Children's Safeguarding Assurance Partnership

Blackburn with Darwen - Blackpool - Lancashire

Serious Case Review

Overview Report

Child LO

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Contents

Introduction

This serious case review (SCR) was commissioned by the Independent Chair of Lancashire Safeguarding Children Board (LSCB) on 06/02/18. This decision was made following discussions at the LSCB Serious Case Review Sub Group and advice from the National Serious Case Review Panel that the criteria had been met for a serious case review to be commissioned in line with Working Together 2015.

During the course of this SCR, the legal statutory guidance for local safeguarding children arrangements has been revised resulting in the deregulation of Lancashire Safeguarding Children Board and the development of a new partnership in line with Working Together to Safeguarding Children (DfE 2018). The newly formed, Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (CSAP) will be responsible for considering the learning from this SCR and for implementing any agreed recommendations suggested.

The catalyst for this review was that a 16-month-old child, who will be known as Child LO, had died and initial findings were that this was due to airway obstruction whilst being left unsupervised within an unsafe sleeping environment. A full and thorough criminal investigation commenced in relation to concerns of neglect, which concluded that there was insufficient evidence to support a prosecution. A Coronal inquiry is awaited.

At the time that Child LO sadly died, the family were not known to Children Social Care but were in receipt of local universal primary health care services and private nursery provision.

The key learning themes identified in this review include**; unsafe sleeping arrangements for babies and toddlers; early years multiagency working and information sharing and multiagency response to domestic abuse.**

Methodology

The methodology for this review was carried out using the systems model approach to learning outlined in the Child Practice Review process provided by "*Protecting Children in Wales Guidance for Arranging Multiagency Practice Reviews"* (Welsh Government 2012).

The overall purpose of the SCR model was to consider what happened in this case and explore why services were delivered as they were. Also, to consider how practice can be improved through changes in the system to improve outcomes for children.

The process involved a Review Panel of representatives made up of senior managers and safeguarding leads who were from the organisations involved in providing services for the child and family. The role of the review panel was to provide relevant information and analysis of their organisation's involvement in order to capture service/practice issues and to agree the key learning themes and actions required for multiagency practice improvement.

A Terms of Reference was produced by the Panel which provided a number of key lines of enquiry.

Main key lines of enquiry

1) Determine whether decisions and actions in the case comply with the policies and procedures of the local services and the CSAP
2) Examine the effectiveness of information sharing and working relationships between agencies
3) Examine inter-agency working and service provision, including quality of assessments for the child and the parenting capacity of all carers within the child's family.
4) Explore the response to risk factors within the family and consider the use of early help processes and their effectiveness.
5) Examine to what extent safe sleep advise and support was provided to the family.
6) Determine the extent to which professionals identified substance misuse (including alcohol) and domestic abuse and the level of support offered to support the family.
7) Establish any learning from the SCR in order to inform future practice development and improve outcomes for children.

There was good attendance at the panel meetings and participants were knowledgeable about their own areas and safeguarding arrangements. They were keen to submit and consider learning issues and to provide support for staff attending the practitioner event.

A composite timeline which included all agency interactions between 19/12/16 till 19/12/17 was scrutinised by both Review Panel and by the practitioners themselves at a Practitioner Learning Event to identify the key themes of learning.

The practitioner learning event was held to bring together those practitioners who were involved with the child and family and had personal experience of the family dynamics and care provided. The role of the practitioner event was to identify frontline challenges, good practice, consider why things happened as they did and to identify any gaps in the system. The practitioners who attended the practitioner learning event were open, honest, articulate and had a good grasp of the issues identified within the review.

Family involvement in the reviewing process is often key to understanding the nature of services provided to individual families. This provides an understanding of how helpful practitioners / services were perceived by family members on a day to day basis.

Unfortunately, mother in this case has declined an offer for her involvement in the review process which has been respected and father has not been contactable.

The Reviewer had access to a number of documents as follows:

- Referral for Serious Case Review Group minutes
- Joint multiagency timeline of significant events/analysis
- Minutes of the Strategy Meeting following Child LO death

- All Pan-Lancashire Policies and guidelines were easily available via Lancashire Safeguarding Children Board website.

Research evidence and national statutory guidance was considered and used throughout this review.

Family composition and context at the time of the child's death.

The child and all family members were white British.

Child LO	Was a happy smiley toddler who loved cuddles and was meeting developmental milestones. Child LO was attending nursery 1 afternoon per week where the child enjoyed playing with toys and other children. During Child LO's life the child lived at 3 different addresses and attended 3 different nurseries. Her parents had split by the time the child was 1 year old.
Half Sibling	Age 2 years. Same father different mother. Half sibling was subject to private law proceedings on behalf of father. Ex-partner was in contention to proceedings because of the risk she felt father posed to her child.
Mother	Age 24 years. Child LO was mothers first baby. She was living with Child LO's father following pregnancy, birth and first year. Shortly after ending the relationship she alleged that domestic abuse was a feature in their relationship. Mother was in employment on and off during the timeline.
Father	Age 23 years. Father had another child from a previous relationship from which he was estranged. He was trying to gain access with the child through court proceedings, but his ex-partner was contesting this due to concerns over drug taking and domestic abuse. Father had a violent criminal background which was unknown to those working with Child LO.
Mother's Partner	Age 22 years. Mother's partner came into Child LOs life shortly after father moved out. The new partner was living in a rented caravan and mother and Child LO moved in with him leaving a furnished flat which had been the family home.
Maternal Grandmother	Mother was supported by the maternal grandmother. She cared for Child LO when mother was at work and did some washing and ironing for her. She was seen on occasions taking or collecting Child LO from nursery.

Circumstances and significant events (05/08/16 – 19/12/17)

Information outside the timeframe.

Mother first presented with an unplanned pregnancy at 15 weeks gestation. This was classed as a late booking and was said to be due to failed contraception, which is not uncommon. Mother attended all antenatal appointments with no safeguarding concerns were noted by agencies during the pregnancy, labour or the birth.

Early in the pregnancy, Father attended the Children Centre to arrange a free solicitor appointment about access to his previous child then age 2, from which he was estranged. A private law application was received by the Children and Family Court Advisory and Support Service (CAFCASS) on behalf of father who was wanting to spend time with his estranged daughter.

This was being contested by his ex-partner who alleged that he was unsafe on the ground that she experienced domestic abuse when they were in a relationship and he had taken money from her without permission. She also alleged that he was a drug user and dealer and was concerned about fathers' criminal associates. Routine police and children social care checks were carried out at the time. Children social care found no information relating to the estranged child on their record keeping system.

August – December 2016 (Child LO new-born – 4 months)

Child LO was born with fathers' private law application ongoing. There were no complications or safeguarding concerns during the midwifery post-natal period.
Shortly after birth, the court made an order which noted concerns regarding historical domestic abuse and drug use. Father was requested to have drug tests but he responded that he could not afford the tests because he had just had a new baby. In view of this, the court were not able to support unsupervised contact between father and the estranged child until drug tests could prove he was no longer taking drugs. Supervised contact was ordered and information sent to CAFCASS who uploaded the information on their system.

During this time period the Health Visitor visited the home (flat) on day 13 following the birth. Child LO was seen with both parents. There were a further 7 visits to the family with one visit resulting in no access because the family were not at home and another contact for treatment of nappy area and oral Thrush. No safeguarding concerns were identified and the child and family were assessed as requiring "universal" level services from the Health Visitor.

January – August 2017

In **April** Child LO (8 months) started nursery (1). Child LO was on role for 2 months with mother arranging to pay on a weekly basis. Nursery staff never met father and mother would pick up and drop off. Child LO was happy and settled in nursery and enjoyed books. Mother used the nursery App to monitor progress. There was one episode of Child LO having a sore nappy area spreading into her thighs for which mother was advised to see the GP. The nursery manager spoke to mother about nursery payment arrears after which Child LO was abruptly removed from nursery without notice.

June – Child LO parents split. Professionals unaware.

In **June** Child LO (10 months) started nursery (2). Child LO was on for 2 months and registered for full day sessions on Tuesdays and Thursdays each week. Child LO only attended 4 out of the 8 sessions she was allocated to attend. The staff member working at nursery 2 had previously worked at nursery 1 so remembered the child from there. Mother told the manager she left nursery (1) due to changing jobs. On Child LO's first day the child

appeared grubby and had a dirty nappy and nappy area soreness. Father collected Child LO on one occasion telling staff he did not know why Child LO had not attended nursery on the days planned. Nursery payment arrears started to appear and following a discussion with mother Child LO was taken out of nursery without notice.

During **August** and just after Child LO (12 months old) left nursery (2) there were 2 Health Visitor home visits to undertake the 1-year development assessment, but the family were not home. A couple of days later a further planned visit was made with mother and Child LO and mother reported that she had split up from Child LO father and was living alone with family support. There were no health or developmental concerns identified during the 1-year assessment.

Late in **August** father made a child protection referral to Children Social Care MASH (Multi Agency Safeguarding Team) and to the Police about concerns he had about Child LO being left unattended for short periods and neglectful home conditions. During this time a further contact was made to MASH by a family friend raising concern about mother drinking alcohol daily and that she had distanced herself from friends and family.

Following on from this mother attended the police station to report that she had allegedly experienced domestic abuse (assault) during their past relationship and was currently experiencing harassment by father. Mother was in a new relationship and wanted the harassment to stop. A PVP (Protecting Vulnerable People) notification was shared with other agencies in relation to this.

Police visited the home for a child welfare check and MASH was informed there were no safeguarding concerns. MASH made a number of attempts to contact mother which failed and resulted in a letter being sent to mother with offer of support and the case was closed.

Father contacted the Health Visitor about concerns that Child LO mother was drinking alcohol regularly whilst caring for their child. The Health Visitor gave assurance that if children social care did not accept the referral, she would carry out a home visit.

September – December 2017

The Health Visitor received the PVP (2 weeks later) and an opportunistic visit took place with mother and Child LO. Mother confirmed she was going to live with her new partner and disclosed that father has been harassing her about contact with Child LO. Mother did not want to give consent to contact with father because he allegedly used drugs and had been abusive to her. The following day father contacted the Health Visitor requesting contact with Child LO. The Health Visitor recommended mother to seek legal advice.

Later in **September** Child LO registered at nursery (3). Child LO was on roll for 3 months. Child LO attended 9 out of 12 sessions available. It was reported to nursery that father had no legal access to Child LO and was not allowed contact. Mothers new partner was listed as step-father. Child LO attended one half day session every week and was waiting for extra sessions.

Early in **October** there was a planned Health Visitor visit to the new partners address which was a static caravan (1) on a holiday park. Child LO was sleeping on the sofa covered with a blanket. Mother stated she had sought legal advice about contact with father. Mother reported that the concerns raised about her drinking were malicious.

During the rest of **October** and **November** Child LO attended nursery (3) where there were no concerns about Child LO's appearance or presentation. There was a discussion with mother about nursery fees needing to be paid when Child LO did not attend. Nursery identified that finances were a problem and payment of arrears to the nursery became an issue.

Child LO had a viral upper respiratory infection early in **November** for which the child was appropriately taken to see the GP.

The day before Child LO died the child attended nursery and had appeared thirsty but was otherwise, happy and well.

Incident

A 999 call was made at 11.42 hrs. Child LO was said to be unresponsive and not breathing. The child had been found face down wrapped up in a duvet. The story given was that the child had been placed to sleep the previous night and seen again at around 01.00 hrs. The child had been heard to cry or chatter at around 07.00 hrs but this had not been responded to by the mother or partner.

The child was found by mothers' partner just prior to the ambulance being called. Basic life support was commenced by a neighbour who had been passing by the caravan and this was continued by the ambulance crew once they arrived. Child LO was transferred to the local hospital Emergency Department where the child was confirmed dead at 12.45 hrs.

Concerns about the sleeping arrangements and home conditions soon emerged. Child LO had been sleeping on a mattress on the floor of a small room which had an overturned table with the feet towards the door preventing Child LO from getting out of the area. There was an adult duvet and child blanket for cover but no sheets. The room was said to have mouldy patches on the walls and condensation was present. Rat droppings were found in the corner of the room.

The living area of the caravan was found to be in a poor state and smelled of smoke and only part of the caravan could be used because the bedrooms were being used to store the private belongings of the owner. The caravan was felt to be colder on the inside than the temperature was on the outside and there was very little heating available in the home for the time of year.

Following relevant investigations, the child was found to have died due to airway obstruction whilst being left unsupervised within an unsafe sleeping environment.

Analysis of practice and organisational learning

There were three main learning themes which emerged during the reviewing process as follows:

- **Unsafe sleeping arrangements for babies and toddlers**
- **Early Years multiagency working and information sharing**
- **Multiagency response to Domestic Abuse.**

Unsafe sleeping arrangements for babies and toddlers

Safer Sleep Guidance

There are clear national guidelines for safe sleeping arrangements for infants which are widely available and promoted on the NHS website, National Institute for Health and Care Excellence (NICE) and Lullaby Trust. The guidance is clear that practitioners such as Midwives and Health Visitors have a responsibility to inform new parents of the guidelines and to provide advice on safe sleeping arrangements. This advice should be routinely provided antenatally and throughout the first few weeks of life, with a reminder at each contact.

Antenatal home visits and early engagement with parents about safe sleep is essential to enable them make safe choices for their babies. Seeing where babies sleep enables front line professionals such as Midwives and Health Visitors to directly assess sleeping arrangements for babies and this activity can usefully provide an opportunity to discuss safe sleep environments and to emphasise the narrative about the dangers of parental alcohol and drugs during the day and before bedtime. The adequacy and safety of the cot and other equipment can also be assessed and discussed at this point.

In this case, it was apparent that the Midwives and Health Visitors had given appropriate safe sleep advise but none had asked to see where Child LO was sleeping during the day and night as would have been expected in accordance with the LSCB “Safer Sleep” guidance. This was because the guidance for professionals to see where baby sleeps had not been fully implemented in all areas and with all teams. The consequence of this was that the Child LO sleeping arrangements were never fully assessed and the opportunity to reinforce the safety messages to the parents about the importance of maintaining a safe sleeping environment was lost.

Following a recently published (November 2019) local Serious Case Review which was commissioned by Lancashire Safeguarding Children Board on behalf of subject Child LR, which related to a child death featuring sudden unexpected infant death (SUDI), further work is being progressed locally to update and fully implement the “Pan-Lancashire Safer Sleeping Guidance for Children”.

Recommendations from the Child LR SCR included the further strengthening of the guidance to promote the requirement for professionals to see where babies sleep and to develop and

implement an individualised safer sleep assessment to help parents understand the risks of SUDIs particularly around the dangers of co-sleeping following drug and alcohol use and to promote safer sleeping environments.

Practice learning
Seeing where babies sleep (day and night) can improve the level of assessment of safety of the cot and baby equipment in use and provide an opportunity for a conversation to provide professional advice about safe sleep environments and promote the message about not co-sleeping with a baby on the evening following drinking any amount of alcohol and/or recreational (and some prescribed) drugs.

The reviewer enthusiastically supports the view that direct observation and assessment of infant sleeping environments is an important factor in promoting the reduction of SUDI deaths. This review further highlights a need for new work to be undertaken to consider sleeping environments for toddlers, particularly those who have recently moved into a new address.

In this case, it is known that Child LO was last seen by a Health Visitor around two months before the child died. On that the occasion the child and mother had just moved into a static caravan (1) with mothers' new partner and the child was seen sleeping on the sofa appropriately dressed and covered by a blanket. There was no discussion around sleeping arrangements or access to a cot or toddler bed. Whilst this conversation would have been useful at the time and would have given an opportunity to discuss relevant toddler bedroom safety. It is important to add that the family moved into another caravan (2) (unseen by the Health Visitor) as the winter became colder.

Apparently, during this move the travel cot used for Child LO was broken and the family did not have the resource for a new cot/toddler bed for the child. This led to a "make-shift bed" being provided as previously discussed.

Prevention of accidental deaths

The Royal Society for the Prevention of Accidents (RoSPA) have recognised that at least one child under-5 is killed in an accident in the home every week. They suggest that the majority of these deaths are preventable by taking a number of safety measures.

Child Accident Prevention Trust also agree and go on to state that asphyxia is the third most common cause of accidental child death in the UK. They explain that babies and young children who are not being supervised can easily get into situations that they do not have the experience or strength to get out of and this can lead suffocation.

We are not yet fully aware of what happened to Child LO or how the child died because this is the role of the Coroner. However, we do know the child was found in unsafe sleeping conditions and therefore, an expansion of the local Safer Sleep Guidance would be of benefit to raise awareness of the risks of toddler deaths and to promote bedroom safety.

Seeing were children sleep at all routine Health Visitor visits including the 9-12month stage of child development assessment, in line with the Healthy Child Programme, this is the time when children may be sleeping in their own room and parents are thinking about the next steps following their child sleeping in a cot. Then seeing the child's sleeping environment again at the 2-year visit, where the child may be in a child bed or parents are thinking about moving to a bed.

A further safer sleep check could also be added to the "transfer in" visit when families are new to the area/accommodation and the status of the child's sleeping arrangements are unknown. More sleeping environment safety checks accompanied by professionals advise may help reduce the number of under 5-year deaths both locally and nationally.

Practice learning
Seeing where babies and young children (pre-school) sleep is an important measure for assessing safe sleeping environments and for identifying the needs of children and families. Although this may be additional work as part of the Healthy Child Programme the benefits of this activity could have the potential to reduce infant and under 5 years mortality rates and could also increase the potential for identifying children and families requiring Early Help support.

Local Child Death Data

The reviewer contacted the local Child Death Overview Panel for data relating to children over 12 months and under 4 years deaths in the bedroom in the area. The local data is as follows;

April 2017 – April 2018 – 1 death
- inappropriate sleeping situation at 16 months

April 2018 – April 2019 – 2 deaths
- sleeping in own bed at 16 months
- found in toy box at 13 months

April 2019 – Dec 2019 - 2 deaths
- sleeping in own cot at 17 months
- in bed on holiday abroad at 2 years

Whilst the number of child deaths under 4 years appear to be low there is still a need for greater awareness raising and assessment of toddler sleeping arrangements in the home. Every child death is a tragedy and as previously stated, the evidence demonstrates that these deaths can be prevented.

Practice leaning – The more practitioners talk to parents about home safety issues and the need to provide a safe sleeping/bedroom environment for babies and toddlers the more informed parents will become about the choices they make to keep their children safe with the potential to reduce infant and pre-school mortality rates.

Parental supervision

The lack of parental supervision of the child during the morning was a potential concern. Child LO was apparently seen during the night-time at around 22.00 hrs and 01.00 hrs, possibly reflective of the child's and adult's bedtimes. It is known that the parents were drinking alcohol on the night of the incident which may have reduced their availability to supervise and support the child. Child LO was heard making a noise at around 07.15am but the child was not attended to. Mother explained later to the police that this was because she was trying to get the child to settle without adult attention.

Child LO was eventually attended to at around 11.00hrs by mothers' partner. The duvet in use was found to be wrapped around the child possibly compromising the child's breathing and this may have resulted in the child's tragic death.

There may be a lesson here for other parents. Young children will normally awake early after a full night sleep usually because they have had enough sleep, or they are hungry and uncomfortable because they have a full nappy. Leaving young children to their own devises at this point of the day serves the child no good purpose. When left to their own devices young children will try to do things themselves but without the strength or experience to get out of trouble as previously mentioned. This can potentially lead to untoward circumstances as found with Child LO.

Practice learning
It is may be not possible to supervise babies and children all of the time. It is therefore, important that babies and young children are placed in cots/child beds specifically designed to maintain their safety and with bedding suitable for their age group. Professionals need to feel confident in asking to seeing where babies and children sleep and in discussing and advising on safe sleep environments.

Professionals in this case were not aware of Child LO's inappropriate sleeping arrangements. Professionals at the practitioner learning event stated that had they been aware of the situation, help in obtaining a cot or an age appropriate child bed would have been forthcoming through the local Children Centre.

Inappropriate living accommodation

Another area of concern for consideration was the use of a static caravan situated on a holiday park during cold winter months. A number of holiday park websites identify that holiday parks cannot legally be lived in all year round. By definition a park is not allowed to be used as a permanent address. It is a legal requirement to own or rent a residential home in addition to renting a caravan. This may explain one of the reasons why mother chose not to give up the flat.

The vast majority of holiday parks shut down and are not permitted to be occupied for at least 6 weeks during winter. Most static caravans are not designed for residential use. It is clear from police accounts that the cold temperature on the outside of the caravan was warmer than the inside. Child LO would have experienced very cold temperatures during the

night and early morning and it is not yet known if this too was a contributing factor in the death.

Practice learning
District councils should be aware of the activities of Holiday Parks in their area and should take steps to ensure that the winter rules about renting accommodation is adhered to. Professionals need to be more curious about why a mother and child is living in a holiday caravan and provide relevant advice and support to address any accommodation issues.

Early Years multiagency working and information sharing

Whilst the child's sleeping environment was a key issue in this case, the reviewer has identified a number of areas where information sharing and multiagency working could be strengthened. It may not have been clear to professionals that Child LO was sleeping in an unsafe environment but there were clues that mother was faced with situations which were more likely to have required the need for Early Help assessment and support.

Those clues included,

- fathers need for supervised contact with a previous child,
- poor living conditions,
- debt of unpaid fees and intermittent severe nappy rash seen at nursery
- domestic abuse allegations following split from father.

Fathers supervised contact with a previous child

Early in pregnancy father was trying to gain access to a previous child via the court. His previous partner (mother of the child) had objected to this because she felt he was not safe to have unsupervised contact with her 2-year-old child. Police checks became available for the court shortly after Child LO's birth which identified a number of police contacts and allegations including:

- Money taken from previous partners bank account without permission
- A number of domestic abuse incidents reported to Police at the time
- Threatened friends
- Regular use of cocaine
- Debts and drug dealing
- Verbally and physically violent and was prosecuted for assault and had a Restraining Order in place.

Whilst this information was effectively gathered and used in court to protect the 2-year-old subject child, professionals were unable to fully utilised this information to consider the risk to Child LO and mother.

Father shared information with the court that he was living with a new partner who had just given birth to a baby. Therefore, the court was aware that he was living with another child who was not being considered for supervision in the same way as the subject child brought before them.

The Family Court Advisor contacted Children Social Care to establish whether father's new partner and baby were known to them. The Family Court Advisor provided the full names of father and mother, but only had baby's first name and no surname. Presumably, this would have been either fathers or mothers' surname. In this case it was actually fathers' surname.

Children Social Care advised that the baby was not known to them and because there was no known address Children Social Care could not take the matter any further. The Family Court Advisor was told that at such a young age the baby would have a Health Visitor who would raise concerns with Children Social Care if there were any.

The reality was that there was enough information to be passed on to the local 0-19 service who could have quite easily checked their NHS systems to match the child's name and find the address in order to inform the Health Visitor of the concerns raised about father. The Health Visitor did not know about father's history until after the child died.

At the time of this this review the MASH team did not have NHS representation readily available in their team. Now that the MASH has a full complement of staff including health staff, there may be an opportunity to consider how this type of information can progress through the MASH system to ensure that front line health professionals are informed of risk factors within the families they are working with on a need to know basis.

It is best practice for concerns about non-subject children who are mentioned within the court processes to be shared with other professionals who are working with the child and family in order to safeguard the child. Had information about concerns regarding father been shared with the Health Visitor working with the child and family, this may have led to further assessment by the Health Visitor and possibly an Early Help assessment being completed to support the child and family.

With no apparent means of sharing information any further, CAFCASS and Court appropriately closed the case with arrangements for father to see his estranged child under supervised contact every other Saturday. There appeared adequate protection for the 2-year old child but none for a new born baby who may have been at greater risk.

Practice learning – Local safeguarding arrangements should include a pathway of how relevant safeguarding concerns about children and families are shared from the Courts down to individual front line staff working with children on a "need to know basis". This would allow front line staff such as Health Visitor to make a better assessment of the needs of children and families.

The consequence of not sharing information with the Midwife, GP or Health Visitor were that they were not aware of father's past history and his involvement with the police and the courts. Given his past violent behaviour against women those working with the family

should have been informed for their own safety as well as the safety of the mother and child.

Record Keeping

It has been found that whilst Midwifery have a system to record demographic details about fathers and any previous children, Health Visiting records do not lend themselves to asking relevant questions about past children and the father's access to them.

Father was actively going to court to gain access to his first child at the time the Midwife and Health Visitor were visiting and they may have been told the information by the parents if they had asked for it.

There appeared to be a lack of professional curiosity and detail about the family circumstances and therefore, nothing recorded in the child's health record which would identify any need to consider Early Help.

Practice learning – Previous children by a mother or father should be routinely recorded in both the Midwifery electronic record and Health Visitor child health record and should include any previous child's name, date of birth, current address and access arrangements. This would clarify the historical family context and enable further assessment of concern where this exist.
It is known, that parents do not always tell professionals what they need to know because they choose to hide vulnerability factors which may heighten the level of professional intervention. Whilst this may be the case, professionals should not presume that parents are not going to give information when asked in the relevant setting. Parents are more likely to disclose their vulnerabilities if they know and trust the professional involved.

Poor living conditions

Practitioners at the learning event stated that although the flat was sparse it appeared warm and tidy and that they had "seen much worse". There appeared to be no professional curiosity about the family's lack of possessions and as previously stated, the Health Visitor did not ask to see where baby sleeps and therefore, the state of other parts of the property were not seen. Further to this, there was no antenatal visit by either Midwife or Health Visitor and therefore, no understanding of how prepared the couple were to cope with a new baby and no opportunity to assess the state of the home prior to Child LO's discharge from hospital following birth.

At the time of mother's pregnancy, routine antenatal home visits were not being carried out by Midwives because they did not have the capacity to do so unless for safeguarding concerns of mother or child. Health Visitors were expected to provide a home visit at around 28 weeks of pregnancy as part of the "universal" health visiting programme but this did not occur. The reason for this is not known.

During the hospital admission for the birth and the postnatal period the Midwifery service had no concerns about the family and there was nothing in the Midwifery record about the state of the home which may have been an omission. Home environments and family circumstances are vital information for all professionals including Midwives, working with children and families in order to consider and recognise vulnerabilities which may require Early Help and support.

The Health Visitor too did not record the appearance of the home conditions and assessed the family needing "universal" level services which is the lowest level of service provision available. However, the Health Visitor did go on to provide a number of additional visits outside the "universal" programme because she felt mother was in need of extra support although, this did not convert to a "universal plus" level of service which would have been expected. It was not clear why these visits took place with no rational recorded in the child health record.

Child LO's (then 13 months) sleeping arrangements were not seen at the flat until the police carried out a welfare check following allegations from father that mother's new partner was dealing drugs from the property (the flat) and there was a pit bull type dog present in the home. Father reported that he thought the home was squalid and that there were machetes on the premises.

The police at the learning event reflected that the flat living area had nothing but a couple of sofas. There was a separate room for Child LO with a toddler bed with mattress and suitable bedding. This was not an enclosed type cot/bed and no concerns were identified at this point. The dog was shut in the kitchen. Given the child's stage of development (13 months) an enclosed type cot would have been advisable.

Based on this assessment, which the police shared with children social care based at the Multi Agency Safeguarding Hub (MASH), there was no further assessment and no further concerns raised by father. Information about fathers contact with MASH was not shared with the Health Visitor as would have been expected.

Apparently, at the time father's concerns were reported, MASH was in the early stages of implementation and since that time changes in the way that MASH have been amended and now the Health Visitor would be informed via the health team based with MASH. This sharing of information is essential in enabling Health Visitors to monitor and assess the any concerns posed to pre-school children. Following the decision for no further action MASH tried to contact mother to offer support following father's contact but they did not manage to engage her and the case was closed.

It is positive that the police and MASH shared information about the conditions at the home, but the reviewer wonders whether the police assessment would have been as child focused as that of a Health Visitor or children social care worker who have training in child development and parenting.

Agencies may presume that when a Health Visitor is involved with a child that they are being well monitored with little for other agencies to do. However, Health Visitors are totally

reliant on information being shared with them in order that they are able to make an assessment about a child in order for them to make an assessment of their wellbeing. Health Visitors follow the Health Child Programme which may mean that for a child receiving "universal" level service the child is not seen by them between 9 – 12 months to 2-2.5 years.

This is a long time in the life of the child and at a time when children are developing rapidly and are at their most vulnerable.

Practice learning
Multiagency working and information sharing are key to keeping children safe from harm. MASH arrangements should include contacting relevant health professionals working with the child and family to share information where there are raised concerns by others in the best interest of the child.

The day after father's claim about the state of the flat, mother then went to the police to disclosed that there had been domestic abuse in their relationship and that father was continuing to hassle her. *Issues around domestic abuse will be covered later in this report.*

Finally, mother left the flat with Child LO to move into a static caravan with her new partner and to get away from the hassle of father.

Debt of unpaid fees and intermittent severe nappy rash seen at nursery.

Child LO attended 3 different nurseries' starting at the age of 8 months, 10 months and 12 months, staying in each of the first 2 nurseries until a conversation is had with mother about unpaid fees, after which the child was taken out of nursery and the fees remain unpaid.

There was no information shared with the Health Visitor about nursery attendance and not all nurseries included the name and contact details of the Health Visitor on their records. Most early years settings locally do ask for this basic information as standard when completing initial registration paperwork as part of 'getting to know you'. Nursery settings develop their own format for recording information they feel they require. Nursery 3 did routinely capture the Health Visitor information although there had been no need for communication at the time.

The reviewer is of the view that there may be an omission in routine information gathering, information sharing and communication in some nurseries. Early years services such as nurseries and Health Visiting need to be more joined up in relation to the health and development of children. Information sharing agreements and parental consent should be in place to link up nurseries more closely together to ensure that nurseries can contact each other about children who move from one nursery to another.

During the time period of this review Lancashire did not appear to have a published an Early Years strategy to reflect how nurseries and other agencies should work together to provide a "safety net" for children. However, there was a Child Poverty Strategy (2014) which appeared to be out of date.

Since that time a new document called “The Early Years of Life” (2020-2023) has been published. This is “a strategy to ensure children, young people and families are safe, health and achieve their full potential in Lancashire”. The document is robust and fully comprehensive and advocates information sharing, “Good and effective partnership working between practitioners and with parents and/or carers so that information can be shared and additional support identified and provided at the earliest opportunity” (page 4). It may be useful to consider how this goal translates in the more practical sense at practitioner level.

The reviewer is of the view that nurseries should be linked to the child’s Health Visitor to ensure that any issues arising for children in the nurseries care are shared. The Health Visitor is well placed to address low level concern with the family. Issues such as unpaid fees can be linked to poverty or other family stressors which may need to be explored further and supported.

Another area where the nursery could have made better use of the Health Visitor was when the child had nappy rash. Instead of recommending seeing the GP the Health Visitor would have been well placed to treat the nappy rash and would have been able to use the episode of care as part of the holistic assessment.

Practice learning –The Health Visitor can only work additionally with families where there is a need to do so. Health Visitors require relevant information from other agencies to enable them to engage families at the correct level of intervention in order to safeguard children and to promote their wellbeing. Better links between Health Visiting and Nursery provision would promote better assessment and better support through Early Help.

The reviewer is aware that Lancashire is in the process of working with its partners to improve Early Help working arrangements. There has been a robust consultation and engagement process taking place in the area which should support and improve multiagency working where there are low level concerns.

Multiagency response to Domestic Abuse.

The crime survey national statists for England and Wales ending March 2018 has identified that 7.9% women and 4.2% men were subject to domestic abuse. It should be remembered that these are reported figures and that many more will experience domestic abuse for several years without telling anyone.

There is a Pan-Lancashire Domestic Abuse Strategy update February 2017 with a clear action plan for future improvements. Lancashire Local Authority document is available on the website which was updated in November 2018. This document is titled Domestic Abuse – Intelligence Assessment. The document identifies the national statistics, improving police response and use of Domestic Abuse Protection Orders (DVPO).

Lancashire Safeguarding Adult Board and Domestic Abuse Strategic Board Guidance (November 2018) is easily available on the Lancashire Safeguarding Children Board website.

It is a fully comprehensive and addresses all areas of domestic abuse. The guidance advocates the use of SafeLives risk checklist and identifies best practice around use of safe enquiries both topics of which would have been useful information to professionals working with Child LO and family. It is of note that there is little information available around the impact of domestic abuse on children contained within any of these documents.

NSPCC (November 2013) "Domestic abuse: learning from case reviews" suggests that professionals need to engage more with men living in the family home, whilst also making sure they see the mother alone. Professionals need to keep in mind the impact on the children living with domestic abuse. Published case reviews had highlighted that professionals sometimes struggle to keep their focus on the child when working with parental domestic abuse because the parent's relationship problems can end up overshadowing those of their children.

Information sharing

Whilst it was clear that father had been the perpetrator of domestic abuse with a previous partner which had resulted in a prosecution and Restraining Order it was not known that there was any domestic abuse between Child LO's parents until the child was 13 months. An assessment of the child's lived experience did not take place as it should once domestic abuse was disclosed.

The GP, Midwives and Health Visitors working closely with the child and family were not aware of father's past history of domestic abuse and were therefore, not able to factor these concerns into the care plans provided by the health services during the antenatal and postnatal period.

There is an intention to improve multiagency information sharing via the local MASH safeguarding arrangements. This should improve relevant information being shared to relevant staff working with children and their families.

Routine enquiry

"Routine enquiry" is supported by the Royal College of Midwives, Royal College of Nursing, Royal College of Psychiatrists and the National Institute for Health and Care Excellence (NICE) public health guidance, 'Domestic violence and abuse: multi-agency working' (NICE 2014).

Routine enquiry involves asking all women (when alone) at assessment about abuse regardless of whether there are any indicators or suspicions of abuse. It was established in maternity, sexual health, health visiting, substance misuse and mental health settings. This was due to the disproportionate number of women accessing these services who have experience of abuse.

The aim of routine enquiry is to recognise the nature domestic abuse and to provide support through relevant local services.

Throughout pregnancy and the first year of Child LO's life neither the Midwife or the Health Visitor asked any routine enquiry questions around domestic abuse. This was partly because father was present at several of the visits and when mother was alone the opportunity to ask relevant questions was not taken as would have been expected.

At the time of the review period the Midwives had not yet fully implemented the routine enquiry programme into their care pathways. Health Visitors were expected to ask the questions, but unfortunately this did not occur. It is not clear why professionals were not using the routine enquiry which is commonly used in most other areas. More work needs to be considered to ensure that routine enquiry is normalised into every day practice locally and professionals need the skills to feel confident about asking questions about personal relationships and domestic abuse.

Mother told the Health Visitor at the 1-year assessment that she had split from her partner (father of Child LO). There was no record or questioning about why or what happened in the relationship and no enquiry about how they were now. Research shows that domestic abuse often gets worse after a split in the relationship and since mother was now living alone with her child it would have been sensible to use routine enquiry to check that there were no welfare concerns.

Practice learning - "Routine enquiry" is an essential part of antenatal, postnatal and follow on care. Recognising and addressing domestic abuse early has a beneficial impact on children and family life. Early help assessment enables professionals to identify risk factors and provide relevant support through multiagency care planning.

Assessment of risk in domestic abuse

Mother did not disclose domestic abuse until the day after father made a referral to MASH about his concerns for his daughter. Mother made a call to the Police about harassment and the call handler recorded that mother had said that her ex-partner had made a threat to kill.

Often threats to kill can be said in the heat of the moment as a throw away comment. The definition of the offence of Threats to Kill is that: *A person who without lawful excuse makes to another a threat, intending that, that other would fear it would be carried out, to kill that other or a third person.*

Following on from the police call, three days later, mother attended the police station and was interviewed to make a statement in support of her claim. She disclosed that she had suffered an historical physical assault, and now father was phoning and texting abuse. There was no repeated allegation of the threat to kill by mother at Police interview and nothing was said by mother to suggest that she was afraid of father. Mother did not want to prosecute father she just wanted him to stop hassling her.

Father was hassling mother following the split because ongoing contact issues with Child LO, which was said to be going through Court for contact arrangements, although the reviewer has seen no evidence of this.

The Police raised a Standard Risk PVP in response to the allegations as a whole and shared with MASH, IDVA, Probation and Health. Father was seen by the Police Officer who had spoken to mother and was told not to hassle mother again and to seek legal advice for contact with Child LO. The Police Officer created a Crime Report for Assault (historic) to comply with Crime Recording Standards. There was no Harassment Warning Notice to support the Police verbal warning to father and no further action taken.

Police Information Notices (PIN) were still being used by Lancashire Constabulary at the time the allegations were being made. PINs are warnings which the police may issues where there are allegations of harassment. These notices (sometimes called Harassment Warning Notices or Early Harassment Notices) are not covered by legislation and do not in themselves constitute any kind of formal legal action.

PIN's stopped being used by Lancashire Constabulary in November 2018 as a result of a joint inspection by Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Crown Prosecution Service Inspectorate (HMCPSI) into local area response to harassment and stalking which took place in July 2017. The inspection recommended that PIN's were stopped to make way for more thorough investigation to better assess and manage the risk of victims and to prosecute more perpetrators.

Mother went on to make a further telephone complaint to the police on the same day as making her statement at the police station. This resulted in an additional Standard Risk PVP being shared with MASH and other agencies.

MASH responded to concerns raised by the PVP and father by gaining reassurance from the police following a child welfare check at the flat and as previously stated, MASH did try to contact mother to offer support around domestic abuse. MASH made a number of attempts to contact mother and after 5 days sent a letter to mother to offer support if required.

Practice Learning
Best practice would be that MASH should ensure that were there are concerns about domestic abuse whereby a mother with pre-school children cannot be contacted, MASH should inform the Health Visitor to enable an assessment of the child's health and development in relation to considering the negative impact of domestic abuse.

Further to this, father made a separate telephone call to the Health Visitor about concerns that mother was drinking alcohol daily whilst caring for Child LO. He reported that hygiene in the flat was poor and that relationships between them was not good. He told the Health Visitor that he had made a referral to MASH and the Health Visitor reassured father that she would carry out a visit at the home if children social care did not accept the referral.

The Health Visitor was unaware of the allegations of domestic abuse at this point. No checks with children social care were made about the situation and a home visit did not take place in response to the contact from father.

SafeLives checklist

The purpose of the SafeLives checklist is to give a consistent and simple tool for practitioners who work with adult victims of domestic abuse in order to help them identify those who are at high risk of harm and whose cases should be referred to a Multi-Agency Risk Assessment Conference (MARAC) meeting in order to manage their risk. When someone is experiencing domestic abuse, it's vital to make an accurate and fast assessment of the danger they're in, so they can get the right help as quickly as possible.

In this case, 2 weeks after fathers call, the Health Visitor received a standard PVP from the police identifying that mother was getting abusive texts from father. No immediate action was taken in response to this. Expected practice would be for the Health Visitor to contact mother and enquire about the PVP and ascertain if a SafeLives assessment was needed. A home visit at this point would have been advisable in order to consider fathers concerns alongside the information provided in the PVP.

The following month the Health Visitor talked to mother at an opportunistic home visit. Mother shared that she was going to live with her new partner and that father wanted contact with Child LO but she was reluctant because he takes drugs and was abusive to her.

There was an opportunity to complete a SafeLives checklist about the nature of the domestic abuse at this point. It would be best practice to fully record all information given about the nature and type of abuse and to consider safety planning. Assessing risk at the point of disclosure assists in appropriate interventions and risk management.

At the following visit Mother was appropriately advised by the Health Visitor to seek legal advice about concerns around child contact. The Health Visitor did not check out fathers claim that he had spoken to children social care about concerns for Child LO and did not check on any further children social care involvement. The Health Visitor noted that Child LO was seen to be appropriately dress and strapped in a pushchair. Mother raised concern about Child LO's behaviour which had recently become more challenging and an appointment was made for the following week to review this.

The Health Visitor appointment took place as planned at a static caravan (1) which was the home of mother's new partner. Mother stated she had sought legal advice about fathers request for contact which was ongoing. The Health Visitor did not take the opportunity to obtain details about the new partner or consider the role he would take in Child LOs care. The nature of the child's declining behaviour was not ascertained as would have been expected.

Practice learning – When circumstances change for children and families it is important to clearly record demographic information about new people entering the family. Gathering information about adults living with children is essential to keep children safe and promoting their wellbeing.

Domestic abuse is a common occurrence when working with children and families. Professionals need to be well trained and confident in all aspects of domestic abuse work and
have a good understanding of the impact that domestic abuse can have on the health, development and wellbeing of children.

Practice Issues

A practice issue is an area of practice which has already been addressed locally but needs to be reviewed and considered in the individual agencies involved.

- Record Keeping is an essential part of assessment and care delivery. All providers of services for preschool children should keep accurate demographic details of adults living with children. Any change in circumstance should be noted and new information included.
- Midwifery and Health Visiting should review their records to additionally include;
  1) Information about previous children to include names, dob, address and contact arrangements. (Midwifery already have this in place)
  2) Evidence of Routine Enquiry about domestic abuse.
  3) Home conditions and living arrangements
  4) Evidence that baby sleep environments have been seen and safer sleep assessment conducted in line with new Pan Lancashire Safer Sleep guidance.
- Nurseries should review their records to additionally include:
  1) Details of previous nursery attended
  2) Name and contact of child's Health Visitor
  3) Consent to share information with Health Visitors and other professionals working with the child and family.
  4) Details of child's father and any father figures including any changes including when and why.
- Antenatal visits –Midwives do not have the capacity to carry out home visits locally**.** Health Visitors are expected to carry out a home visit through at around 28 weeks of pregnancy. This did not occur in this case. A review of how service monitoring is being conducted should be reviewed to ensure that the commissioner is alerted to gaps in service provision.
- MASH should always discuss safeguarding concerns with both police and health before making a threshold decision. This statutory requirement has been in place since Working Together 2015. New MASH pathways have been implemented to improve threshold discussions and to share information to promote child welfare when the threshold for children social care intervention has not been reached.
- SafeLives checklist should be further implemented into all professionals practice when working with adults suffering domestic abuse.
- CAFCASS and childrens social care have reviewed their information sharing processes to take account of risks to children linked to private law proceedings.
- Child Focus – all training and polices should include the importance of maintaining a child focus.

Good practice

There was a number of good practice examples recognised across the time period of this review as follows:

- Health Visitor made an opportunistic visit to Child LOs family home following concerns being raised by father and the PVP.
- Police Officer welfare check was of the flat was of good quality and with good understanding about Child LOs sleeping environment which was satisfactory at the time.
- Communication between Police and Children Social care was good and well documented.

Conclusion

This SCR provides learning from the tragic death of a 16-month-old child who died in an unsafe sleeping environment. A Coronal inquiry is planned for the near future.

Although this SCR has been significantly delayed due to a Police criminal investigation, a number of identified improvements in practice have already been addressed. There remains a number of issues which have been identified and warrant the consideration of Blackburn with Darwen, Blackpool and Lancashire Children's Safeguarding Assurance Partnership (CSAP) who are now responsible for safeguarding children in the local area.

This review should be shared to promote learning across the safeguarding partnership.

Recommendations

The following recommendations are for the consideration of CSAP as follows:

Recommendation 1

CSAP should ensure that the updated Pan-Lancashire Multiagency Guidance on Safer Sleeping includes clear instruction on when and how safe sleep assessments are conducted in line with Child LR Review and expand the scope of the guidance to include children under 5 years.

Intended outcome *– To improve the safety of sleeping environments for preschool children to reduce the incidence of possible accidental death.*

Recommendation 2

CSAP should request assurance from Lancashire Public Health that the new Early Years Strategy 2020-2023 is being fully implemented particularly around information sharing.

Intended outcome *– To promote the improvement of local multi-agency working and information sharing around pre-school children.*

Recommendation 3

CSAP should review and further implement the Lancashire Domestic Abuse Guidance to include:

a) more focus on the impact of domestic abuse on children;
b) ensure use of routine enquiry during pregnancy and beyond; and
c) improve use of SafeLives check list when working with domestic abuse disclosure.

Intended outcome *– To improve standards of domestic abuse processes locally.*

Recommendation 4

CSAP should ensure that the new Multi-Agency Early Help arrangements are robustly implemented and front-line professionals fully understand their role and responsibilities in identifying vulnerable families.

Intended outcome *– To improve Early Help work with children and their families.*

Recommendation 5

CSAP should request written assurance from the District Councils in their area, that work is being progressed to enforce winter closure of Holiday Parks in line with the expected regulation.

Intended outcome *– To reduce the risk of children and families living in holiday park accommodation during the cold winter months.*

References

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Royal Society for the Prevention of Accidents (RoSPA)
https://www.rospa.com/

Child Accident Prevention Trust
https://www.capt.org.uk/suffocation-prevention

SafeLives DASH risk checklist
https://www.bing.com/search?q=safelives+checklist&form=EDGEAR&qs=HS&cvid=ead20418bf2f44e08cdc9b1b23e2f8d4&cc=GB&setlang=en-GB&elv=AY3%21uAY7tbNNZGZ2yiGNjfMr5%21hUnjRCdF7BNLMfsOJLfWywyHD0qIgfdutElqJbwx8uPAzkpnXNmH04VSor4Qo6oKh0tlykjYlxt96IdOL0&plvar=0

Co-Sleeping with your baby – The Lullaby Trust (2019)
https://www.lullabytrust.org.uk/safer-sleep-advice/co-sleeping/

Reduce the risk of sudden infant death syndrome (SIDs) (NHS 2019)
https://www.nhs.uk/conditions/pregnancy-and-baby/reducing-risk-cot-death/

Statement of Reviewer Independence

The reviewer, Kathy Webster is independent of the case and of Lancashire Safeguarding Children Board and its partner agencies.

Prior to my involvement with this Serious Case Review;

- I have not been directly concerned with the child or any of the family members or professions involved with the child, or have I given any professionals advice on this case at any time.
- I have no immediate line management of the practitioners involved.
- I have appropriate recognised qualifications, knowledge and experience and training to undertake this review.
- The review has been conducted appropriately and with rigours analysis and evaluation of the issues as set out in the Terms of Reference.

Kathy Webster – Independent Reviewer