LOCAL CHILD SAFEGUARDING PRACTICE REVIEW - EMMA OVERVIEW REPORT

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THE FOUNDATION FOR FAMILIES

Contents

Glossary of Acronyms

ADHD	Attention Deficit Hypertension Disorder
CAMHS	Child Adolescent Mental Health
CIN	Child in Need
CPP	Child Protection Process
CSPR	Child Safeguarding Practice Review
CSC	Children's Social Care
HSCCG	Hartlepool and Stockton On Tees Clinical Commissioning Group – Primary Care
HSFT	Hartlepool and Stockton On Tees NHS Foundation Trust
HSCH	Hartlepool and Stockton On Tees Children's Hub
HSSCP	Hartlepool and Stockton on Tees Safeguarding Children Partnership
HDFT	Harrogate and District Foundation Trust
HV	Health Visitor
ICPC	Initial Child Protection Conference
LSCB	Local Safeguarding Children's Board
MARAC	Multi -Agency Risk Assessment Conference
MGM	Maternal Grandmother
NTHFT	North Tees and Hartlepool Foundation Trust
NSPCC	National Society for the Prevention of Cruelty to Children
SCBU	Special Care Baby Unit
SCR	Serious Case Review
SPOC	Single Point of Contact
TEWV	Tees Esk and Wear Valley
TEVWFT	Tees, Esk and Wear Valley NHS Foundation Trust

Introduction

1. This Child Safeguarding Practice Review (CSPR) concerns a child; Emma, who had been discovered by her mother not to be breathing and was pronounced dead by paramedics. Emma was three months old at the time of her death on the 10th May 2020. The review is to consider how agencies worked together and with the family leading up to her death.

2. Emma died as a result of (suspected) asphyxiation. It is believed that the asphyxiation was caused by Emma being propped up on a pillow in her pram and her head having fallen forwards, restricting her airways.

3. The Mother in this case had four other children

Sibling 1	17 months
Sibling 2	6 years
Sibling 3	9 years
Sibling 4	Adopted 2010

4. The new Working Together to Safeguard Children 2018 guidance sets out the process for new national and local reviews. Local safeguarding partners must make arrangements to identify and review serious child safeguarding cases within a defined criteria, and, in their view, raises issues of importance in relation to their area.

5. The Hartlepool and Stockton on Tees Safeguarding Children Partnership (HSSCP) (formerly the Local Safeguarding Children Board (LSCB) led on safeguarding arrangements and the local review.

6. This case was brought to the attention of agencies for consideration as a CSPR in May 2020.

7. As part of this process the HSSCP conducted a Rapid Review and it was decided that a local CSPR was appropriate.

8. As part of the Rapid Review process, partners identified what appeared to be rapid decline in living conditions which are indicative of neglect, even though neglect had not previously been a significant issue for the family.

9. There were a number of other cumulative factors that impacted upon the life and care of Emma and how partners supported and protected Emma and other family members.

Background

10. On the 2nd May 2020 Mother had gone to bed and later asked Sibling 2 to check on Emma; who was discovered unconscious in her pram. Paramedics at the scene and police in attendance raised issues in relation to neglect. The blankets and cushion in the pram were covered in mould and not suitable for a child to be sleeping in. The home address was described by the emergency response staff as being in a chaotic state, with faeces and dirty nappies strewn around, clothing in piles and loose tablets on the floor. Despite there being a cot in the property, this had not been used and Emma had been sleeping in a pram with inappropriate bedding and being propped up on a pillow.

11. Medical examination of Emma following her death ruled out any non-accidental injuries and indicated that suspected cause of death was asphyxiation. Emma had some marks around neck and chest (pressure marks from chin on chest) which suggest that Emma's head had flopped forwards, restricting her airway. The doctor also noted some signs of neglect upon examination such as animal hairs under her arms and in her fingers, dirt in the crevices of her body and severe nappy rash.

Family History

12. The Mother of Emma had been a looked after child herself and became pregnant at 16.

13. There had been previous Children Social Care (CSC) involvement with Emma's family in 2010 in respect of neglect where Mother's first child (Sibling 4) was placed for adoption.

14. Further concerns in respect of neglect were raised in 2013 when Mother's second child (Sibling 3) was two years old, however the family did not require any further support from CSC.

15. At the time of Emma's death, Mother had three other children in her care; Sibling 3 and Sibling 2 from a previous relationship and Sibling 1.

16. Siblings 2 & 3 both had health needs, Sibling 2 was very overweight and Sibling 3 had enuresis and was known to CAMHS.

17. The most recent period of CSC involvement with the family commenced in 2018, due to Mother's then new partner, (Father to Emma), having had a historical offence of sexual abuse (a rape dating back to 1997). The family had previously been supported by professionals via a Child Protection Plan under the category of sexual abuse. At the time of the death the case was closed and stepped down into Early Help.

18. Concerns were identified by professionals of a history of neglectful parenting, drug use and sex work as part of the ICPC.

19. Father and Mother ended their relationship and a number of domestic abuse incidents were recorded involving both parties between February and May.

20. Concerns led to MARAC discussions around the children witnessing domestic abuse incidents.

The CSPR: Process and Methodology

21. Working Together 2018[1] now provides the statutory guidance around Child Safeguarding Practice Reviews (formerly Serious Case Reviews (SCRs)) and the responsibilities upon the Safeguarding partners in how these are undertaken.

22. The guidance outlines that the Safeguarding partners must make arrangements to:
    - identify serious child safeguarding cases which raise issues of importance in relation to the area and
    - commission and oversee the review of those cases, where they consider it appropriate for a review to be undertaken

23. Serious child safeguarding cases are those in which:
    - abuse or neglect of a child is known or suspected and
    - the child has died or been seriously harmed

24. The purpose of these reviews, at both local and national level, is to identify improvements to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving.

25. As part of this process, Safeguarding partners should promptly undertake a Rapid Review of any cases that fall within the criteria and decide whether a local CSPR is appropriate.

26. Partners from the HSSCP followed this process in response to the serious incident notification submitted by Stockton Local Authority on 20th May 2020 which fell within the criteria of a serious case.

27. In light of the ongoing Covid-19 pandemic, the National Child Safeguarding Practice Review Panel requested that consideration is also given to whether, or what extent, the current Covid-19 crisis may have impacted either on the circumstances of the child or family or on the capacity of the services to respond to their needs.

28. Rapid Review members agreed that whilst the Covid-19 crisis will have undoubtedly impacted upon the circumstances for the child and family, it was potentially the other cumulative vulnerabilities which appear to have been more impactful on Mother's mental health and ability to care for her children.

29. A decision was made to undertake a local CSPR. Although the Rapid Review identified learning, HSSCP considered there was additional learning around the apparent sudden decline in home conditions and considered that a focused review was needed to explore this further.

30. The case does not raise issues that warrant a recommendation for a National CSPR.

31. As part of their duty to ensure that the review is of satisfactory quality, the Safeguarding partners should seek to ensure that:
    - practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
    - families, including surviving children, are invited to contribute to reviews. This is important for ensuring that the child is at the centre of the process.

[1] Working Together to Safeguard Children, (2018), Dept of Education

They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

32. The CSPR was designed and led by Clare Hyde MBE, and Mark Griffin, Independent Reviewers, from The Foundation for Families (a not for profit Community Interest Company). Ms. Hyde developed a review model that would enable participants to consider the events and circumstances, which occurred during the timeframe. Ms. Hyde and Mark Griffin are the authors of this report.

33. The methodology used was the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).

34. This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for Local Safeguarding Partnerships (previously LSCB's) to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice. However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of Safeguarding Partners is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the Safeguarding partners may identify additional learning issues or actions of strategic importance. These may be included in the final CSPR report or in the action plan as appropriate.

35. This approach also takes account of work that suggests that developing over prescriptive recommendations has limited impact and value in complex work such as safeguarding children. For example, a 2011 study of recommendations arising from SCRs 2009 -2010, (Brandon, M et al), calls for a limiting of 'self-perpetuating and proliferation' of recommendations. Current thinking about how the learning from SCRs/CSPR's can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation rather than over complex action plans.

36. A Governance Group was convened of senior and specialist representatives from agencies involved with the family in the time covered, to oversee the conduct and outcomes of the review. All panel members were independent of the family and casework. The role of the panel was to assist the Lead Reviewers in considering the evidence, formulating the recommendations and quality assuring this report.

37. The Governance Group agreed terms of reference for the CSPR, taking cognisance of national guidance. Key lines of enquiry were also agreed for the agencies who had been involved with the family.

38. The Lead Reviewers considered the combined chronology to consider in detail the sequence of events and any key practice episodes that underpinned those events.

39. Agencies provided a chronology and Agency reports as part of the Rapid Review process.

Independence

40. The Lead Reviewer, Clare Hyde, was CEO of Calderdale Women Centre for 14 years (between 1994 and 2009) and developed nationally acclaimed, high quality services and support for at risk women and families. Ms Hyde contributed to Baroness Corston's review of women with vulnerabilities in the criminal justice system which was commissioned by the Government following the deaths of several women in custody.

41. Ms Hyde also designed and facilitated a multi-agency review of child sexual exploitation in Rochdale in 2012 and is currently the Independent Chair of several SCRs and Domestic Homicide Reviews and has designed and led several Learning Reviews on behalf of Local Safeguarding Children and Adults Boards.

42. Mark Griffin has experience within strategic partnerships that provide the framework for safeguarding children and vulnerable adults as a senior manager in the police and a Local Authority. This includes managing a LSCB, Safeguarding Adults Board, and latterly the new Safeguarding partnership arrangements. He also led on the production and progression of Serious Case Reviews, Child Safeguarding Practice Reviews and Safeguarding Adult Reviews.

43. Prior to this he was the Head of Safeguarding in the Leeds District, West Yorkshire Police, between 2012 and 2017, responsible for one of the largest departments in the country as the Safeguarding lead for Children and vulnerable Adults. This involved both partnership and operational responsibilities. As a Safeguarding expert, he worked with and advised Her Majesty's Inspectorate of Constabulary (HMIC) undertaking inspections, at an operational and strategic level and within the partnership.

Governance

44. HSSCP conducted the Rapid review on the 22nd June 2020. This involved a number of professionals from Stockton and Hartlepool the Local Authorities, Cleveland Police, Hartlepool and Stockton on Tees Safeguarding Children Partnership (HSSCP), North Tees and Hartlepool NHS Foundation Trust (NTHFT), Tees, Esk and Wear Valley NHS Trust (TEWV), Tees Valley Clinical Commissioning Group (CCG), Harrogate and District Foundation Trust (HDFT), Community School and Sanctuary Housing. The review made the recommendation for a CSPR, and the Safeguarding Partnership Chair's decision was to commission the review.

45. The Governance Group met and communicated electronically during the Covid-19 Pandemic. The overview report was ratified at the HSSCP on 8th February 2021.

46. The Group comprised of:

Title	**Organisation**
HSSCP Business Manager	HSSCP
Independent Chair	HSSCP
Director of Children's and Joint Commissioning Services	Hartlepool Borough Council
Director of Children's Services	Stockton Borough Council
Director of Nursing and Quality	NHS Tees Valley CCG
Detective Superintendent	Cleveland Police
Temporary ACC	Cleveland Police

Confidentiality

47. Working Together 2018 provides the guidance around the content and publication of the final report.

48. Reviews are about promoting and sharing information about improvements, both within the area and potentially beyond, so safeguarding partners must publish the report, unless they consider it inappropriate to do so. Published reports or information must be publicly available for at least one year.

49. When compiling and preparing to publish the report, the Safeguarding partners should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. The Safeguarding partners should ensure that reports are written in such a way so that what is published avoids harming the welfare of any children or vulnerable adults involved in the case.

Family involvement

50. The family was made aware that a CSPR was being undertaken and were invited to contribute and Emma's Mother and maternal grandmother (MGM) spoke to Clare Hyde, Lead Reviewer in November 2020. Their views are reflected within the report.

Staff involvement

51. The staff who were involved with the families participated in an online learning event in November 2020.

Race, Religion, Language and Culture

52. Emma and her parents are English White British and siblings 2 & 3 are dual heritage. Religion is not considered to be a feature of their lives.

Summary of Agency Involvement and Key Events

53. Although the scope of this SCPR covers the period of 3rd March to 10th May 2020 key events which occurred before that timescale have been included in this section of the report.

54. There are a significant number of events which are not described in this report however these are described within the integrated multi-agency chronology.

55. Mother was previously a child looked after and became pregnant at 16. This first child was adopted due to neglect in 2010.

56. There were concerns about home conditions and neglect with Sibling 3 and he was on a Child Protection Plan from October 2011 to October 2012.

57. In 2014, Mothers third Child (sibling 2) was born and there is one recorded concern about signs of neglect (wet nappy and clothes).

58. Around January 2017, Mother was in a relationship with Father. He had been arrested, charged with (but not convicted of) a historical offence committed against an eight year old child when he was 16.

59. In April 2018 Mother was pregnant with Sibling 1.

60. In July 2018 Mother was recorded as not being allowed to have unsupervised contact with the children as she was allowing them to have contact with their Father. By this stage she was living at MGM's house who was to provide supervision, as required by CSC.

61. In July 2018, HDFT noted "Strong recommendations to remove children if mother doesn't allow them to be spoken to alone" and notes included significant history of neglectful parenting, drug use and sex work.

62. July 2018 a Strategy Meeting was held for the unborn baby at 28 weeks.

63. In July 2018 the case was progressed to ICPC.

64. Sibling 1 and Sibling 2 were made subjects of Child Protection Plan in August 2018 (Sexual abuse due to risk posed by Father).

65. In August 2018 police received information that Mother may move around the area to avoid authorities and suggestion she would lie to the police.

66. By September 2018, Sibling 3 had several emerging health and learning needs.

67. Sibling 1 was born December 2018. Father was not allowed unsupervised contact or intimate care.

68. In March 2019 it was noted by health visitor that Father was still awaiting NSPCC assessment in respect of his sex offence.

69. March 2019 Sibling 2 was noted to be very overweight and had failed hearing and vision test.

70. In April 2019 primary school spoke to Mother about the hygiene of Sibling 3. She explained that he likes playing in mud which was why he had dirty finger nails.

71. 18th April a GP appointment for Sibling 2 was attended due to possible urine infection nothing further about this in records.

72. 27th April CSC noted that risk assessment of Father had been carried out.

73. 2nd May 2019 a Capacity to protect assessment was completed but not shared by CSC. Parents were noted to be adhering to the safety plan. No clear information that professionals were fully aware of the risks.

74. On 5th June a positive assessment of Mother's ability to protect was carried out. Father was still not to have unsupervised contact and it was noted that he would always be a risk to children. The children remained on a Child Protection Plan.

75. 9th August 2019 it was noted that Mother was pregnant (Sibling 1 was 8 or 9 months old). She was on the waiting list for housing and still living with MGM in a one bedroom flat.

76. 27th September the children were stepped down to CIN. Father had secured his own property but was on 8pm curfew with no overnight stays and no intimate care.

77. On 9th October 2019 Sibling 3's school noted his dirty fingernails.

78. 11th October 2019 a single agency assessment carried out by CSC was positive. However, this contradicted what was said in June 2019 about Fathers risk to children.

79. 14th October 2019 primary school noted that Mother was living in a new flat.

80. 25th October first attendance tag for Sibling 2 & 3 as they were missing from school.

81. November 2019 Sibling 1 suffered a burn from a radiator, Mother sought treatment for this but missed a wound review appointment.

82. 21st November at an ante natal appointment it was noted that Mothers was smoking 10-15 cigarettes a day.

83. 27th November Sibling 3 was not taken to an ENT appointment.

84. December 2019 - both Siblings 2 &3 school attendance had fallen below 90%.

85. Also in December, school recorded concerns about Sibling 3's dirty fingernails (third concern). School shared their concerns about hygiene and attendance at a CIN meeting. It was noted that Mother and the children were living with MGM.

86. By January 2020 the children's attendance at school had dropped to 83% and 88% and school expressed concern to Mother about lack of reading at home with Sibling 3.

87. 23rd January 2020- Mother attended hospital with ruptured membranes. She was 33 weeks pregnant.

88. 24th January- Emma was born at 33 weeks by C-Section and spent 11 days in the special care baby unit (SCBU). It was noted by maternity staff that the flat they were staying was not appropriate.

89. The hospital reported that they were to carry out Finnegan's assessment[2] because of Mother's use of Tramadol. This is the first mention of Tramadol use in agency records.

90. 28th January - Father was assessed as being safe enough to live with Mother and the children however he was still to have no unsupervised contact and intimate care.

91. 28th January – Sibling 1 was not taken to medical appointment.

[2] The Finnegan scale assesses 21 of the most common signs of neonatal drug withdrawal syndrome and is scored on the basis of pathological significance and severity of the adverse symptoms, which sometimes requires pharmacological treatment

92. 4th February- Mother and Emma were discharged from SCBU and were unsure where they would be living. They moved into Father's home with Sibling 1 and the two older siblings remained at MGM house.

93. 5th February - the police were called by MGM who said that Mother was being held against her will by Father at his house. The police attended immediately and a verbal altercation took place between Mother and Father. The other children were not present.

94. It transpired that Father was having a relationship with another woman and Mother had found out. The police were later called by the other woman as Father was also threatening her.

95. Between then and 6th March the children's school attendance fell to 76%.

96. 4th March a letter regarding school attendance posted to Mother (formally beginning attendance procedures) requiring evidence for medical appointments.

97. On 7th March Mother attended hospital at 12 noon with Emma who had stopped breathing at 4am (i.e. eight hours earlier). MGM had performed 'rescue breaths' and the baby had resumed breathing. The hospital shared this information with CSC as they were concerned that Mother had delayed seeking medical attention.

98. 11th March 2020 – Domestic abuse incident whilst Mother living at MGM house. Father harassing and threatening her.

99. 12th March - Mother moved into her own tenancy (Sanctuary Housing).

100. In late March Emma was admitted to hospital with pneumonia and bronchiolitis.

101. 6th April Sibling 1 was admitted to hospital with bronchiolitis.

102. 9th April at a MARAC discussion it was noted Sibling 3 was self-harming. The children were exposed to numerous domestic abuse incidents and there were concerns about hygiene and children not taken to medical appointments.

103. 15th April a phone call took place between the social worker and Mother about not seeking help when Emma stopped breathing on 7th March. It was noted that Mother was remorseful and admitted that she was under strain due to the relationship breakdown.

104. 22nd April school recorded that the children's work packs were not collected from school and following unsuccessful attempts to contact Mother, school requested the Single Point of Contact (SPOC)to do a home visit to home address. SPOC could not gain entry and there was no response to their phone call.

105. 23rd April – the SPOC reported that following a conversation with social worker that Mother has changed address. SPOC revisited with work packs.

106. On 23rd April the case was closed to CSC as Mother and Father, assessment had concluded he could live within the family home, but it transpired the couple were no longer in a relationship.

107. On 24th April the health visitor visited the family home. No concerns were noted about the home conditions or the wellbeing of Emma. This was a pre-planned visit.

108. 29th April - Mother spoke to Sanctuary Housing and said that MGM was supporting her which helped her anxiety.

109. 30th April - the police visited Mother at home following domestic abuse incidents between herself and Father. The children were seen and there were no concerns about them or the home conditions.

110. 7th May a pest control officer went into the flat to remove rat trap (The infestation was outside and no rats were found in the property). The pest control officer noticed the flat was dirty, smelt and there were hygiene issues within the kitchen.

111. On the 10th May 2020 Emma died. As previously described, she had been put to bed overnight in her pram propped up by a pillow (it's clear from what her mother said in conversation with Clare Hyde, Independent Reviewer that this was a regular occurrence).

Summary Analysis of Key Findings

112. This section sets out an analysis of key findings and associated learning points and recommendations that are designed to offer challenge and reflection for the HSSCP and partners.

113. The key lines of enquiry for the CSPR were explored through the process of considering the details submitted by agencies as part of the Rapid Review and also the learning event.

114. The analysis also draws upon relevant research and upon findings from other serious case reviews.

115. The major themes which have emerged during this review are:

- Over optimism and over reliance on Mother's ability to parent and manage a partner who posed a risk for a sex offence and contact with 4 children.
- Lack of professional curiosity in assessing Mothers' behaviours and understanding the impact of childhood and historical adverse experiences and in particular Mother's ongoing relationship with her own mother (MGM).
- Recognising the impact and role of the Father and MGM in assessments.
- Assessments and multi- agency interventions should recognise and support all areas of risk, not a "headline" risk of sexual abuse.
- Missed opportunities in identifying indicators of neglect

- Professional curiosity and multi-agency oversight to assess or identify significant changes in circumstances and conditions, particularly the timing of step down and closure of the case
- Sleeping arrangements for babies and how these are communicated with parents.
- Information sharing and recording.

116. The terms of reference themes provide the headings for this section of the report.

What was life like for the children in this family? Consideration of agencies understanding of the known needs and vulnerabilities of the family at this time and how these were considered, supported and met.

117. The Rapid Review identified a number of needs and vulnerabilities:

- Housing situation (instability, size, location and impact of this)
- Four children (two under two years, one of which was a premature baby)
- Mother's use of medication / Mental Health
- Additional needs of siblings
- Domestic abuse Incidents
- Relationship breakdown
- Delayed presentation at hospital with Emma for a life threatening incident
- Recent house move (no longer living with another adult for support)
- Covid-19 (potential isolation / four children at home due to school closure)

118. During the time period considered under this review there were a number of incidents that would have impacted this family, leading to increased stress, anxiety and trauma. In order to satisfy care plan requirements that Father had no unsupervised contact with the children, a great deal of responsibility was placed upon Mother. Added to this pressure were other factors including overcrowding and domestic abuse, which escalated once the parents had ended their relationship. Of more significance, it is now known by all agencies that Mother had been using Tramadol for many years. In the weeks leading up to Emma's tragic death Mother had to care for four children with little support, with Emma and Sibling 3 hospitalised with chest infections and a change of home address.

119. Taken together with the fact that Covid 19 'lockdown' had begun and the family were being stepped down to early help; these stresses were not noticed by professionals and the aggregated cumulative factors appear to have led to a decline in Mother's ability to cope with the demands of looking after four very young children each of whom had health and learning needs. It is clear that life would have been uncomfortable, unsafe and possibly traumatic for the children given these circumstances.

120. Partners who participated in the learning event recognised that stresses on Mother escalated post December 2019, at a point when professionals had already made the decision to close the case and there was, therefore, a lack of multi-agency oversight.

121. There were a number of key missed opportunities prior to Emma's death. The incident during which she stopped breathing and was not immediately taken to hospital, and in late March she was admitted to hospital with pneumonia and bronchiolitis. Excoriation (nappy rash) in Emma's case was described by the nurse who examined her post mortem as "*the worst she had ever seen and that it would not have been an overnight rash*".

122. There were incidents and issues which gave clear indications that the children had significant health and other needs and parental and professional responses to these were not always good. For example:

123. In the months leading up to Emma's death professionals identified that Sibling 2 was overweight, but it appears that HDFT (School nurse) closed the case without further action. She was also treated for stigmas.

124. In February 2019 Sibling 1 was suffering from a dermatological disorder, with a sore nappy area. In November 2019 he was admitted to hospital with bronchiolitis/ viral induced wheeze and this continued and he was readmitted in April 2020 for bronchiolitis.

125. Mother and Father had concerns with Sibling 3 around an Autistic Spectrum Disorder which led to a CAHMS assessment, and soon after he was accessing ophthalmology and ENT following the insertion of grommets. Around this time advice was offered regarding enuresis and Mother reported he was being bullied. It seems that Mother declined further help, if not, the school nurse would have remained involved through the HDFT enuresis pathway. There was an opportunity for HDFT to have shared this information with the health visitor who was involved with family and could have supported with this, but this opportunity was missed. In October 2019, although Sibling 3 was on the SEN register, CAMHS noted that he was unlikely to get a diagnosis yet despite Sibling 3 not being brought to the appointments, the case was stepped down.

126. Finally, in April 2020, following a domestic abuse incident, the case was discussed at MARAC. It was noted that Sibling 3 was self-harming but school were not made aware of this information.

127. In August 2018 HDFT records show that the ICPC reported there were no health needs identified for the children. This appears to be a contradictory picture of the actual needs within the family.

128. Over a period of time there was a decreasing educational attainment and attendance. In July 2018, professionals were aware of issues, with Sibling 3 having 88% attendance at school, Sibling 2 - 50% attendance at nursery. By the 25th October, the first attendance tag was recorded for Siblings 2 & 3 as missing from school. In January 2020 the children's attendance briefly rose above 90% but then dropped to 83% and 88% and school expressed concern to Mother about lack of reading at home with Sibling 3. Between February and March, the children's school attendance fell to *76%, leading to the commencement of attendance procedures. School were unaware that parents had ended their relationship and commented at the Learning Event that had they known this their concerns would have increased as Father was felt to be a stable presence in the family. Work packs for the children were not collected but were delivered. (Covid 19 lockdown measures) Overall, the picture follows the timeline of escalating incidents and non-engagement with a decline in educational attendance.

    *The Government doesn't set specific attendance targets, but schools are expected to set their own. An attendance rate of 95% is generally considered good; this allows for children to miss 9.5 days across the school year. Persistent absence (PA) is defined as an attendance rate of 90% or below.

129. School identified hygiene concerns with Sibling 3 on three occasions between April and December 2019 and shared these with Core Group members.

130. There were incidents when the children were not brought to scheduled appointments. Two of these incidents involved Emma who was aged three months at the time. The CCG acknowledged that these missed appointments do not appear to have been shared with other practitioners. The chronology highlights some consistency that the parents did bring the children to health appointments, particularly at the time they were in a relationship.

131. Housing was a challenge for the family, particularly overcrowding, and would have created additional pressures to care appropriately for the children. Mother struggled to access housing and following the birth of Emma it would appear the family were living between Father's home and MGM's one bedroomed flat. This impacted upon sleeping arrangements and Emma was known to be sleeping in the pram. Mother had told professionals that Sibling 1 slept in a travel cot, but it was ascertained that he was sleeping with his Mother. Overall poor housing, overcrowding and moving between Father and MGM homes following the birth of Emma created instability for the children.

132. Once Mother moved to her home in March 2020, she did raise some concerns with the housing provider, Sanctuary Housing. This was around vermin and this led to rat traps being laid, however there are no records to confirm that rats were found. Nevertheless, believing that rats were in the property would have added to her anxiety.

133. Following the relationship ending, there were a number of domestic abuse incidents, some of which were experienced by the children and led to the MARAC referral.

134. Emma was assessed on the Finnegan Score due to Mother taking Tramadol during pregnancy, however Mother had said she was not taking medication during this pregnancy. GP records have revealed that Mum has been prescribed Tramadol since about 2007 for pain relief. Prescriptions have been issued and collected regularly since. This vital information had not been shared by Mother or the GP with the core group or midwife.

135. Mother was also taking citalopram for depression and GP's were concerned over an addiction to the Tramadol. Tramadol does contain codeine so it can be addictive and can also cause drowsiness. On the day Emma died Mother had gone back to bed this could have been the effect of the Tramadol or just the overall circumstances and stresses within her life at the time. It would certainly have impeded her ability to be a 'present parent' to her very young family.

136. The learning event established that there was a "disconnect" between the North Tees and Hartlepool Foundation Trust (NTHFT) neo-natal unit and CSC. This had already been identified through an internal review. When Emma was born an alert came up that Mother was prescribed Tramadol and to monitor the baby, but this alert had been added to systems with Sibling 1 and had not been removed as it should have been after a certain period of time. Regardless, no information was given to the midwife and it transpired that midwives are reliant on expectant women to advise on their medical history, there is no automatic cross check.

137. In January 2020, CSC noted that Emma was assessed on the Finnegan Score due to Mother taking Tramadol during pregnancy, Mother said she was not taking medication during this pregnancy.

138. Recognising Mother's own adverse childhood experiences should have provided professionals with an understanding of her mistrust of agencies, possible fragility in coping or intentional efforts not to disclose certain information. Mother was previously a Child Looked After and her first child had been removed from her care. There was also a suggestion from professionals who participated in the learning event that she had been exploited as a child. There was also a lack of professional curiosity and understanding in recognising that her avoidance / dishonest behaviours may also stem from fear, loss and trauma.

139. A study conducted by the Community Technical Assistance Centre of New York (CTAC) and the Managed Care Technical Assistance Centre of New York (MCTAC) looked into childhood trauma and how this impact as adults, categorised as PTSD.

The results found that early home life helps a child to develop a model of the world but when early home life involves trauma, their internal model is distorted. A history of childhood trauma can impair a parent's ability to accurately read and respond to their child's emotions. There may be difficulties assessing risk in potential partners and difficulties cutting ties with abusive family members and mother may present as overprotective in some situations but lacking awareness of dangerous situations in others.[3]

140. These theories are supported by David Shemmings, who says parenting problems, such as neglect and child abuse, can occur when losses or trauma experienced by parents have not been resolved. A common reaction to unresolved trauma is parental dissociation, with parents "likely to neglect the emotional needs of their children and/or have difficulty in assessing risk in their partners". Social workers need to be in a position to judge if they suspect unresolved loss or trauma is a factor in parenting problems, one option is the adult attachment interview, in which open-ended questions are asked about childhood relationships and experiences.[4]

141. Mother also maintained a relationship with her own mother who had been neglectful / abusive to her as a child and also with Emma's father who was a source of potential risk to her own children. This did not trigger professional curiosity or to consideration that Mother's attachments to MGM and Father were symptomatic of unresolved traumas or ongoing coercion and abuse.

142. This 'willingness' to maintain a relationship is explained by research which focuses on survivors of abuse "Many survivors of childhood abuse have such profound deficiencies in self-protection that they can barely imagine themselves in a position of agency or choice. The idea of saying no to the emotional demands of a parent, spouse, lover or authority figure may be practically inconceivable. Thus, it is not uncommon to find adult survivors who continue to minister to the needs of those who once abused them and who continue to permit major intrusions without boundaries or limits." (Trauma and Recovery Judith Herman, M. D. New York: Basic Books, 1992 pg. 81)

143. Another study looking at poor parenting practices, which includes factors such as neglect and aggression toward the child, found that maltreatment as a child was associated with poor parenting practices for mothers, and that childhood sexual abuse specifically was associated with aggressive parenting behaviours. (Newcomb MD, Locke TF. Intergenerational cycle of maltreatment: A popular concept obscured by methodological limitations. Child abuse & neglect 2001; 25(9): 1219-40.)

144. At the learning event, health professionals raised a suggestion that Mother may have cognitive issues, which appeared recently identified. This too would have impacted on how she processed and responded to information e.g. safe sleeping arrangements, use of Tramadol in pregnancy.

145. As a result of Father's sexual risk, the family had previously been supported by professionals via a Child Protection Plan under the category of sexual abuse. Restrictions were placed upon Father and there were pressures upon Mother to ensure compliance with agreements.

[3] https://ctacny.org/ (2018)

[4] https://www.communitycare.co.uk/2011/09/15/effect-of-early-trauma-on-parenting-skills/ (2011)

146. The role and influence of Father was seen as a positive and negative factor in the life of the children and Mother. Partners recognised and assessed that he was a stabilising factor with Mother and within the family however he was the reason the children were subject to CP Plans. At the learning event the school felt that Father was a stabilising influence and they weren't aware of the relationship split or subsequent domestic abuse incidents. Contrary to this view was that he was assessed as posing a risk through sexual abuse, and this may have had a psychological impact upon Mother.

147. As previously described children who have endured trauma and abuse suffer psychological harm. There is a spectrum of traumatic disorders, ranging from the effects of a single overwhelming event to the more complicated effects of prolonged and repeated abuse. Therapeutic work which directly addressed the complex impacts of childhood sexual abuse and neglect would be fundamental to Mother's recovery and her capacity to become a successful parent.

148. There is a paucity of research which addresses what therapeutic and other interventions can be used effectively with women and girls who have endured traumatic childhoods specifically in order to support them as they become parents.

149. It is only by taking into account Mother's own childhood experiences of trauma and abuse, her on-going vulnerability and troubled and abusive relationships with males that we might consider that her capacity to parent may have been compromised.

150. It transpired that Father was involved in another relationship whilst with Mother, which was the cause of the relationship breakdown. Furthermore, this was at a time when Mother was again pregnant, around March 2020. (Mother concealed this pregnancy until November 2020) Following the breakdown of the relationship Father perpetrated a number of domestic abuse incidents. The impact of the dishonesty and domestic abuse will undoubtedly have placed exceptional strain on Mother (which counters any positive assessment of Father as a protective factor).

151. The date of the relationship break down is unknown however on the 7th February 2020, police attended at Father's property following a report that he had locked her in the property. It transpired that Mother was living with MGM. The next domestic abuse incident occurred in March 2020, when Father set fire to a hoover outside of MGM's house. There followed a number of incidents between the parents which required the involvement of professionals.

152. MGM was also influential upon the family. In a similar way to Father's influence it is unclear if this was positive or negative, a view echoed by professionals who attended the learning event. It was also noted by professionals at the learning event that it was Siblings 2 & 3 that MGM looked after not Sibling 1 and Emma immediately following Emma's birth. (In the days leading up to Emma's death Mother said that having MGM in her life helped her cope with stress).

153. During an assessment, CSC acknowledged that there were historical concerns about MGM but she was assessed as a protective factor. Other professionals thought MGM's influence negatively impacted on Mother's ability to engage with professionals.

154. Emma had been at MGM's house when she stopped breathing on the morning of the 7th March 2020, when there was a significant delay in bringing her to A&E. It is unknown why MGM and Mother did not act and immediately contact professionals for such a serious incident. As outlined, there is also a suggestion that Mother was using MGM's prescription of tramadol, it is not known if this was with MGM's knowledge or not.

155. In summary the family were living with multiple stressors. Mother's vulnerability and own history of trauma and loss may well have impacted upon her ability to cope and to ask for help when she needed it. It is clear that daily life for the children may not have been safe, nurturing or comfortable. It is also clear that Mother's need for support increased significantly at the very point at which support and oversight were being reduced.

Key Learning and Recommendations

156. At key points in this case, partners were unaware of relevant information of needs and vulnerabilities with the family. This would have informed assessments and single agency involvement. There were missed opportunities in considering these in totality and engaging with the family at times of increased need.

157. Communication between partners should be more effective to enable vital information to be shared in a timely manner. HSSCP may want to seek assurance that reflects this learning point.

158. Partners were over optimistic in Mothers' parental abilities, and placed a significant responsibility upon her around managing the Father's sexual abuse risk. Partners should ensure that assessments and expectations recognise parental capabilities.

159. The Mother regularly portrayed an image to professionals that she was able to cope and was a capable parent, yet there were multiple ongoing and emerging issues that affected this. Partners should exercise sufficient professional curiosity with mothers in assessing their abilities to cope and care for their children.

160. There was a lack of professional curiosity in recognising Mothers' behaviours. Recognising Mother's background and mistrust of professionals, possible fragility in coping or intentional efforts not to disclose information. Assessments of parents should take into account historical information and the impact of this on coping mechanisms.

161. Mother's own childhood experiences of trauma and abuse, her on-going vulnerability and troubled and abusive relationships were not assessed against her capacity to parent. HSSCP may wish to consider an assessment tool and the provision of therapeutic services for mothers in similar circumstances.

What did the multi-agency support and oversight look like?

162. The review established that at times records were inaccurate and key information was not shared effectively.

163. Effective information sharing is one of the most basic tenets of good child protection practice and is one of those lessons that is 'so important that [it must] be re-emphasised and potentially relearnt as people, organisations and cultures change' (Sidebotham, 2012, p.190).

164. Good information-sharing practice that helps to consolidate multi-agency working; others show a reluctance among practitioners to pass on information and confusion about what they can and cannot share.

165. **Eliciting information**: Some services may be less familiar with passing on information than agencies with a lead statutory role and may also be unclear about what information should be shared and when. Although it is a service's responsibility to understand their role in safeguarding children, statutory agencies could be 'more creative in eliciting information other than through formal, documented channels'.

166. **Language**: The language used to talk about children's circumstances can hinder or support effective safeguarding. It can paint a vivid picture of context and risk when making a request for protective interventions; conversely, stock phrases can dilute or obscure concerns.[5]

167. The police held significant information about the parents, but this was not accurately shared and recorded by partners. This information is crucial to understanding the context of children's lives and hence for effective risk assessment and planning. Partners had inaccurately recorded that Father was a convicted sex offender, when in fact, he had been charged but not convicted. There was some reliance placed on an NSPCC assessment of his risk to the children but this was a limited assessment due to the historical nature of the offence and his denial of wrongdoing.

168. In a similar way there was inaccurate information recorded by partners about Mother's background which may have misinformed assessments.

169. There was a failure in sharing information with school around domestic abuse through the locally adopted Operation Encompass. This is an established procedure in a number of Local Authorities, whereby police forces communicate with the schools attended by children who have been exposed to domestic abuse or other forms of adverse childhood experience.

170. CAHMS had also failed to share the information about Sibling 3's self-harming. There would have been increased opportunity to monitor the impact of the domestic abuse upon the children if the information had been shared wider, with health visitors and other health partners. Partners have recognised this gap and changes to processes are intended to widen the notifications to enable this.

171. A significant area of ineffective information sharing was Mother's use of Tramadol. The IT systems within the various parts of the health system were not synergised, GP's failed to share the use of the drug since 2007 and latterly the information was not shared with midwifery teams by the neo-natal unit.

172. Partners recognised missed opportunities in convening multi-agency meetings at key points in this case, particularly between January and May when there was an escalation of need and risk. Partners reflected there should have been increased oversight at key points, particularly at times of increased vulnerability. As described elsewhere in this report; between January and May there were a number of incidents which were indications that all was not well for the family. These included
    - Relationship breakdown
    - Delayed presentation with Emma when she stopped breathing
    - Hospitalisation of Emma and a Sibling with severe respiratory illnesses

[5] https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2014-to-2017

- Problematic housing situation
- A number of domestic abuse incidents
- The impact of Covid 19 lockdown –less oversight and support- increased isolation and anxiety

173. Professionals placed an over reliance on Mother's ability to parent and manage family dynamics. Partners commented on Mother's positive engagement with Core group and that she addressed issues when they arose, but this was pre-December 2019. After this point there was a notable change.

174. Whist partners believed that Mother engaged with the Core group it has since transpired that Mother was pregnant at time of Emma's death, and that she concealed this pregnancy. It is also clear that she did not share information about her Tramadol use with professionals.

175. Partners were conscious of the behaviour of the parents, and Core group had recognised the dishonesty in the past as a danger statement which was discussed in conferences. However, this did not always increase understanding of why Mother was dishonest or change the view that she was engaging well with professionals.

176. The incident when Emma stopped breathing was not dealt with as a safeguarding referral. It is unknown if she had been propped up whilst sleeping on this occasion as sleeping arrangements at the time were not checked by partners. A multi-agency meeting would have allowed partners to look into this in more detail but there appears to be little oversight in exploring the circumstances of this incident and responding to prevent any reoccurrence.

177. The issue of fractured or partial perspectives of the context for the child links in with the issues around effective information sharing, and also emphasises the importance of both collating and reflecting on the information held by different professionals and agencies. It is inevitable in such a complex service landscape, when multiple agencies are involved with a family at one time, that this holds significant challenge. For this reason, solutions need to be identified at systems level as far as possible.[6]

178. There were also missed opportunities to assess the whole family and associated risks rather than individual aspects, and understand the bigger picture. The Core group provided a positive opportunity to deal with some issues but certain information was unknown and not shared, particularly Mother's use of Tramadol, domestic abuse and the relationship ending. A health visitor was supporting the care of the younger children but unaware of the issues linked to the older children. Overall, the focus of many professionals was the risk posed by Father for sexual abuse, which appears to have fixed professionals focus on this single issue. This distracted from wider issues, particularly neglect and Mother's vulnerabilities given her own childhood experiences.

179. Because the main assessment focussed on the potential harm from Father of sexual abuse, partners missed the new (and existing) vulnerabilities and risks which led to what appeared to be a dramatic decline in living conditions and the care of Emma. It is however, likely that the decline began when the relationship between the parents ended and Mother 'managed' to convince professionals on the limited contacts she had with them that she was coping.

[6] https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2014-to-2017

180. Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement (Reder et al, 1993). Published case reviews highlight the importance of practitioners being able to recognise disguised compliance, establishing the facts and gathering evidence about what is actually happening in a child's life.

181. The understanding of the influence and potential negative impact of MGM was varied across partners. Multi-agency assessments considering the wider implications of Mother's ongoing relationship with her may have identified this.

Key Learning and Recommendations

182. At key points in this case, information was not shared or recorded effectively. Individual agencies should ensure record keeping and information management systems within their organisation are robust and routinely implemented and that any deficit in the information is addressed by practitioners with appropriate management oversight.

183. Partners recognised missed opportunities in convening multi-agency meetings at key points in this case, particularly between January and May when there was an escalation of need and risk.

184. There was a key missed opportunity for a multi-agency response to the incident following Emma stopping breathing. The HSSCP may wish to seek assurance that such incidents will trigger multi-agency responses in the future.

185. There would have been increased opportunities to monitor the impact of the domestic abuse upon the children if the information had been shared wider through Operation Encompass processes, with health visitors and other health partners. Partners have recognised this gap and changes to processes are intended to widen the notifications to enable this.

186. Local Safeguarding partner should ensure practitioners are trained in recognising and responding to parental engagement. Practitioners should exercise professional curiosity in recognising barriers or that disguised compliance could be occurring, and the reasons why this may be occurring.

187. Partners should recognise the importance of both collating and reflecting on the information held by different professionals and agencies, to enable assessments to consider all and cumulative impacting factors.

Where there any indicators of neglect?

188. Neglect is a key and recurring theme in Serious Case Reviews. From detailed work on the available 175 SCR final reports, neglect was apparent in the lives of nearly two thirds (62%) of the children who suffered non-fatal harm, and in the lives of over half (52%) of the children who died.

189. In all nine SCRs where neglect was the key issue the mother was noted as the prime source of harm; this related to six non-fatal neglect reviews, but also to the three SCRs relating to extreme fatal neglect, involving deprivational abuse. Again, this in part reflects the fact that a mother is likely to be the sole or main carer.
190. Evidence suggests that some adults who were abused or neglected as children are at increased risk of intergenerational abuse or neglect compared to those who were not maltreated as children (Kwong, Bartholomew, Henderson, & Trinke, 2003; Mouzos & Makkai, 2004; Pears & Capaldi, 2001).

191. Research also consistently shows the presence of an intergenerational cycle of care involvement for some families. For example, one study found that **adults who were taken into care when they were children are 66 times more likely than their peers to have their own children taken in to care** (Jackson and Smith, 2005).

192. Mother's first child was removed and adopted under the criteria of neglect. Records also show that MGM has a history of neglectful parenting and Mother herself was a child looked after.

193. Between 2013 and 2017 there were four referrals for neglect.

194. School identified hygiene concerns with Sibling 3 on three occasions between April and December 2019. At least two were discussed with Mother and on the last occasion the concerns were shared at the CIN meeting.

195. A health clinician had also noticed Sibling 3 was unkempt on a few occasions between 2018 and 2019, this was shared at a MARAC meeting.

196. Partners recognised indicators of neglect but the main focus of attention was around the potential risk that Father posed. Sibling 1 was added to a Child Protection Plan as an unborn child, and this was because of low-level neglect, however, professionals did not identify any immediate concerns throughout the Child Protection Plan.

197. Through the Core group meetings partners identified neglect as an issue that "reoccurred periodically but was addressed". At the learning event partners highlighted that there was clear communication with Mother and Father when concerns were identified, and the parents appeared to address these concerns. These Core groups ended at a critical point as the parent's relationship broke down suddenly and traumatically and partners reflected that information sharing was less effective after this time. This was a missed opportunity to identify a deterioration in Mother's ability to cope and any consequent indicators of neglect.

198. The learning event recognised that at the ICPC the home was noted to be clean and tidy and was continually observed.

Key Learning and Recommendations

199. The Core groups ended at a critical point and partners reflected that information sharing was less effective after this time. This was a missed opportunity in identifying indicators of neglect.

200. The multi-agency partnership response to neglect should ensure practitioners are competent and confident in working with all aspects and types of neglect including assessment of parenting capacity, motivation to change and sustainability of any improvements once services withdraw. Practitioners need to be equipped to recognise possible feigned compliance and to address this in assessment and plans.

201. The focus on the single issue of the sex offence meant that partners were not as alert to indicators of neglect.

What did the multi-agency decision making look like at case closure?

202. The sole reason that the case was closed / stepped down was because the relationship between Mother and Father had broken down and the source of the risk was therefore thought to have been removed.

203. This decision was optimistic and did not allow for any consequences of a relationship breakdown (or for a possible reconciliation). Mother was now the sole parent of 4 children including two babies and was living in overcrowded conditions. Even without her history of trauma and loss this would have been extremely stressful. The beginning of Covid 19 'lockdown' will have increased stress for Mother and yet the decision to close the case and step down to 'early help' was not revisited.

204. The core group was able to challenge Mother when concerns arose and she responded positively to these challenges. The step down from Child Protection to Child in Need and then down to Early Help removed this oversight and challenge and the difference between the three levels of intervention was significant, in terms of formal procedures for multi-agency working and supporting the family.

205. The last multi-agency meeting was January 2019, at which point the decision to step down to Early Help was made, although CSC have no record of a referral or formal discussions with the Early Help team. This was likely due to education and health remaining involved with the family. The case was kept open to enable CSC to assist with housing application but there was no activity, meetings or action to deal with escalating issues between January and May. The case was closed to CSC on the 19th April. Partners could have convened a multi-agency meeting between these dates if the mounting pressures and stresses upon Mother had been understood and shared. The timing of the step down was detrimental in understanding the cumulative and escalating issues that were impacting upon the family and in delivering support at a critical time.

206. It was overly optimistic to step down to Early Help. The coordinated multi-agency approach was no longer in place and whilst there was a transfer to Early Help, there is no evidence to assess what support would be provided and when it would be provided.

207. When the health visitor attended at the family home on the 24th April, she was unaware that the case had been closed.

208. Partners who participated in the learning event acknowledged an inconsistency of the Early Help offer locally and lack of understanding of what support Early Help actually provides.

209. It was appropriate that Emma was made the subject of Child Protection Plan but when this was stepped down there was no contingency plan. It is not clear why, when later incidents of harm occurred, partners did not reconvene multi- agency intervention and oversight. There was no holistic review of the possible emerging risk resulting from the incidents occurring in the life of Emma's mother.

Key Learning and Recommendations

210. The decision and timing to close and step down the case resulted in a lack of multi-agency oversight at a key point in the life of Emma.

211. The decision to step down the case was overly optimistic and could have been revisited given the changing and escalating circumstances within the family and the possibility that Mother and Father would reconcile.

212. Partners acknowledged an inconsistency of the Early Help offer locally and understanding what Early Help involves. The HSSCP may wish to seek assurance around communication and consistency of approach.

Compare the conditions reported by professionals on attending the incident with agencies last observations. (When was the last meaningful visit / involvement and what was the nature of this? What was observed?)

213. Professionals involved in the review did not identify any concerns with the condition of houses occupied by Mother and Father with regard to neglect and hygiene but did recognise difficulties with finding suitable housing, moving between houses and overcrowding.

214. Mother moved into her own tenancy with Sanctuary Housing on the 12th March 2020. By this point she had ended her relationship with Father.

215. Sanctuary Housing staff check houses and report any child safeguarding issues to CSC. There were no concerns reported in this case. At this time the country was in a national lockdown which restricted opportunities for professionals to physically visit and contact people. There were a number of interactions between staff from Sanctuary Housing and Mother, but these were outside the home during key period (March – May).

216. Mother said that she had heard rats in the property and reported these concerns. The Pest Control Officer found an infestation of rats in sheds directly outside the property but no rats were found in the flat. The officer attended at the flat on the 20th April and later to remove the traps. In his opinion the kitchen was particularly dirty, smelt and there were hygiene issues. Mother thought the rats had access through the kitchen cupboard and had tied them together with a dirty tea towel. These conditions were the same on both visits.

217. There were some issues with ventilation but these were addressed with the landlord of the building.

218. The last 2 physical visits to the house by professionals were 23rd and 25th April 2020. The health visitor conducted a planned visit and reported that the house was clean. Emma was seen, weighed naked and there was no evidence of nappy rash noticed during the visit. Mother had discussed nappy rash on the 6th April and resolved it with cream from the GP. Mother did not raise any concerns or worries at this visit. Emma was alert and focused sociable and smiling. The health visitor noted a good reciprocal relationship seen between Mother and Emma. The health visitor followed NICE guidelines[7].

219. The property probably would have remained in a similar state when the police attended the following day in relation to a domestic abuse incident and they did not identify any concerns.

220. The house was found to be in a poor and unsafe condition 15 days later by the police and paramedics responding to Emma's death. Both agencies raised issues in relation to neglect. The blankets and pillow in the pram were covered in mould and not suitable for a child to be sleeping in. The home address was described as being in a chaotic state, with faeces and dirty nappies strewn around, clothing in piles and loose Tramadol tablets on the floor. Animal hairs were found on Emma who also had an extreme case of nappy rash and maggots were found around the floor area and some underneath all of the layers in the pram. (Mother did not mention any problems with maggots when the health visitor attended on the 23rd April and the health visitor didn't spot any infestation. Mother didn't have a dog but MGM did).

221. There no further information recorded about the conditions in the house between the 25th April and the death of Emma as there were no further agency visits, checks or assessments. As previously described, the decision to step down from Child Protection arrangements removed oversight of the family at a key point in the life of Emma and effectively partners were not able to assess or identify significant changes in conditions.

222. Mother appeared to be coping and gave this impression to professionals but had not disclosed her use of Tramadol and was unlikely, given her history, to have admitted that she was struggling to cope. The visit on the 23rd April was planned and gave sufficient time to make the house appear clean and reassure professionals.

223. Following Emma's death, Mother admitted to sometimes doubling her dose of Tramadol. This level of the drug could result in her feeling dizzy and / or drowsy and impact upon her ability to care for the children. This could also account for the decline in home conditions.

224. This CSPR has not been able to establish if this significant variance in the housing conditions between the last visit by professionals and the death of Emma was due to rapid decline or hidden decline, or a mixture of both.

[7] NICE (National Institute for Health and Care Excellence) https://www.nice.org.uk/guidance

The review *has* identified that multi-agency oversight was not in place at a critical point in the life of Emma, and when it was the focus was not on neglect or on Mother's vulnerabilities and the impact that this could have on her parenting.

Key Learning and Recommendation

225. Partners were unable to assess or identify significant changes in conditions at a key point in Emma's life, as there was only minimal agency visits and limited checks or assessments.

226. The review has identified that multi-agency oversight was not in place at a critical point in the life of Emma, and when it was the focus was not on neglect.

227. This review has been unable to establish the reasons for the rapid decline in conditions in the home of Emma, which were not identified by agencies. Partners should exercise professional curiosity and recognise increased pressures and vulnerability.

Single agency learning

228. This section of the report details analysis of further key issues which emerged during the review.

229. Agencies involved in this review identified a number of areas of learning.

230. The police recognised the need for accurate sharing and recording of information. This resulted from the mistaken belief that Father was convicted sex offender. The service also reviewed and made changes to the Operation Encompass process, to address the failures in sharing domestic abuse incidents with the school and to share information to Health partners.

231. Following the failures to share relevant information by GP's around the drug use by Mother the CCG will review processes to address this.

232. HTHFT had identified ineffective information sharing between neo-natal care and CSC during an internal review, changes have been made to systems.

233. NTHFT - Sleeping arrangements were mirrored by Mother in that Emma was propped up by Mother upon discharge from SCBU. NTHFT advise mothers that this practice should not be replicated. Partners felt that this message should be strengthened to ensure families are aware of correct arrangements.

Key Learning and Recommendations

234. HSSCP should seek assurance that these changes have been implemented around the identified areas of learning and that these changes have addressed the issues.

Additional Analysis

235. This section of the report details analysis of further key issues which emerged during the review.

Sleeping Arrangements for Babies

236. Paramedics who attended on the 10th May found Emma in her pram. Despite there being a cot in the flat this had not been used and she had been sleeping in a pram with inappropriate bedding and being propped up on a pillow.

237. As outlined, the incident when Emma stopped breathing on the 7th March 2020 was not dealt with as a safeguarding referral and no multi-agency discussion took place. Mother wasn't asked how Emma was sleeping at that time however, had the health visitor been informed of the incident then this it may have prompted a discussion on safe sleep.

238. When the incident of non-breathing occurred on the 7th March, Mother stated that her other daughter had breath holding episodes when she was younger. Mother stated she had been told to give rescue breaths and deal with incidents this way. The family disclosed that a similar incident had happened to Sibling 3 when he stopped breathing when he was a baby so the family wasn't overly concerned. CSC were unaware of this incident.

239. The Lead Reviewer discussed the sleeping arrangements with Mother. She insisted that her habit was that she put Emma to sleep propped up in the carry cot of the pram and said that this was due to her being premature and it was the position she was in in hospital. The cot was for Sibling 1 but he didn't like it so slept in bed with Mother and Emma slept in the carry cot part of the pram and she stated that all professionals were aware of this.

240. The health visitor was aware of Sibling 1 sleeping in Mother's bed but the impression given to her was that Emma was in the cot.

241. There are no records to indicate that Emma was propped up during visits and at the Learning Event the health visitor confirmed that safe sleep had been promoted. Mother stated that when she was living with MGM, Emma was in a carry cot and Sibling 1 was in a travel cot.

242. NTFHT procedures for babies who are inpatients involve monitoring sleep with a slight tilt on the mattress, (not with pillows), as this can help with breathing. The crucial difference is that babies are attached to an oxygen monitor. Discharge discussions with babies' parents/ carers stress safe sleeping arrangements and specifically that babies should not be propped up by pillows or cushions.

243. Mother also advised the Lead Reviewer that Emma had reflux and slept better in a propped up position and that she believed that this protected her from being sick in her sleep and choking.

Key Learning and Recommendations

244. Safe sleeping arrangements for babies who have spent time as in-patients in SCBU or neo natal care should be carefully explained by discharge staff with parents / carers taking into account any cognitive (or other communication) difficulties that they may have. This should be reinforced by health visitors, midwives and social care staff once babies are returned home.

245. Safer sleeping advice should be given, repeated and reinforced by professionals in all agencies both during pregnancy and infancy and carers' understanding of the expectations checked at each meeting. Where there are concerns about co-sleeping in unsafe circumstances, Child Protection Plans should include a specific requirement regarding safer sleeping arrangements.

Voices of the Children

246. A thematic report of Ofsted's evaluation of SCR's from 1 April to 30 September 2010[8] recognised that many of the cases concerned babies and young children who were too young to express their feelings in words. One SCR highlighted good practice in addressing this issue. Attention had been given to reporting and recording observations of the parents' interaction with their baby during his time in the neo-natal unit. Staff were aware of risk factors and early indicators in the context of safeguarding. In this case, staff observations did not make them concerned as both parents seemed appropriately involved in caring for their baby.

247. There are five main messages with regard to the voice of the child. In too many cases:
    a. the child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings
    b. agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute
    c. parents and carers prevented professionals from seeing and listening to the child
    d. practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child
    e. agencies did not interpret their findings well enough to protect the child.

248. CSC and the health visitor did observe that Emma was loved by her Mother and had a good relationship with her siblings.

249. The review has found that Mother's coping strategy in displaying a willingness to engage and ability to cope may have prevented professionals from seeing and listening to the child and concerns.

250. The school recognised the hygiene issues of Sibling 3, and possible linked neglect concerns. This required attention to detail in noticing dirty finger nails, which shows a level of interaction and observation.

251. Partners were aware of development and health needs of Emma and her siblings which indicates an understanding of their lived experience.

[8] The voice of the child: learning lessons from serious case reviews, Ofsted (2011)

252. The review has found that there was disproportionate focus placed upon the potential risk of Father and sexual abuse rather than Mother's vulnerabilities and her relationship with MGM and Father both of whom were sources of potential risk / negative influence in her children's lives.

253. A common theme in these SCR's, has been the tendency for agencies to overlook the role of fathers, male partners and other men living within the families. In this case Father was a source of potential risk to the children and yet was acknowledged as a stabilising factor in the family's life.

254. The lack of multi-agency oversight at a key point in Emma's life limited agencies abilities to recognise and interpret potential harms and consider Emma's daily lived experience.

Key Learning and Recommendations

255. Partners should be cognisant of potential coping strategies and disguised compliance when considering the voice and lived experience of the child.

256. Partners should focus upon the voice and lived experience of the child when assessing and responding to known risks within the family.

257. Partners should consider all potential impacts and particularly cumulative factors when interpreting the voice and lived experience of the child.

Good Practice

258. The school's involvement with the family and in particular Sibling 3 was good in identifying hygiene concerns and contributing to the Core Group. The school understood Mother's reliance on Father.

Conclusions

259. This review has been unable to establish why the living conditions in the house of Emma appeared to change so dramatically in the final days of her life. Whilst the conditions were not the direct cause of her death, they were indicative of a mother who was struggling to cope and who was not therefore meeting Emma's needs and ensuring that she was in a safe sleeping position.
260. Mother's own childhood experiences of trauma and abuse, coupled with substance misuse and her relationships with MGM and Father had a significant impact upon her ability to care for Emma and three other children. It appears that the trauma had not been addressed, key information was not shared between partners and assessments did not focus on cumulative risks, and in particular, neglect.
261. There were a number of incidents over the preceding few months that cumulatively increased need and risk, and could have been predicted. At such a critical point partners had reduced multi-agency oversight and closed the case. The timing of this decision, meant that partners were unable to recognise this rapid decline.
262. Emma, who was a premature baby with a recent serious respiratory infection, died of asphyxiation caused by unsafe sleeping arrangements, Mother believed this was a correct way to allow a baby to sleep, yet professionals, including those who had shared safe sleeping information with Mother were unaware of this sleeping arrangement.

263. There are important lessons from this review, many of which mirror the lessons from other reviews:
    - Over optimism and over reliance on Mother's ability to parent under extreme stress.
    - Assessments and multi- agency interventions recognising all areas of risk.
    - Missed opportunities in identifying indicators of neglect.
    - Professional curiosity to assess or identify significant changes in circumstances and conditions.
    - Sleeping arrangements for babies and how these are communicated with parents.
    - Information sharing and recording.
    - Lack of Multi-agency oversight at times of increased vulnerability.

264. Partners who attended the learning event had recognised some of these learning points and taken steps to address single and inter-agency working.

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