SERIOUS CASE REVIEW

OVERVIEW REPORT

BABY N

Report author:

Karen Tudor

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1: INTRODUCTION

1.1 This Serious Case Review (SCR) is about the work done with Baby N and his family prior to the baby's death in the summer of 2015. He was four months old when he died, the cause of death was described by the coroner as "sudden unexplained death in infancy" (SUDI).

SUMMARY OF THE CASE

1.2 The subject of the Review, Baby N, was born in the spring of 2015. He was a healthy boy, born after a full term pregnancy. The baby's mother was 16 when she became pregnant and his father was 17. His parents did not live together but were both involved with his care. The baby lived with his mother, maternal grandmother and his mother's younger sibling.

1.3 The baby's parents both had complicated histories. His mother had witnessed domestic abuse as a child and been taken into the care of the local authority. She was twice placed for adoption but returned to the care of her mother when the placements broke down. The baby's father had an unsettled childhood: his own father had left the family when he was very young and his relationship with his mother was difficult and at times violent.

1.4 Whilst the baby's mother was attentive to his needs and seen to provide good care of him, the family lifestyle included some of the factors associated with SUDI. Because of the concerns, which included possible drug use, risk of domestic abuse and cluttered home conditions, the family were identified as vulnerable before the baby was born.

1.5 A pre-birth risk assessment was started prior to the baby's birth but was not completed. The parents were resistant to the involvement of professionals: they missed some appointments, were occasionally aggressive with staff and at the beginning of the review period refused to allow the social worker access to the family home.

1.6 The parent's resistance, along with the identified concerns, led to child protection enquiries, after which a child protection conference decided to make the baby subject to a Child Protection Plan in the category of neglect. A Contract of Expectations was drawn up with the family. The Child Protection Plan was reviewed after three months and remained in place as little had changed.

1.7 Sadly, in the summer of 2015, Baby N died.

CONDUCTING A SERIOUS CASE REVIEW

1.8 When abuse or neglect of a child is known or suspected and either the child has died or the child has been seriously harmed and there is cause for concern as to the way in which services have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) has to consider whether a Serious Case Review should be carried out.

1.9 In this case risks to the baby had been identified before he died and he was the subject of a multi-agency Child Protection Plan. The Bournemouth and Poole Safeguarding Children Board under Regulation 5 of the Local Safeguarding Children Boards Regulations 2006, decided the criteria for a SCR had been met. The recommendation was confirmed by the Chair of the Bournemouth and Poole Safeguarding Children Board and notification of the decision was made to the Department for Education.

1.10 The focus of the Review was:

- *To gain an understanding of the quality of assessment and risk analysis of family functioning;*
- *To look at the effectiveness of information sharing;*
- *To consider the effectiveness of the services offered; who did what and why;*
- *To identify any learning from the Review, research and other relevant Reviews.*

From Baby N, Terms of Reference

METHOD

1.11 A Review Group was established and agreed the review period would be the thirteen months from June 2014, the date the pregnancy commenced, to July 2015, the date of the baby's death.

1.12 The Review must be conducted in line with government guidance, *Working Together to Safeguard Children 2015*. In view of the move towards using systemic models and practitioner involvement to promote learning, the Board decided to use a review model known as a Partnership Learning Review.

1.13 The principles of the model echo those prescribed in Working Together, that Reviews should be:

> *"proportionate, that professionals involved in the case should be engaged in the learning and that the family have every opportunity to contribute to the Review."*

1.14 Key elements of the Partnership Learning Review model are:

- Appointment of a suitably qualified and experienced Independent Reviewer to review practice, facilitate meetings and to write the report;
- Preparation of a detailed chronology and analysis of practice by managers independent of the case but with knowledge of the local context;
- Involvement of family members to contribute their views about the service they received;
- "Learning Events" for those involved with the case to discuss their role, their actions and what they were thinking at the time, as well as what worked well, the practice challenges and what can be learnt from this case;
- Oversight of the process by a Review Group chaired by an independent senior manager and comprising multi-agency partners, none of whom had involvement with the case. The agencies involved in the Review are listed in Appendix 2.

LEARNING EVENTS

1.15 In this case two Learning Events were held, both attended by 12 practitioners all of whom knew the family and most of whom had met the baby. Agencies who worked with the family were represented including midwifery, health visiting, children's social care, the police, housing, youth offending service, community mental health team and the targeted team.

1.16 The meetings provided an opportunity to discuss the case and the key practice events such as risk assessment, child protection conferences, planning, the impact of hoarding, communication between agencies and working with resistant families. It also provided an opportunity to explore why and on what basis some decisions had been made. The participants were able to agree the facts presented in the chronology and the themes for learning.

1.17 In between Learning Events the practitioners undertook some personal research into relevant areas, for example current thinking about SUDI and the impact of hoarding, and they reported their findings to the group.

FAMILY INVOLVEMENT IN THIS REVIEW

1.18 The baby's family were invited to contribute to the Review and persistent efforts were made to encourage their participation. Unfortunately they chose not take up the invitation.

FINDINGS

1.19 Information was collated from the written reports, Learning Events and the Review Group, relevant documents, research and findings from other SCRs. The report includes a detailed description of key practice events, what happened and why, followed by an analysis of any learning.

1.20 The findings are presented as Themes, divided into the pre-birth and post-birth periods, these are:

- Assessment of Risk;
- Management of Risk and Risk Reduction.

1.21 A Glossary of Terms is appended to explain the terminology.

2: FACTUAL SUMMARY OF THE CASE

FAMILY BACKGROUND

2.1 In order to protect the privacy of the family their names have been changed. Significant family members are:

"BABY N" TO BE KNOWN AS BABY NATHAN	Died aged four months
RACHEL HARRIS	Baby's mother, aged 17 when baby born
MRS HARRIS	Baby's maternal grandmother
SOPHIE HARRIS	Baby's maternal aunt, aged 9
MR HARRIS	Baby's maternal grandfather
BEN BROWN	Baby's father, aged 18 when baby born
MRS BROWN	Baby's paternal grandmother

FAMILY HISTORY

2.2 Baby Nathan was born in the spring of 2015. His mother and father were aged 17 and 18 years respectively at the time and they are both white British.

2.3 Rachel Harris had witnessed domestic violence as child and several of her siblings had been taken into care and adopted. Rachel had also been placed for adoption but two placements had broken down and she returned to live with her mother when she was about 10 years old.

2.4 Ben Brown's father had left home when Ben was very young. Records indicate that, as a child, Ben had been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD). He had a history of drug abuse dating back to his early teenage years.

THE COUPLE'S RELATIONSHIP

2.5 Ben and Rachel did not live together, Rachel lived with her mother and younger sister (aged 9). The records suggest that Rachel's father may also have stayed at the family home from time to time after Nathan was born. When Nathan was born he lived with his mother and maternal grandmother.

2.6 Ben lived with his mother until an injunction resulting from domestic violence prevented this. He then became homeless and "sofa-surfed", allegedly staying with various friends.

2.7 The baby's parents said their relationship ended when Nathan was about a month old, although Ben continued to have regular contact at the baby's home.

2.8 The baby's home was a two-bedroom maisonette above a shop. The larger bedroom was on the top floor, divided in order to provide two "rooms" – one for Rachel and Nathan and one for Rachel's mother.

2.9 Rachel's mother was known to be a "hoarder" and the flat was very cluttered with toys, clothing and household goods. Home conditions were discussed at the Child Protection Conferences and addressing them formed part of the baby's Child Protection Plan.

3: KEY EVENTS

SUMMER 2014

- June: Rachel Harris became pregnant she was aged 16, Ben Brown was 17.
- Ben Brown was in court for breach of a Reparation Order, this led to a discussion about his anti-social behaviour.
- July: Rachel fainted and went to hospital, she was referred to Early Pregnancy Clinic.
- Ben Brown was arrested for assaulting his mother. She was assessed as being at high risk and a MARAC was convened.
- As a result of the assault Ben was referred to CAMHS by his GP. He didn't engage with the service and the case was closed.
- August: Rachel self-referred to the maternity services.

SEPTEMBER 2014

- September: Ben was in court regarding his assault on his mother. He was sentenced to a three-month Reparation Order with Supervision. Ben told the Youth Offending Service (YOS) worker he was due to become to become a father. He also said he had stopped using drugs.
- October: Ben was arrested for possession of cannabis.
- October: Rachel was assessed by maternity services as vulnerable and referred for an enhanced service.
- Ben became homeless when his relationship with his mother broke down.
- November: the local authority service working with young people not in education, employment or training, heard about Rachel and referred her to Children's Social Care, an assessment commenced.
- November: a social worker visited Rachel but was not allowed into the house.

WINTER 2014

- December: YOS completed their work with Ben and closed the case.
- A domestic abuse incident between Ben and Rachel was reported to the police. The incident involved shouting, the couple would not cooperate with the police and no further action was taken.
- The couple twice presented themselves at the housing department as homeless, both times they were removed from the building for being aggressive and abusive to staff.

WINTER 2015

- January: Ben assaulted his mother, an injunction was ordered to prevent him entering her home.
- February: a MARAC was convened and some decisions about Ben and his mother's contact with the (as yet unborn) baby were made by Children's Social Care.
- Rachel missed some maternity appointments and was avoiding the social worker who was trying to carry out an assessment.
- February: Section 47 child protection enquiries were initiated.
- Ben was referred to the Community Mental Health Team (CMHT) by his GP.

SPRING 2015

- Baby Nathan was born. It was a normal delivery and he was of average weight. He was tested for presence of drugs and found to have cannabis in his urine.
- March: an Initial Child Protection Conference was held and a Child Protection Plan put in place, the category was Neglect.
- A Core Group was convened and a Contract of Expectations was signed by both parents.
- The parents said their relationship had ended although Ben was seeing Rachel and the baby frequently.
- A Review Child Protection Conference was held and the baby remained subject to a Child Protection Plan.

SUMMER 2015

- June: Rachel's father was thought to be staying at the family home. He had a history of drug use and domestic violence.
- Ben was arrested on suspicion of assault (of a neighbour).
- August: Ben was assessed by Steps to Wellbeing Service (mental health provider) and referred for Cognitive Behaviour Therapy although he never took up this opportunity.
- Baby Nathan died, aged 17 weeks.

4: BABY NATHAN'S EXPERIENCE

4.1 Baby Nathan was born in the spring of 2015 and he lived for 17 weeks. The cause of his death was unexplained and described by the Coroner as "sudden unexpected death in infancy" (SUDI).

4.2 Baby Nathan's parents were in a relationship until he was about 10 weeks old but after they parted he is said to have had almost daily contact with his father, always in the presence of his mother. Although Nathan's father was known to have a volatile temper and a history of domestic abuse with his own mother, there was never any suggestion that he was other than a loving and proud father who handled Nathan sensitively, provided for him materially and took steps to ensure he was well cared for.

4.3 Baby Nathan's mother clearly loved her son and everyone who saw them together describes their relationship as close. He was a breast-fed, healthy baby who, after a slow start, was gaining weight steadily. He was a wanted and much-loved child. His mother had many photographs of him, all of which showed him happy and content.

4.4 Nathan lived with his mother, grandmother and 9-year-old aunt. He had contact with his paternal grandmother and saw his father frequently. He was surrounded by his family and it is likely that he felt safe and secure in their care.

4.5 Although Nathan's home conditions were cluttered, he was always clean and well dressed and all his practical needs were met. Nathan shared an attic room with his mother and it is believed he slept in a Moses basket for some of the time. He did have a crib but this was found on top of a high cupboard and did not appear to be in use.

4.6 Despite being cluttered, the bedroom was clean and comfortable but it lacked ventilation. Nathan died on one of the hottest nights of the year, during which he was co-sleeping with his mother. The Coroner's report indicated that over-wrapping was a contributory factor in his death.

5: ANALYSIS – PRE-BIRTH PERIOD

ASSESSMENT OF RISK

IDENTIFICATION OF VULNERABILITY

5.1 Health Services first became aware of Rachel and her pregnancy in the summer of 2014, when Rachel was aged 16 and about six weeks pregnant. She was seen in the Emergency Department of her local hospital because she had fainted and when she was found to be pregnant they referred her to the Early Pregnancy Clinic.

5.2 The Early Pregnancy Clinic should routinely share information with a patient's GP but, in this case, Rachel was not registered with a GP and it appears this opportunity was lost.

5.3 Five weeks later, Rachel referred herself to Maternity Services via the internet. Booking took a further three weeks because of workload pressures. Rachel was now 11 weeks pregnant. NICE Guidance for antenatal care state that pregnant women should be accessing services by week 10 of their pregnancy. In these early weeks women are given information and advice about diet and supplements, food hygiene and smoking cessation. Screening is available to detect anomalies including Down's Syndrome.

5.4 The delay in booking meant that Rachel missed out on the opportunities for early health intervention.

5.5 When Rachel was booked in, Maternity Services carried out an initial assessment of her health and social needs in line with NICE guidance, their Antenatal Booking and Antenatal Care Pathway Protocol.

5.6 The assessment identified Rachel (who was still 16) as a vulnerable patient and she was referred for consultant-led care which meant she would be more closely monitored, as well as be seen by a midwife from the specialist team for vulnerable women. This was good practice.

5.7 The maternity assessment format covers areas such as smoking, drug and alcohol use, and risk of domestic abuse. Rachel disclosed that she smoked and used cannabis. A urine screening and toxicology test were planned for week 28 of the pregnancy but this was not followed up. This was a missed opportunity to gather information which could have contributed to the pre-birth assessment.

5.8 Rachel later disclosed to the midwives information about Ben's history of domestic violence. She had also missed several appointments at the clinic and the staff felt she did not appreciate the value of antenatal care. It was this combination of factors which led to a safeguarding referral to Children's Social Care when Rachel was about 22 weeks pregnant.

5.9 Early identification and follow-up of vulnerable women is important in ensuring they access services and that relevant information is shared with other agencies in a timely way.

5.10 The delay, in this case caused by pressures of work, is being addressed by midwifery as part of their agency review of this case. The LSCB should ensure that the antenatal care pathways are clear and working effectively.

FOR THE LSCB

The LSCB should seek assurance that antenatal care pathways are clear and working effectively.

REFERRAL TO CHILDREN'S SOCIAL CARE

5.11 The Young People's Targeted Community Team is a service provided by the authority's Children Young People and Learning service (CYPL). At that time the service primarily focused on young people not in education, employment or training.

5.12 In November 2014 the Targeted Team reviewed Rachel's situation and on learning she was pregnant, referred her to Children's Social Care.

5.13 Children's Social Care spoke to the midwifery services who, at the same time, had planned to refer Rachel and the referral was documented.

5.14 A social worker was allocated to the case with a view to completing a pre-birth assessment. Rachel was then about 22 weeks pregnant.

PRE-BIRTH RISK ASSESSMENT

5.15 Children's Social Care had every intention of carrying out a pre-birth risk assessment and contacted the midwife. The midwife shared the information she had about Rachel and said that Rachel had missed two antenatal appointments. The midwife was also concerned about the home conditions, seen through the window when she attempted to make a home visit.

5.16 The social worker's manager agreed a pre-birth assessment was appropriate and that it should be completed within the following two weeks. The social worker visited Rachel at home but was not allowed inside. From the doorstep she explained the reason for the visit and that Children's Social Care would need to consider using the Child Protection Procedures if Rachel did not engage with services offered.

5.17 The same day the social worker asked their legal services for advice and was advised to consider making enquiries under section 47 of the Children Act, Child Protection. This would have meant starting a child protection investigation.

5.18 The social worker felt a child protection investigation was not appropriate at this stage and a week later made another home visit and saw Rachel and her mother together. The social worker explained why an assessment was necessary and the plan was to complete the assessment, working with both Rachel and Ben.

5.19 In the last two weeks of February, two weeks before the baby was born, the social worker made several further attempts to contact Rachel and Ben without success. Three days before

the baby was born, Children's Social Care decided to start a Child Protection Investigation and convene an Initial Child Protection Conference.

5.20 The pre-birth risk assessment was never completed and the social worker only had one further contact with Ben when he went to her office complaining about contact arrangements for the baby (as yet unborn).

COMPLETING THE ASSESSMENT

5.21 An assessment was completed in the week after the baby was born and before the Initial Child Protection Conference. From the records, it was based on one further visit from the social worker to the family and a telephone conversation with the midwife. A report was provided to the conference.

5.22 Two further domestic abuse incidents had been recorded between the time of the social worker's first home visit and the conference. The first was a dispute between Ben and his mother, allegedly about Rachel and the pregnancy. The second was a verbal altercation between Ben and Rachel to which the police were called.

5.23 The first incident led to a MARAC, after which Children's Social Care had decided that Ben was to have his contact supervised by Rachel, and that Ben and his mother were not to be together with the baby at any time. The completed assessment did not give adequate consideration to these events.

5.24 The lack of a pre-birth assessment was a missed opportunity to get to know this family, their history, parenting knowledge and skills and what the concerns for the baby might be.

5.25 The failure to complete the pre-birth assessment was due to a combination of factors:

- The family were hard to contact;
- The social worker did not prioritise the work in the face of other pressures and an assumption she made in the early stages that this case was not likely to reach the child protection threshold;
- This assumption was not challenged by a manager as part of the social worker's supervision;
- There was inadequate management and supervision of the case.

5.26 It is difficult for practitioners to know how best to try and encourage families to co-operate, in this case a detailed understanding of the family' history might have helped workers see and understand both sides of the story. Achieving a balance of care and control is important and it appears from the recording that the social worker informed the family of the possibility of a child protection investigation if she wasn't allowed access. Although it is important to be honest with families, from their perspective, the fact this information was presented so early was unlikely to help them to trust workers and share information freely.

5.27 The failure to complete the assessment was compounded by lack of management oversight and monitoring of compliance. The legal department had advised the social worker to consider initiating child protection enquiries but this was considered to be unnecessary by the social worker. This decision-making should have included the social worker's manager.

5.28 Good supervision is essential both in monitoring compliance and making sure staff have all the

background information available. It should help them reflect on their thinking about cases and how to approach families.

LEARNING POINTS

Supervision and management support is essential to help practitioners manage, monitor and think systemically about a case where neglect is, or might be an issue.

Pre-birth assessments provide an opportunity to understand a family's circumstances and enable interventions to be appropriate and timely.

FOR THE LSCB

The LSCB should seek assurance that all staff have access to regular, good quality supervision.

THE ROLE AND CONTRIBUTION OF THE GP

5.29 Rachel did not register with a GP until January 2015, three months before Nathan was born. When she did register, there were no records for her from 2009–2015. The GP was not aware of this gap until the review team recognised the issue while collating the chronologies. The practice is now in the process of locating the records.

5.30 The GP was in a good position to discuss the risk of SUDI with Rachel. He would have known that she was 17 years old, a smoker and may possibly also have known about her drug use. He is likely to have known something about the family background.

5.31 What stopped the GP from exploring these issues was time pressure and a tendency to address the presenting problem and the assumption that Rachel's mother was a protective factor in the family. In discussion about this case as part of this review, the GP also acknowledged a reluctance to be seen to be "investigating" the family.

5.32 Unfortunately time constraints prevented the GP from attending the Learning Events but the practice has taken the opportunity to reflect on learning from this case. Also, the transfer of patient records is addressed in the updated GP2GP guidance which reinforces the benefits of direct electronic transfer.

LEARNING POINT

GPs often have information about families which if sought and shared (with appropriate consents being given) can give insight into family functioning. This information will make assessments more effective and lead to better planning and appropriate services being provided.

INPUT FROM THE YOUTH OFFENDING SERVICE (YOS)

5.33 Ben had been known to the YOS since January 2012 because of his previous offending behaviour. They were actively working with him from the start of this review period, June 2014, to December 2014, by which time when Rachel was six months pregnant.

5.34 The case was co-worked by a police officer and a youth justice worker, both members of the YOS team. The focus of their work was on Ben's two assaults on his mother which resulted in a Reparation Order, a Restraining Order preventing him from going to his mother's home, and Ben subsequently becoming homeless. The YOS completed a risk management plan. The intention was to share the plan with Children's Social Care but this never happened.

5.35 When Rachel was about 18 weeks pregnant, Ben told the YOS he was going to become a father. They knew Ben quite well, despite his intermittent engagement: he had 16 contacts with YOS before he completed his order in December 2014, three months before Nathan was born.

5.36 As part of their supervision, YOS did some work with Ben about becoming a parent, mainly aimed at anger management (the focus of their work) along with some basic parenting skills. They decided to refer the couple to Children's Social Care but they were unsure about the meaning of confidentiality and whether it was appropriate to pass on the information. They did make a safeguarding referral about three weeks later.

5.37 As part of this review the YOS identified incomplete actions, particularly around their own Risk Management Assessment and action plan, gaps in supervision and lack of communication with other agencies and failure to work jointly with agencies where this was indicated. YOS did not to attend the first MARAC about Ben and his mother which would have provided an opportunity to share their knowledge of Ben and contribute to the action plan.

5.38 There have been significant changes in the management of the YOS with the merger of the Bournemouth and Poole YOS and Dorset YOS in July 2015. The service has identified a number of learning points from this review which they will follow up. These are predominantly around sharing information and indicate a need for a more proactive approach to multi-agency working.

5.39 The YOS agency review also raised questions about their worker's understanding of confidentiality and their responsibility to seek and to share information when a child might be at risk of harm or in need of services.

FOR THE LSCB

The LSCB should satisfy itself that all agencies fully understand the need to share information and how this should be done if a child may be at risk of harm.

CONTRIBUTION OF MULTI-AGENCY RISK ASSESSMENT CONFERENCE (MARAC)

5.40 Following a domestic incident, the police routinely carry out a DASH risk assessment to ascertain the level of risk to the victim. If the risk is assessed as high, the case is referred to a multi-agency group, known as a MARAC, and a meeting is held in order to agree a protection plan for the victim.

5.41 In this case Ben's assault on his mother led to first of the two MARACs in July 2014 when Rachel was about seven weeks pregnant. The YOS didn't attend the meeting.

5.42 To their credit, the MARAC, in addition to considering the victim of the assault, Ben's mother, also considered Ben's relationship with Rachel, although no one at the meeting knew about the pregnancy.

5.43 One of the outcomes from the MARAC was a plan to share information about Ben's history with Rachel. This would be using the guidance from the Domestic Violence Disclosure Scheme, known as Clare's Law, which enables the sharing of information about domestic violence with relevant people.

5.44 This action was never completed because, despite several attempts, the police weren't able to make contact with Rachel.

5.45 Although the record of conversations between Rachel and the social worker indicate that Rachel was aware of Ben's history, there is no evidence that the risks to Rachel of domestic abuse were ever fully explored.

5.46 On the basis of what they observed, no one in the professional network explored the risk to Rachel. Further thought should have been given to the links between Rachel's childhood experiences of witnessing domestic violence, her youth, choice of partner and her pregnancy, all linked with increased risk of domestic abuse. The police should have followed up their intention to talk to Rachel.

FOR THE LSCB

In this case an action identified by the MARAC to share information with a potential victim of domestic abuse was not followed up. The LSCB should seek assurance that the MARAC has an adequate system in place to monitor compliance with agreed actions.

CONSIDERATION OF COMMON ASSESSMENT FRAMEWORK

5.47 Following a Serious Case Review in Bournemouth and Poole into the death of Baby F in 2010, one of the actions for the LSCB was to:

> *"develop a comprehensive multi-agency teenage pregnancy strategy which will include an agreed multi-agency package of intervention, addressing concerns or difficulties identified."*
>
> *From SCR Baby F – Action Plan, July 2010*

5.48 As a result, the pan-Dorset Child Protection Procedures, "Protocol for the Protection of the Unborn Child" was published. This states that, where low-level risks are identified, professionals should consider using the Common Assessment Framework if it is considered that:

> *"the unborn baby … be "in need" or at risk of significant harm, [in which case] a referral to Children's Social Care must be made."*

5.49 The Protocol also draws attention to the need to consider young people under 17 as "a child in their own right" and to include an assessment of their own needs as well as those of the unborn child.

5.50 Before Nathan was born, the agencies that had had contact with Rachel and Ben had between them identified their vulnerability: they were teenage parents with a complex history, had missed appointments, there was some drug use, there were concerns about housing conditions and Ben's mental health and domestic violence history, plus the fact that Rachel had not registered with a GP.

5.51 Each agency had carried out an assessment based on what they knew; however, despite the history and the guidance in the Protocol no-one considered initiating a CAF to access Early Help.

5.52 This meant that prior to the birth of the baby assessments weren't shared and although we cannot know whether this family would have engaged with services, the opportunity the opportunity for Early Help was missed.

WHY WASN'T A CAF INITIATED IN THIS CASE?

5.53 Discussion at the Learning Event indicated that half of the practitioners were not aware of the Protocol for the Protection of the Unborn Child.

5.54 Most of those involved with the family understood their responsibility to refer to Children's Social Care if they had concerns about a family and knew that a pre-birth assessment was a likely outcome. In general, the concept of shared ownership of early help or a CAF was not part of everyday thinking.

LEARNING POINT

The Protocol for the Protection of the Unborn Child provides comprehensive guidance for sharing information, assessing need holistically and planning and coordinating intervention.

FOR THE LSCB

For the Protocol for the Protection of the Unborn Child to be effective, practitioners need to know about it and understand its purpose. The LSCB should ensure that the protocol is up to date and consider how to promotes its effectiveness.

SUDI, SIDS AND COT DEATH

5.55 "Sudden Infant Death" is the term used to describe the sudden and unexpected death of a baby. If, after investigation, the cause of death remains unexplained it will usually be registered as Sudden Infant Death Syndrome (SIDS) or the medical term "Sudden Unexpected Death in Infancy" (SUDI).

5.56 "Cot death" was a term commonly used in the past to describe the sudden and unexpected death of an infant. It is not used very often now because it suggests that death occurs when the baby is asleep in their own cot which is not always the case.

> Around 290 children under one die every year of SUDI in the UK. Most are babies under 6 months and boys are known to be at slightly greater risk than girls. Babies born to mothers under 20 are at greater risk than those born to older mothers; although numbers are very small, the risk is four times greater than the combined categories of babies born to mothers aged 20 and over.
>
> *Sudden Infant Death Statistics, Office of National Statistics, 2015*

5.57 While the causes of SIDS are not fully understood, established risk factors include:

- Dwelling in an area of perceived high deprivation;
- Co-sleeping;
- Parental alcohol consumption;
- Smoking;
- Parental mental health;
- Domestic violence;
- Premature/low birth weight;
- Parental substance misuse.

5.58 The Office of National Statistics (ONS) indicates two other risk factors are associated with SUDI: overheating and an unsafe sleeping environment. The evidence indicates that increased risk is associated with excessive insulation, high room temperature, and/or overwrapping. For the first time in five years the number of deaths rose in 2013, this was considered to be as a result of babies being overwrapped during some exceptionally cold weather.

SAFE SLEEPING

5.59 The ONS report refers to the risks of the sleeping environment including the danger of the baby's head being covered. In December 2014 NICE updated its guidance following a debate about the risks of co-sleeping, the new guidance indicates that parents and carers should be informed of the association between co-sleeping and SUDI and the factors which increase risk, such as parental drug use and smoking.

5.60 The Child Death Overview Panel (CDOP) reports that the number of deaths from SUDI in Bournemouth and Poole are in line with the national average.

LOCAL PRACTICE DEVELOPMENTS

5.61 In order to try and reduce the numbers of SUDI deaths, in 2014 Dorset Health Care conducted a survey to inform best practice around co-sleeping.

5.62 The survey led to the publication of "Co-Sleeping Guidance for Front Line Staff Working with Families with Young Babies" in December 2014. The guidance includes a "Sleeping Care Pathway" which identifies some of the risk factors associated with SUDI and provides information for parents to decide whether co-sleeping is safe for them. Interestingly it refers to risk of "cot death" and doesn't mention the terms SIDS or SUDI; nor does it mention the heightened risk for mothers under 20.

5.63 The guidance also provides additional information for professional staff in advising about co-sleeping and risk of SUDI. It points out the need to re-visit the safe sleeping pathway "as feeding methods may change and with it the appropriate advice must be given".

5.64 In Baby Nathan's case at least three of the established risk factors were present, plus the added factor of Rachel's age, the heat in the baby's bedroom and the risk of overwrapping.

5.65 After Nathan died, the Coroner stated that, although the cause was essentially unexplained, the post mortem results indicated that he had been co-sleeping with his mother and overheating had been a factor in his death.

NEGLECT AND SUDI

5.66 In the 2012 biennial study of findings in Serious Case Reviews, Brandon et al found evidence of neglect in 60% of the Reviews (Brandon et al 2012). A follow up study, "Neglect and Serious Case Reviews" (Brandon et al 2013), indicated that neglect can be life-threatening, especially in young babies. The study reflects on the indications of neglect and identified as a category of neglect:

> *"Sudden unexpected death in infancy: unexplained infant deaths within a context of neglectful care and a hazardous home environment."*

5.67 The report says:

> *"It should be stressed that these maltreatment related cases represent a very small proportion of unexpected infant deaths – there are currently over 200 SUDIs per year in England and Wales (Sidebotham et al 2011). However, these cases do account for one in six of all death-related Serious Case Reviews."*

5.68 In discussing learning from other SCRs, Brandon highlights the need to consider the importance of interacting risk factors, and the report states:

> *"Our previous work (Brandon et al 2008) has emphasised the importance of an interacting risk perspective. This holds true for these cases of SUDI where interacting risk factors for example prematurity, parental smoking, alcohol misuse, deprivation and co-sleeping would have elevated the risk to the infants. However there is little indication that a combination of risk factors was considered in this light."*
>
> *Brandon et al, Neglect and SCRs, 2013*

5.69 In this case the records show that Rachel was advised about the risks of "cot death" several

times before she and the baby were discharged home. Written information for new parents uses the term "cot death" and in general, that is how staff refer to the risk of SUDI when talking to parents. The reason they use this term is that practitioners consider that it is clearer to families than SIDS or SUDI.

5.70 In this case the relevant staff were confident that a full explanation was given to the parents that "cot death" didn't mean babies at risk always died in their cots; however, the term is out of date and agencies should consider whether it is wise to continue its use.

5.71 Once the information had been given, opportunities to follow up whether the parents had absorbed and understood the advice were limited. Midwives handed the case over to the heath visitor when Nathan was 10 days old. Although the baby was seen regularly at the clinic, the health visitor only visited the baby's home twice in the three months before his death.

5.72 Rachel had said she didn't want home visits and the health visitor was unaware of health visiting practice guidelines which advocates at least monthly home visits if a baby is subject to a Child Protection Plan; the health visitor hadn't seen the baby's sleeping environment and although this is not written down as a requirement to good practice, the other practitioners had assumed that health visitors would do this. This was a missed opportunity for a health view on the baby's sleeping arrangements, particularly when the baby was getting too big for a Moses basket. Dorset Health Care Trust is addressing these learning points as part of their agency review.

5.73 To summarise, although several of the risk factors associated with SUDI were present in this family, some of the practitioners were not familiar with them. The baby was considered to be at risk of neglect but the risk of SUDI was not discussed in any of the multi-agency meetings. If this had been considered, a more robust plan could have been developed detailing how the risks could be reduced.

LEARNING POINTS

Knowledge of the risk factors associated with SUDI will help practitioners assess which families are at greatest risk and how best to advise them. The term "cot death" can be misleading for families, it is important to ensure parents are clear that it doesn't mean babies only die when sleeping in cots.

Parents benefit from being reminded about the risk of SUDI, especially after they are discharged home following a hospital birth.

If more than one agency is visiting a baby considered to be at risk of SUDI, they should be clear about who is seeing the baby's sleeping environment and what they are looking for. If there is a Child Protection Plan this should be included in the plan.

FOR THE LSCB

The LSCB should consider including risk of SUDI in all Child Protection Planning for children under the age of one year who are considered at risk of neglect.

Given the vital role of health visitors in safeguarding babies, the LSCB should ensure there is clarity about the health visiting role and responsibilities with regard to assessing a baby's sleeping environment.

6: ANALYSIS – POST-BIRTH PERIOD

MANAGEMENT OF RISK AND RISK REDUCTION

POST-NATAL CARE

6.1 Following the birth of the baby, midwifery visited Rachel at home on days 3, 4, 5 and 7. The Child Protection Conference was on day 9 and discharge from midwifery took place on day 10. This is in line with their post-birth guidelines.

6.2 The staffing arrangements at the midwifery unit meant that over the five home visits, Rachel was seen by five different workers including three different midwifery support workers (the latter are unqualified and not necessarily trained to an adequate level in child protection).

6.3 The focus of the midwife's visits was primarily practical help and advice for example about feeding. Whilst visits by several workers might adequately address this need, it is a narrow focus and compromises the ability of the service to contribute to any assessment of risk. This was relevant in this case as Rachel had already been identified as vulnerable and a Child Protection Conference was planned to take place when Nathan was 9 days old.

6.4 Also, considering Rachel's perspective as a new mother who was anxious about professional intervention, having so many different people visiting would not have helped gain her trust or increase her confidence.

6.5 Since this case midwifery have changed their practice to delay discharge to 14 days post-birth if a child is subject to Child Protection Planning. This enables the named midwife to hand over to the health visitor, enabling some continuity.

CHILD PROTECTION ENQUIRIES

6.6 Section 47 of the Children Act 1989 places a duty on local authorities to investigate and make inquiries into the circumstances of children considered to be at risk of "significant harm". The investigation will lead to an assessment and, if concerns are upheld, a Child Protection Conference.

6.7 There is a clear procedure detailing what needs to happen to complete Section 47 enquiries, this is primarily a list of people to be contacted for information. In this case the enquiries were incomplete: they didn't include YOS who had detailed knowledge of Ben, Ben's GP who had referred him for a mental health assessment, the EWO or schools who had some information.

6.8 There is no indication that reference was made to any records about the family history held by children's social care. Whereas knowledge of the family history might have raised areas for further exploration, the initial analysis of risk was based on the presenting factors and this continued to be the case in the work with the family right up to the baby's death.

6.9 The lack of a full picture meant that although there was some information about the immediate concerns, the pregnancy, the domestic violence and the housing conditions, there were gaps in the background information and family history. It is important that social workers know about and understand the meaning of a family's history and this opportunity was overlooked.

6.10 It is especially significant that there was no information sought or provided about Rachel's younger sibling who was, in effect, invisible in all the assessment work carried out with this family.

LEARNING POINT

In gathering information and carrying out an assessment prior to a child protection conference, background history is essential in order to understand family functioning and risk.

The needs of all children in the household should be considered.

INITIAL CHILD PROTECTION CONFERENCE

6.11 Following the Section 47 enquiries, an Initial Child Protection Conference was held when Nathan was 9 days old. Both parents were present at the conference and had the baby with them.

6.12 The reasons given for holding the initial conference were:

- The domestic violence between Ben and his mother;
- Rachel's lack of engagement with professionals;
- Concerns about the home conditions.

6.13 The notes of the conference show that each of the above factors was discussed with information being provided by those present and then discussed with Ben and Rachel. There was a unanimous decision to make Baby Nathan subject of a Child Protection Plan in the category of neglect.

6.14 In addition to recognising the impact of the limited assessment, discussion at the Learning Events indicated that another issue for practitioners attending the conference was that it was hard to raise and discuss concerns without running the risk of alienating the already resistant parents.

6.15 It was good practice that the chair of the conference was able to identify the parents' fear of "losing their child" (into care) as a reason for their resistance to interventions. However, there was no opportunity to discuss how this might influence outcomes or how practitioners might work most effectively with the family.

6.16 In the Learning Events the practitioners identified that more opportunity for discussion without the parents present would help, by allowing time to reflect on information and events and discuss them freely before sharing and explaining any findings to families.

LEARNING POINT

When working with families who are resistant to intervention, professional-only meetings allow free exchange of information and analysis of risk and discussion about how best to overcome barriers to engagement.

THE CHILD PROTECTION PLAN

6.17 When a conference decides a child should be subject to a Child Protection Plan, this is drawn up by conference members. It may be developed in Core Groups and then again at the Review Child Protection Conference.

6.18 One of the LSCB action points following the Serious Case Review of Baby F in 2010, was to "be assured that all Child Protection Plans are specific, measureable, achievable, realistic and timely (SMART)".

6.19 In this case the plan did not meet that standard. The plan described what needed to be done in general terms, for example: "the home conditions to be of an adequate standard" and "continuation of the single assessment".

6.20 The health visitor was asked as part of the plan to "ensure [the baby's] health needs were met to enable him to reach his milestones and ensure full health to ensure positive outcomes". She concentrated on the baby's development, feeding and weight gain. During this time the baby was being breast-fed, gained weight and observations of Rachel with the baby were all indications she was managing well and baby was well cared for. There was nothing in the plan which linked the health visitor's action to any risks to this particular baby.

6.21 The timetable for the work was either "as soon as possible" or "ongoing". The planned outcomes were also very general, for example: "to ensure [the baby] is kept safe and not exposed to any risk of witnessing domestic abuse".

6.22 In the agency chronologies and in discussion at the Learning Event it was clear to participants that the plan was not SMART. It is not known to the Reviewer whether this conference was exceptional. Participants indicated that conference chairs have an individual style and notes of conferences vary accordingly.

FOR THE LSCB

The LSCB should re-visit the actions arising from the Serious Case Review – Baby F, and satisfy itself that child protection planning is robust and effective.

POST-CONFERENCE ASSESSMENT

6.23 Following the Conference, one part of the Child Protection Plan was to continue the assessment of the family.

6.24 Although both parents continued to demonstrate ambivalence about wanting to engage with services after the conference, in line with policy a new social worker from a different team was allocated to the case and this provided an opportunity for further assessment of what the risks were and what work might be done to bring about change and what the outcomes might be.

6.25 The new social worker was at a disadvantage because she didn't have a detailed understanding of the family or parents history which might have helped her see the broader picture and considered such things as attachment theory, the underlying factors and risk of domestic abuse and the background to and implications of the hoarding.

6.26 The multi-agency child neglect guidance advocates the use of genograms and chronologies, neither of which was used in this case and both of which would have been useful.

RISK OF NEGLECT

6.27 In this case the conference had decided that Baby Nathan was at risk of neglect.

> *"Neglect is the most common form of child maltreatment in England, almost half of Child Protection Plans are made in response to neglect, and it features in 60% of Serious Case Reviews."*
>
> *Department for Education, 2013; Radford et al, 2011*

6.28 *Working Together 2015* defines neglect as:

> *"…the persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to:*
>
> - *Provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
> - *Protect a child from physical and emotional harm or danger;*
> - *Ensure adequate supervision (including the use of inadequate care-givers);*
> - *Ensure access to appropriate medical care or treatment.*
>
> *It may also include 'neglect of or unresponsiveness to a child's basic emotional needs'."*
>
> *Working with Neglect*

6.29 Neglect is a particularly difficult area of work for practitioners, and defining the risks and deciding whether the child protection framework is appropriate for intervention presents a challenge. In the Learning Events practitioners commented that they felt in neglect cases, "there is no common language of risk assessment", and the perceived risk "means different things to people at different times".

6.30 Assessing risk of neglect can be complicated by thinking about chronic problems rather than one-off events and when considering actual and/or potential risk alongside a parent's intentions and apparent insight.

6.31 Marion Brandon summarises this as:

> *"…practitioner uncertainty regarding thresholds, criteria and what constitutes significant harm and neglect can lead to confused opinions. Unrealistic practitioner optimism may also result when small changes to a child's circumstances are made which are given too much 'weight' when the overall risks remain unchanged. Disguised parental 'compliance' may reassure practitioners that the parents share the same concerns and are working towards improving matters, whereas in reality little is changing to improve the life of the child."*

6.32 In order to bring some clarity Brandon et al suggest that:

> *"Defining neglect in terms of the likelihood of significant harm or impairment to the child's development rather than on whether the child has been harmed, may encourage practitioners to focus on whether a child's needs are being met, regardless of parental intent."*

6.33 In this case there were a number of assumptions made by practitioners about how this family functioned. The assumptions were made on the basis of what they saw and heard from the family.

6.34 In discussion in the Learning Event practitioners were unanimous that Rachel was a good mother and a "protective factor" for Nathan. Rachel's mother was also described as a "protective factor". The relationship between Rachel and Ben was seen as positive and Rachel was assumed to have a satisfactory knowledge of basic parenting skills.

6.35 What led practitioners to see Rachel as a protective factor was her acknowledgement of Ben's poor relationship with his mother and the potential for this to overspill, coupled with her intention to ensure her baby did not "end up in care". Rachel's mother was seen as a "protective factor" based on her support for Rachel.

6.36 What practitioners also saw were the positive aspects of Rachel's care of this new-born baby, she was breast-feeding him, she had all the necessary equipment including a Moses basket for him to sleep in, she appeared to have a close bond with him and he was always clean and appropriately dressed.

6.37 Assessing risk of neglect and deciding what needs to be done is difficult, especially when the risks are not observed or "in front of you", as one practitioner put it, but based on potential, possibility or probability. In such cases it is helpful to pay attention to the "unseen factors", those which are there, but are in the background.

6.38 Rachel was just 17 and had had a troubled childhood: she had witnessed domestic abuse which had led to the permanent removal from home of her older siblings and of Rachel being placed for adoption and enduring two placement breakdowns.

6.39 The impact of this history on Rachel, on her parenting capacity, or on her mother, was not explored or considered in any assessment of family functioning or risk. In the circumstances it was naive and unrealistic to expect her to "supervise" contact between the baby and his paternal family.

6.40 Although addressing the home conditions and hoarding were part of the child protection plan, Rachel's mother's own background, the loss of her older children and the meaning of the hoarding behaviour was also not considered.

6.41 In addition, there were at least two significant events after Baby Nathan was born which could have impacted on the risk assessment. First, Rachel said she had ended her relationship with Ben and second, Rachel's father was alleged to be staying at the family home (he had a complicated history of violence and drug use). It appears to the Reviewer that the implication of these events was not considered.

LEARNING POINTS

While it may be helpful to see family members as a resource, the concept of a parent or relative being a protective factor is complex and must be based on assessment not just a parents self-reporting.

Risk assessment is a dynamic process, if new information comes to light or the family circumstances change this may affect the nature and degree of the risk.

THE USE OF TOOLS IN ASSESSMENT

6.42 In common with many neglect cases, a key challenge for practitioners working with this family was not to become overwhelmed by the inter-related risk factors.

6.43 Whist Professor Eileen Munro in her Review of Child Protection Practice in 2011 questioned the impact of:

> *"increased prescription of practice … which diminishes professional responsibility for judgements and decisions has an unintended consequence of reducing the job satisfaction, self-esteem and sense of personal responsibility experienced by child protection workers."*

6.44 There are occasions when the use of tools and models for assessment can direct thinking, focus the mind and help professionals be more objective in discussing finding with parents. Their use can also facilitate discussion about the impact of neglect on the child, for example how the home environment might impact on a child's health.

6.45 Tools can also be helpful in working with resistant families who often can't see the point of professional intervention. In such cases there is an additional risk that the needs of the child will be lost while efforts are made to engage the parents. The use of tools also helps address the need, highlighted by practitioners in this case, for a shared language in discussing neglect.

6.46 In this case it is notable that none of the tools available to help with objective assessment of neglect or to address the practitioner's concerns about the home conditions were used. This meant that during discussion about the case it was difficult to form a clear view about what exactly the concerns were, and listening to the practitioners discuss the family there were times when it seemed questionable whether there were any signs of neglect at all.

6.47 The pan-Dorset Child Protection Procedures provide useful guidance on identification and management of neglect. It advises use of tools such as:

- The Graded Care Profile;
- The Home Conditions Assessment and Parenting Daily Hassles Scale;
- The use of photographs if there are concerns about home conditions.

6.48 There is also a "neglect flowchart" which indicates what needs to be considered if neglect is a concern.

6.49 In this case practitioners didn't consider using the home conditions assessment, photographs or the flow chart which points towards specialist advice to assess the home environment. Some practitioners do not find the Graded Care Profile helpful; they report that it is complicated and requires additional training before it can be used.

6.50 In hindsight those who attended the Child Protection Conference agreed that photographs would have been helpful in reaching a consensus about the degree of the problem of the home conditions and the baby's sleeping arrangements.

LEARNING POINT

When assessing risk of neglect, the use of tools such as the home conditions inventory, a graded scale or clutter image rating, will help with objective measurement of the problems and evaluation of progress.

FOR THE LSCB

The LSCB should seek assurance that the tools it promotes in its Child Protection Procedures are effective and up to date and promote their use in multi-agency Child Protection training.

CONTRACTS OF EXPECTATIONS

6.51 At the Initial Child Protection it was suggested that a "Contract of Expectations" was drawn up to be signed by both parents. The use of these documents is not unusual in Child Protection Practice, they are often used to supplement the Child Protection Plan and to assure the local authority that parents know what is expected of them

6.52 In this case the "contract" was a document listing 17 things Baby Nathan's parents were expected to do to demonstrate they were providing "good and acceptable care of [their] child on a day-to-day basis". The list included, for example:

- *not to swear, shout at or in front of the baby;*
- *Nathan is not be in the sole care of Ben, any contact with paternal grandmother must be in the presence of Rachel or maternal grandmother;*

- *Nathan to sleep in appropriate Moses basket/cot with clean sheets and bedding. Bedding to be changed weekly, unless soiled and then be changed immediately with mattress aired."*

6.53 The parents and maternal grandmother were asked to sign the "contract" when Nathan was about three weeks old. The document was also signed by the social worker who agreed to "undertake regular visits, provide support and guidance and liaise with other agencies on the parents' behalf if required".

6.54 The benefits and risks of using documents of this nature are widely documented. For example, SCIE in an SCR concerning a baby state:

> *"These agreements can often be found in use when a child is the subject of a child protection plan. But the setting of unrealistic expectations, the lack of any real consequences when breach occurs, and the lack of a reliable system for monitoring and review, renders these agreements worthless. In their current form and use, written agreements pose a threat to the reliability of the multi-agency safeguarding system … At best these agreements were benign: they provided no added protection to the children. At worst, they served to undermine the protection of the children by providing a false sense of security."*
>
> *SCIE baby I Lambeth April 2015*

6.55 Research, including interviews with parents, indicates that parents feel they have little choice but to sign these documents. Joanna Nicolas in a piece for the *Guardian* Social Care column spoke to two mothers who both said:

> *"What choice did I have? Don't sign it and they'll take my children, or sign it and they leave you alone."*
>
> *Partnership Agreements fail to Keep Children Safe*
> *Joanna Nicolas, the* Guardian, *April 2014*

6.56 In this case the document appears to try and cover a range of issues from how and when to change the baby's bed to advice about keeping pets and attending a parenting group. The case recording does not make it clear whether there is any link between the items listed and the parent's behaviour, i.e. had they been known to swear in front of the baby or had they failed to change the baby's bedding in good time?

6.57 There is no obvious link between the Contract of Expectations and the Child Protection Plan and no clear plan about how compliance was to be monitored.

6.58 To their credit the local authority have already recognised the potential pitfalls of using these documents and are in the process of producing new guidance in the near future.

LEARNING POINT

Contracts of Expectations can be effective but in very limited circumstances and only if their purpose and how they will be monitored is clear to practitioners and families.

ASSESSING THE IMPACT OF HOARDING

6.59 One of the features of this case was Rachel's mother's hoarding behaviour which impacted on the family's living environment and on the baby's bedroom.

6.60 Hoarding Disorder is not uncommon; some studies suggest 2–5% of the population may be affected. It can be a symptom of a mental disorder such as Obsessive Compulsive Disorder (OCD), depression or schizophrenia, or it may occur without any indication of any other mental health problems. Symptoms may include a persistent difficulty discarding or parting with possessions (regardless of the value others may attribute to these possessions) with strong urges to save items and/or distress associated with discarding. The accumulation of a large number of possessions can fill up and clutter living areas of the home to the extent that their intended use is no longer possible, i.e. you cannot cook in the kitchen or sleep in the bedroom.

6.61 Although there have been studies about the impact of hoarding in adult safeguarding, none of the practitioners in this case had come across hoarding behaviour before. The adult studies (see Suzy Braye, David Orr and Michael Preston Shoot) highlight the risks of perceiving hoarding as a lifestyle choice and failing to appreciate that it can be a safety risk. Practice guidance reinforces the need for holistic assessment and effective multi-agency working.

6.62 In this case the social worker's assessment and Child Protection Conference noted the baby's home conditions as a "concern" and the child protection plan included "ensuring the home environment is free from risk of harm".

6.63 All the professionals who had seen the home conditions commented on them. Descriptions were either of the baby's sleeping accommodation or the home in general, and they concluded that it was:

> *"immaculate; only just adequate; clean and tidy; cluttered but tidy; small space but appropriate for now; OK; acceptable; extremely cluttered; a pigsty, not dirty but untidy."*

6.64 The range of descriptive comments demonstrates just how hard it is to agree the degree of the hoarding or its impact on the baby's environment without an objective measure. There are, however, readily available risk assessment models designed to measure the degree of hoarding.

6.65 The one which used by Bournemouth Fire and Rescue Service and Poole Housing Partnership is known as "Clutter Image Rating". This assessment tool consists of a series of photographs of varying degrees of clutter rated 1–9. The amount of clutter in any property, or photographs of the clutter, can be measured against the scale and an objective rating agreed.

6.66 Depending on the rating, the Fire Service will take appropriate action. For example a Level 4 in any room in a household where there are children will prompt a safeguarding referral. Although the primary focus of the Fire Service is on safety and fire prevention, they will also encourage the person to seek help and refer on as necessary to mental health services, the housing provider or any other relevant agency. If the Fire and Rescue Service receive a referral from any other agency they will send an officer from their community safety team to assess the clutter rating of the property and give advice.

6.67 Other models of risk assessment highlight environmental factors which might impact on health, such as air quality or not being able to access basic cooking or sanitary facilities.

6.68 In addition to an objective measure of the degree of hoarding, the use of an objective risk assessment enables practitioners to give thought to the effects of hoarding on any children in the household. This is particularly important in assessing the sleeping environment of a baby and considering the risk factors associated with SUDI. If risk of SUDI is to be included as a standing item in Initial Child Protection Conferences (LSCB recommendation), conferences should also include a routine question about the child's sleeping environment.

6.69 In this case, as well as considering the environmental impact, it would have been useful to give consideration to any unresolved emotional or psychological factors which might be contributing to the hoarding behaviour, and then how these factors might affect family relationships and parenting capacity.

6.70 Although Rachel's mother was asked to start clearing the home, it seems unlikely, given what is known about hoarding behaviour, that she would be able to de-clutter the flat without help.

LEARNING POINT

Hoarding behaviour can impact on the health and safety of children. An objective measure of the problem, its impact and the factors which lie behind it will enable a more effective intervention.

FOR THE LSCB

The LSCB should consider using the Dorset Fire and Rescue Service hoarding training package as part of safeguarding training.

WORKING WITH RESISTANT FAMILIES

6.71 The terms "hard to reach", "service resistant" and "hard to engage" are terms commonly used to describe families who resist intervention and appear to go out of their way to avoid efforts to help them. Families commonly fail to keep appointments, miss meetings and provide reasons why they cannot do what is asked of them. They might avoid meetings, be aggressive or challenging or live lives that are too chaotic for any meaningful work.

6.72 In this case the chronology details missed appointments, refusing entry to the family home, resisting home visits, aggression towards some workers and a refusal to engage with services offered.

6.73 To their credit, staff were persistent in their attempts to work with this family and conference participants did try and understand the reasons behind the parent's reluctance to engage. The meeting recognised the parents' anxiety, arising from their own history with social care, of having the baby removed from their care. It is also possible that Rachel and her mother were embarrassed about the home conditions and this contributed to their reluctance to be seen at

home. It is not surprising given their history that this family appeared not to want professional intervention in their lives.

6.74 Both health and social care practitioners acknowledged that they felt the effectiveness of their work was compromised by the attitude of the family.

6.75 It would have been helpful if managers had acknowledged this challenge in supervision and explored the impact and different ways of working.

7: SUMMARY

a) Baby Nathan died in the summer of 2015, his death was found to be unexplained, described as Sudden Unexpected Death in Infancy (SUDI) also known as SIDS.

b) There are known risk factors associated with SUDI and in this case there were several factors present. There is no evidence that the presence of these factors influenced the work with this family in any practical way.

c) We cannot know whether, if anything had been done differently regarding the SUDI risk factors, it would have made a difference to the outcome in this case but this review does provide an opportunity for learning, especially where there are indicators of neglect and the baby is subject to a Child Protection Plan. It is important that everyone working with families with babies understands the SUDI risk factors, how to identify them and what can be done to reduce the risk.

d) Assessing the risk of neglect and deciding how to intervene to bring about change is a day-to-day challenge for workers. Each agency involved with this family did carry out their own assessments which indicated the vulnerability of this young couple as they were about to become parents; however, there was little evidence of effective sharing of information before the Child Protection Conference. Several agencies didn't complete planned actions and this also inhibited the sharing of knowledge about the family.

e) The authority's Protocol for the Protection of the Unborn Child provides useful guidance and highlights the importance of remembering that teenage parents are still children. Half of the practitioners working with this family were not familiar with the document which includes information about the benefits of using the CAF process and the concept of Early Help.

f) It is debatable, in view of their past history, whether this family would have been more open to a different way of working but initiating a CAF could have opened up an alternative approach to working with this young family.

g) The assessment carried out by Children's Social Care was neither robust nor timely. Learning from this case reminds workers that family history is an important indicator of both risk and the family's capacity for change.

h) The use of tools, to help measure and define the risk, increases the potential to bring objectivity into the assessment and develop a shared understanding of the family situation among the multi-agency group. Also, in common with many SCRs, this case draws attention to the importance of professional curiosity and an enquiring mind, to question what other factors might be relevant which aren't immediately obvious.

i) It is notable in this case that there was reluctance among the practitioners to address some of the issues directly with the family. This was partly because of lack of clarity about professional roles, partly because of the risk of alienating a family who were resistant to professional help and also a lack of confidence about how to ask about sensitive matters.

j) The lesson here is that supervision and management oversight play an essential part in helping those on the front line reflect on their practice and develop their critical thinking. Supervision

can also remind practitioners about practice guidance and the tools which are available to them to challenge assumptions and encourage professional curiosity.

k) The number of "Learning Points" and "Actions for the LSCB" in this case indicates that there was no single practice episode or incident which defined this case. There were a series of actions, each of which impacted on the effectiveness of the next.

l) Brandon et al in their paper "New Learning from Serious Case Reviews: a two year report for 2009–2011", in discussing how learning takes place, say that:

> *"Recommendations can be helpful if they lead to definitive action but implementing them should not be seen to imply that learning has taken place. The best learning from Serious Case Reviews may come from the process of carrying out the review."*

m) In this case preparation of the agency chronologies, discussing the case and participation in the Learning Events provided an opportunity to reflect on the practice and explore what worked well and the factors which inhibited progress. Some changes have already taken place and other learning will be disseminated by the LSCB as part of their role in promoting continuing professional development.

FINALLY

The author acknowledges that Nathan was a much-loved baby. It is hoped this review will contribute to ongoing learning and the development of services for other children.

8: APPENDIX 1 – LIST OF AGENCIES

SERIOUS CASE REVIEW GROUP	AGENCIES INVOLVED WITH THE FAMILY
Interim Service Director, Bournemouth Council, Chair of the Group	Borough of Poole, Children's Social Care
Service Unit Head, Children and Young People's Social Care, Borough of Poole	Youth Offending Service
Senior Manger 0–5 services, Children and Young People's Learning, Borough of Poole	Housing
Designated Nurse Consultant, Dorset CCG, representing health Services	Children and Young People's Learning
DCI Public Protection, Dorset Police	Dorset Police
Consultant, Public Health, Dorset	Dorset Healthcare Foundation Trust, including Steps to Wellbeing Service
	Poole Hospital NHS Foundation Trust, Midwifery and Paediatric Services
	Dorset CCG, GPs

9: APPENDIX 2

THEMED SUMMARY OF LEARNING

KNOWLEDGE AND INFORMATION

- The Protocol for the Protection of the Unborn Child provides comprehensive guidance for sharing information, assessing need holistically and planning and coordinating intervention.
- Knowledge of the risk factors associated with SUDI will help practitioners assess which families are at greatest risk and how best to advise them. The term "cot death" can be misleading for families, it is important to ensure parents are clear that it doesn't mean babies only die in when sleeping in cots.
- Parents benefit from being reminded about the risk of SUDI especially after they are discharged home following a hospital birth.
- Hoarding behaviour can impact on the health and safety of children. An objective measure of the problem, its impact and the factors which lie behind it will enable a more effective intervention.

SKILLS AND EXPERIENCE

- Pre-birth assessments provide an opportunity to understand a family's circumstances and enable interventions to be appropriate and timely.
- In gathering information and carrying out an assessment prior to a child protection conference, background history is essential in order to understand family functioning and risk.
- The needs of all children in the household should be considered.
- Risk assessment is a dynamic process: if new information comes to light or the family circumstances change this may affect the nature and degree of the risk.
- Whilst it may be helpful to see family members as a resource, the concept of a parent or relative being a protective factor is complex and must be based on assessment not just a parents self-reporting.
- When assessing risk of neglect, the use of tools such as the home conditions inventory, a graded scale or clutter image rating, will help with objective measurement of the problems and evaluation of progress.
- Contracts of Expectations can be effective but in very limited circumstances and only if their purpose and how they will be monitored is clear to practitioners and families.

MULTI-AGENCY WORKING

- If more than one agency is visiting a baby considered to be at risk of SUDI they should be clear

about who is seeing the baby's sleeping environment and what they are looking for. If there is a child protection plan this should be included in the plan.

- When working with families who are resistant to intervention, professional-only meetings allow free exchange of information and analysis of risk and discussion about how best to overcome barriers to engagement.
- GPs often have information about families which if sought and shared (with appropriate consents being given) can give insight into family functioning. This information will make assessments more effective and lead to better planning and appropriate services being provided.
- Supervision and management support is essential to help practitioners manage, monitor and think systemically about a case where neglect is, or might be an issue.

RECOMMENDATIONS FOR THE LSCB

- The LSCB should seek assurance that antenatal care pathways are clear and working effectively.
- The LSCB should satisfy itself that all agencies fully understand the need to share information and how this should be done if a child may be at risk of harm.
- In this case an action identified by the MARAC to share information with a potential victim of domestic abuse was not followed up; the LSCB should seek assurance that the MARAC has an adequate system in place to monitor compliance with agreed actions.
- For the Protocol for the Protection of the Unborn Child to be effective, practitioners need to know about it and understand its purpose. The LSCB should ensure that the protocol is up to date and consider how to promotes its effectiveness.
- The LSCB should consider including risk of SUDI in all Child Protection Planning for children under the age of one year who are considered at risk of neglect .
- Given the vital role of health visitors in safeguarding babies, the LSCB should ensure there is clarity about the health visiting role and responsibilities with regard to assessing a baby's sleeping environment.
- The LSCB should re-visit the actions arising from the Serious Case Review – Baby F, and satisfy itself that child protection planning is robust and effective.
- The LSCB should seek assurance that all staff have access to regular, good quality supervision.
- The LSCB should seek assurance that the tools it promotes in its child protection procedures are effective and up to date and promote their use in multi-agency child protection training.
- The LSCB should consider using the Dorset Fire and Rescue Service hoarding training package as part of safeguarding training.

GLOSSARY OF TERMS

ADHD and ODD: Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder: The symptoms of ADHD include inattention and/or hyperactivity and impulsivity. ODD is often linked to ADHD, children who have it can be stubborn, get angry, have tantrums and don't do what parents and teachers tell them to do.

CAMHS: Child and Adolescent Mental Health Services. CAMHS are specialist NHS services, they offer assessment and treatment when children and young people have emotional, behavioural or mental health difficulties. The response to a referral depends on the level of need.

Child Protection Plan: When a Child Protection Conference is held the conference must decide if they think a child is at risk of harm and if so in which category. They then draw up a Child Protection Plan detailing what needs to be to reduce the risk.

Chronology: This is a summary of the significant events in the life of the family, it provides a summary and helps practitioners avoid seeing events in isolation.

Common Assessment Framework (CAF): This is a process for gathering and recording information about a child for whom a practitioner has concerns identifying the needs of the child and how the needs can be met. It is a shared assessment and planning framework for use across all children's services and all local areas in the UK. Sometimes referred as Early Help, it helps to identify in the early stages the child's additional needs and promote coordinated service provision to meet them.

Contract of Expectations: This is a document drawn up by Children's Social Care which sets out what parents must do or not do regarding the care of the child. It is usually signed by parents and their social worker.

Core Group: This is a meeting of the family and professionals working closely with them which takes places in between Child Protection Conferences, it is a smaller meeting and less formal. The purpose is to discuss and develop the Child Protection Plan and monitor how effective it is being.

DASH Risk Assessment: The introduction of the new Domestic Abuse, Stalking and Harassment and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model means that all police services and a large number of partner agencies across the UK use a common checklist for identifying and assessing risk.

Genogram: This is a family tree which is drawn up with a family and provides useful information about family members and family history.

Graded Care Profile: This is an assessment tool which considers the various aspects of parenting and gives each one a score.

MARAC: A Multi-Agency Risk Assessment Conference is a meeting where information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs) and other specialists from the statutory and voluntary sectors

Pre-birth risk assessment: This is a multi-agency risk assessment carried with a family usually starting about 20 weeks into the pregnancy. It is led by Children's Social Care.

Protective Factor: The term refers to the skills, strengths, resources, supports or coping strategies in individuals, families, communities or the larger society that help people deal more effectively

with stressful events and mitigate or eliminate risk in families. In child protection it usually refers to a person, usually a family member, who can help protect a child from risk from another person or a situation.

Reparation Order: These are designed to help young offenders understand the consequences of their offending and take responsibility for their behaviour. They require the young person to repair the harm caused by their offence either directly to the victim or indirectly to the community. Examples of this might be cleaning up graffiti or undertaking community work. The Order is over-seen by the Youth Offending Service.

Section 47 Child Protection Enquiries: Section 47 of the Children Act 1989 places a duty on local authorities to investigate and make inquiries into the circumstances of children considered to be at risk of "significant harm" and, where these inquiries indicate the need, to decide what to do.

SUDI: Sudden Unexpected Death of an Infant is the sudden death of an infant under one year of age, which remains unexplained after a thorough investigation. The term tends to be used inter-changeably with Sudden Infant Death Syndrome (SIDS). and sometimes as "cot death".

YOS: Youth Offending Service.

Youth Referral Order: This is an order available for young offenders who plead guilty to an offence whereby the young offender is referred to a panel of two trained community volunteers and a member of the youth offending team. It can be for a minimum of three months and a maximum of twelve months.

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