug abuse, any form of testing would have been considered disproportionate. It is noteworthy however that there is no evidence of contact with IRIS to understand whether M1 or F1 had had any further interaction with that service or to understand in greater depth what they key issues (e.g. usage triggers, patterns of use and abstinence) may have been for both M1 and F1 to consider in any assessment or support of this family going forward.

5.3 Was there sufficient challenge by practitioners if the parents did not comply with advice and instructions?

There is no evidence that F1 did not comply with instructions by professionals. The exception was the attendance at appointments. This issue is dealt with in the report, but it is clear in this case there was insufficient challenge on this issue by any professional.

5.4 Was there appropriate safeguarding supervision of front-line practitioners?

In the case of health professionals there were clear lines of supervision that were followed. However, given the issue around missed appointments and the fact that SCSC did not follow up on MARFs submitted by health professionals, there needs to be clearer levels of supervision in safeguarding cases.

Supervision occurred on a sufficiently frequent basis on this case, however records reviewed were not sufficiently reflective and did not appear to locate current concerns or behaviour within previous concerns. This was also observed in management decisions on the MASH assessment of 27 March and the single assessment in mid-April 2017.

5.5 Was appropriate advice provided and followed regarding safer sleeping practices?

Health visitors, midwives both ante-natal and post-natal provided safer sleeping advice and smoking cessation advice in an appropriate way.

Section Six – Key Findings

KS tragically died from an unascertained cause. There was no known action that professionals in Sandwell could have taken to prevent this death.

This case has demonstrated that if agencies in Sandwell had better shared information and complied with both national and local procedures, the level of support to F1 and her family could have been more effective but would not have affected the final tragic outcome for KS.

Section Seven – Recommendations

6.1 Recommendation one

The Board should undertake a review of safeguarding training to ensure that pre-birth procedures are understood and implemented appropriately.

6.2 Recommendation two

The Board should seek assurance from the Health Forum that health professionals engaged in antenatal and post-natal work are trained in the appropriate use and application of escalation procedures, issues of disguised compliance and over optimistic assessments.

6.3 Recommendation three

The Board should conduct a review of training and procedures to ensure professionals are aware of the significance of frequent missed appointments by individuals and disguised compliance behaviour, particularly in the case of pregnant women. They should also consider a review of policies regarding the procedure to follow when an individual regularly fails to attend appointments.

6.4 Recommendation four

The Board should consider conducting a multi-agency learning event to examine issues of:

- information sharing;
- disguised compliance;
- professional curiosity;
- over optimism;
- lack of hypothesis forming;
- escalation procedures;
- pre-birth procedures.

6.5 Recommendation five

The Board should satisfy itself that the processes within the MASH are fit for purpose and professionals understand their responsibilities with regard to the Sandwell Multi-Agency Thresholds Document, the Sandwell Pre-Birth Procedures document and the way in which they are applied. The Board should ensure there is appropriate risk thresholds training.

6.6 Recommendation six

F1's difficult parenting history has been recognised in this review. The Board should consider what support is available for parents who have grappled with ongoing drug use, mental health and domestic abuse. In particular, the Board should consider the connectivity between adult services (drug and alcohol and mental health services in particular) and those cases that involve a child at risk.

6.7 Recommendation seven

Work is currently underway, within health, to develop a safeguarding children group. This group should include representatives from across the health spectrum and Children's

Services. The terms of reference for the group should ensure that the focus of this group is to share information around children and families at risk and need of support. There needs to be clarity about the way in which this group interacts with current MASH arrangements. The Clinical Commissioning Group may be best placed to manage this process.

Section Eight – Conclusion

This is a tragic case in which a 2-month-old baby has died, and the cause of death is unascertained. The pathologist was able to say that there was no evidence of overlay or any form of non-natural causes of death.

This review has established that there was no action any professional could have taken to prevent this tragic death. There are however a number of areas where agencies need to consider improving their safeguarding services. F1 had a history of drug abuse and her first 3 children had been placed with relatives because there was a concern that they would suffer from neglect if left in her care. This family history should have alerted to professionals to the risks that F1's unborn children might face and the potential impact of the demands of caring for twin infants alongside two older children. In fact, the twins were due immediately after a particularly traumatic time in F1's life which further heightened risk to the unborn babies.

Several referrals were made to Children's Services but on each occasion, it was decided that assessment and potentially child protection procedures did not need to be considered. This was a mistake and Sandwell's Pre-Birth Procedures should have been adhered to.

Sandwell Children's Services have now been placed in a Trust and the issues considered in this report should form part of improvement planning.

Appendices

Appendix One – Terms of reference

Sandwell Safeguarding Children Board Terms of Reference in respect of KS

The period of Review for this Serious Case is from August 2015 when mother finished a methadone reduction programme to the date of death. Reference should however be made about the extent of agency involvement prior to this period (if relevant and appropriate).

The focus of this SCR will be on KS and their mother, father and step-father. However, please incorporate information about siblings and wider family if you feel this directly influenced any decision-making in the safeguarding of KS. A family key for the immediate family will be sent separately.

Agencies that identified significant background history (where relevant) on family members predating the review period and subsequently should submit a brief summary account of that history.

All agencies should review all records held electronically, on paper or in patient held records.

At this point, in-depth chronologies only are being requested and should be completed using the template provided by Sandwell Safeguarding Children Board. Please note any learning, opportunities for improvement, or good practice in the comments section of the chronology.

Genogram

A family key is supplied with paperwork. All agencies should submit a genogram if there is additional information.

Chronologies

The following agencies should submit chronologies on the template provided by Sandwell Safeguarding Children Board:

- Children's Social Care
- SWBH NHS Trust
- Sandwell and West Birmingham CCG (GPs)
- Birmingham Community Healthcare NHS Trust
- West Midlands Police
- Black Country Women's Aid
- Sandwell Drug and Alcohol Support Service
  - Education have been requested to provide an overview report
  - Police have been requested to complete criminal background checks

Information from Agencies is requested by the 31 January 2018.

The Terms of Reference are as described in Working Together

- To keep under consideration whether further information becomes available as work is undertaken that indicates other agencies should carry out individual management reviews.
- To establish a factual chronology of the action taken by each agency.
- To assess whether decisions and actions taken in the case comply with safeguarding procedures.
- To determine whether appropriate services were provided in relation to the decisions and actions taken in the case.
- To recommend appropriate interagency action and learning from the case in the light of the findings.
- To assess whether action is needed in any agency.
- To examine interagency working and service provision for children.
- To establish whether interagency and single agency policies and procedures supported the management of the case.
- To consider how and what contributions can be sought from family members.
- To establish lessons for practice and clear recommendations and an action plan from the overview report.

Key Lines of Enquiry and Scope of the Review

When completing a chronology could agencies please consider the following points:

1. **Was support offered to the family appropriate, timely and adequate?** Practitioners should review how support was assessed and evaluated.
2. **Was sufficient scrutiny of drug use by parents provided?** Both by the Drug and Alcohol support service and the midwifery service.

3. **Was there sufficient challenge by practitioners if the parents did not comply with advice and instructions?** Practitioners should comment on instances requiring challenge and whether actions taken and outcome were satisfactory.
4. **Was there appropriate safeguarding supervision of front-line practitioners?** Was supervision carried out within timescales and monitored appropriately?
5. **Was appropriate advice provided and followed regarding safer sleeping practices?**

All agencies should consider whether their policies, procedures, management and supervision resources adequately supported practitioners working with this case and aided appropriate decision making and professional judgement.

In addition to the requirements of Working Together to Safeguard Children the overview report writer will:

- Comment on whether individual agency chronologies have addressed these Terms of Reference and all relevant issues.
- Arrange meetings / interviews with practitioners as appropriate
- Interview any relevant family members if appropriate
- Analyse the inter-agency working assessments and provision of services.
- Determine whether actions taken, decisions made were in accordance with current safeguarding policies, procedures and practice.
- Comment on professional judgement and decision making based on evidence.
- Consider what different decisions if any may have led to a different conclusion.
- Identify whether more could have been done, the lessons learnt and make findings and recommendations.
- Involve agency decision makers in an interim and final analysis of the decision making in this case based on the available information and case material presented
- Provide an executive summary.
- Present the findings to the Sandwell Safeguarding Board and Partner agencies as a learning event if so invited.

Sandwell Safeguarding Children Board will follow Working Together 2015 which states: *'The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.'*

Appendix Two – Pre-birth procedures

Referral

Where agencies or individuals anticipate that prospective parents may need support services to care for their baby or that the unborn child may have suffered, or be likely to suffer, significant

harm, a referral to local authority children's social care must be made **as soon as concerns are identified.**

A referral should be made at the earliest opportunity in order to:

- provide sufficient time to make adequate plans for the baby's protection
- provide sufficient time for a full and informed assessment
- avoid initial approaches to parents in the last stages of pregnancy, at what is already an emotionally charged time
- enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome for the baby
- enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth.

Early referral is also essential if legal action is required to protect the unborn child. Statutory guidance advises local authorities to take into account the risk of early birth and to send pre-proceedings letters/letters of issue before 24 weeks.

The referrer should clarify as far as possible, using the local early help assessment arrangements or the equivalent, their concerns in terms of how the parent's circumstances and/or behaviours may impact on the baby and what risks are predicted.

Concerns should be shared with prospective parent/s and consent obtained to refer to local authority children's social care unless obtaining consent in itself may place the welfare of the unborn child at risk e.g. if there are concerns that the parent/s may move to avoid contact with investigative agencies.

Pre-birth assessment

A pre-birth assessment should be undertaken on all pre-birth referrals as early as possible, **preferably before 20 weeks**, where:

- a parent or other adult in the household, or regular visitor, has been identified as posing a risk to children
- a sibling in the household is subject of a child protection plan
- a sibling has previously been removed from the household either temporarily or by court order
- the parent is a looked after child
- there are significant domestic violence issues
- the degree of parental substance misuse is likely to impact significantly on the baby's safety or development
- there are significant concerns about parental ability to self-care and/or to care for the child e.g. unsupported, young or learning disabled mother
- any other concern exists that the baby may have suffered, or is likely to suffer, significant harm including a parent previously suspected of fabricating or inducing illness in a child or harming a child
- a child aged under 13 is found to be pregnant.

Pre-birth Strategy Meeting/Discussion and Section 47 enquires

The need for a section 47 enquiry should be considered and, if appropriate, initiated at a strategy meeting/discussion held as soon as possible following receipt of the referral. The expected date of delivery will determine the urgency of the meeting

Consideration of the need to initiate a section 47 enquiry and hold a strategy meeting/discussion should follow the procedures described in chapters 8 and 9 of these procedures (Strategy Meeting/Discussion and Child Protection Enquiries). Ideally the strategy meeting/discussion

should take place at the hospital where the birth is planned or expected, or where the responsible midwifery service is where it would be if the parents have not booked for service provision.

The meeting must decide:

- Whether a section 47 enquiry and pre-birth assessment is required (unless previously agreed at any earlier ante-natal meeting).
- What areas are to be considered for assessment.
- Who needs to be involved in the process.
- How and when the parent/s are to be informed of the concerns.
- The actions required by adult services working with expectant parent/s (male or female).
- The actions required by the obstetric team as soon as the baby is born. This includes labour/delivery suite and post-natal ward staff and the midwifery service, including community midwives.
- Any instructions in relation to invoking an emergency protection order (EPO) at delivery should be communicated to the midwifery manager for the labour/delivery suite.

The parents should be informed as soon as possible of the concerns and the need for assessment, except on the rare occasions when medical advice suggests this may be harmful to the health of the unborn baby and/or mother.

The section 47 enquiry must make recommendations regarding the need, or not, for a pre-birth child protection conference.

Pre-birth Child Protection Conferences

A pre-birth conference is an initial child protection conference concerning an unborn child. Pre-birth conferences should always be convened where there is a need to consider if a multi-agency child protection plan is required. This decision will usually follow from a section 47 enquiry and pre-birth assessment.

A pre-birth conference should be held where:

- a pre-birth assessment gives rise to concerns that an unborn child may have suffered, or is likely to suffer, significant harm
- a previous child has died or been removed from parent/s as a result of significant harm
- a child is to be born into a family or household that already has children who are subject of a child protection plan
- an adult or child who is a risk to children resides in the household or is known to be a regular visitor.

Other risk factors to be considered include:

- the impact of parental risk factors such as mental ill health, learning disabilities, substance misuse and domestic violence
- a mother under 18 years of age about whom there are concerns regarding her ability to self-care and/or to care for the child.

A pre-birth conference has the same status as an initial child protection conference and must be conducted in a comparable manner (see Child Protection Conferences).

The conference should be held as soon as the assessment has been completed and **at least 10 weeks before the due date of delivery.** Where there is a known likelihood of a premature birth, the conference should be held earlier."