Plymouth Safeguarding Children Partnership

Local Child Safeguarding Practice Review

Baby Isla

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Contents

Note: The names of those involved in this case have been changed to ensure their anonymity and the privacy of individuals and wider family members.

1.0 ISLA – A PEN PORTRAIT

1.1 This review focuses on a seven-week-old baby girl who died in September 2020. For the purposes of this review, she is referred to as Isla. Isla is of British white ethnicity and at the time of her death lived with and in the care of her mother and father, who within this review will be referred to as Karen and Colin, respectively. Isla had three older siblings who also live at the family home. Isla's eldest sibling is an 8-year-old boy who will be named throughout this review as Daniel. Daniel has complex needs, including autism and severe learning difficulties. Daniel and his family are supported by children's social care (Children's Disability Team) and the hospital Children Development Centre in respect of these complex needs. Daniel attends a school with specialism in meeting the needs of children and young adults with complex needs. Isla also had two older sisters, aged under 6, who are named in this review as Elizabeth and Susan, respectively. Elizabeth has some additional needs but neither Elizabeth or Susan were, at the time of Isla's death, open to children's social care as children in need. Susan is described by her general practitioner as fit and well and has no additional needs.

1.2 Karen and Colin describe Isla as perfect in every respect, a baby that completed their world and meant everything to them. To give birth to Isla represented a blessing to them both as Karen carried age and significant medical related anxiety throughout her pregnancy, often believing that she would miscarry. Both parents speak with affection about Isla's beautiful red hair, dark eyes, and dainty presence. A corner of the dining room holds photographic and other memories of Isla, as a visible representation of the daughter they cherished. Part of the rear garden of their home has also been set aside as a 'fairy garden,' a place for her family to reflect on the happiness Isla brought to them.

2.0 THE CRITICAL INCIDENT THAT LED TO REVIEW

2.1 On the morning of 18 September 2020, Isla was discovered by her father, at their home address, unresponsive in the arms of her sleeping mother. Colin called the ambulance service using the 999 system. Both Colin and Karen remained on an open line to the ambulance control room whilst Karen attempted cardiopulmonary resuscitation (CPR). When Karen gave the first breath into Isla, she described that there was "an eruption of blood from Isla's mouth." An ambulance subsequently attended the home and CPR was then undertaken by clinicians. Isla was taken to the Emergency Department by ambulance and CPR continued, but Isla was declared dead on arrival. During CPR provided by clinicians, blood had been found around Isla's mouth.

2.2 In the early hours of 18 September, the family report that Isla had been given a feed by Colin and was initially placed in the cot. She would not settle in the cot and slept resting in the right arm of her mother, Karen, supported by a 'V' shape pillow. Isla was swaddled and face up which was reported to be her normal sleeping position. Karen slept in the dining room of the property, in a single leather square seat in the corner of the room next to Isla's travel cot. It was in this seat that Isla was discovered by Colin to be unresponsive in Karen's arms around 8am that morning.

2.3 Following police and ambulance clinicians' attendance at the family home on the date of Isla's death, significant concerns were raised in relation to the sleeping arrangements of Isla and her mother. The family report that Colin slept in the lounge of the property with Daniel, so he could provide for Daniel's care and support needs, manage Daniel's limited sleeping pattern (sometimes sleeping as little as 20 minutes within 24-hour periods) and to promote Karen's and Isla's opportunity to sleep. Following attendance at the home on the morning of this critical incident, it was seen by the police that Isla's travel cot was cluttered and showed no signs of her having been able to sleep in it. Colin and Karen challenge this assertion, and they report that Isla had slept in the cot the previous night, and during the night of her death she had also been placed in the cot to sleep as she was described by her parents as restless and grisly. The family report that the cot only contained soft toys and blankets, covered by a

changing mat. Colin and Karen believe the 'clutter' described when the police arrived is likely to have been because of frantic attempts to revive Isla and the panic that arose when she was found to be unresponsive. However, the police reported feeling that the scene they encountered was not about one morning of panic, but many weeks and months of a neglectful home environment.

2.4 As well as the general unease with the sleeping arrangements agencies were also concerned about the condition of the family home, mother's complex needs, medical history, and substance misuse.

2.5 A full post-mortem was carried out with ancillary tests. Following post-mortem toxicology[1], it was established that neither alcohol nor drugs played a part in Isla's death and the cause of her death is unascertained. There is no information which suggests Isla's death was caused by a non-accidental injury. Due to the possible sleeping circumstances, the forensic pathologist has stated that Isla's death would not fulfil the criteria of a 'sudden infant death syndrome or SIDS[2].' Following investigation by the police, criminal proceedings have not been instigated against the parents or any other individual. An inquest is still awaited at the time of concluding this report (May 2022).

3.0 COMMISSIONING AND PURPOSE OF LOCAL CHILD SAFEGUARDING PRACTICE REVIEW

3.1 This review was commissioned by the Plymouth Safeguarding Children Partnership (PSCP) in accordance with the Working Together to Safeguard Children (2018) statutory guidance.[3] Following discussions between Devon and Cornwall Police and Plymouth City Council it was agreed that Isla's death met the criteria of a serious incident notification in that:

- Abuse or neglect of Isla was known or suspected **and**
- Isla had died.

3.2 A Serious Incident Notification was submitted by the local authority to the National Safeguarding Practice Review Panel ("the Panel"). As a consequence of this notification the Plymouth Safeguarding Children Partnership ("the partnership") undertook a rapid review which identified key learning points and findings for the partnership. These are set out in paragraph 4.4 below. The rapid review concluded in October 2020 and recommended that a local child safeguarding practice review should be undertaken under the Working Together to Safeguard Children (2018) guidance. Findings and recommendations contained within the rapid review were welcomed by the Panel with immediate learning being identified, which included:

- The need to improve multi-agency awareness of safe sleeping and to work with families to have sight of sleeping arrangements within the family home.
- A review of the criterion and guidance used for the 'Red, Amber Green' rating system which informed the green risk assessment for this family by the Children's Disability Team, meaning virtual home visits as opposed to physical visits could be facilitated during the Covid-19 pandemic.

[1] Conducted in accordance with child death review (Working Together to Safeguard Children (2018), Chapter 5)
[2] This refers to the sudden and unexpected death of an infant under 12 months of age, with onset of the lethal episode apparently occurring during normal sleep, which remains unexplained after a thorough investigation including performance of a complete post- mortem examination and review of the circumstances of death and the clinical history. (The Royal College of Pathologists, Sudden unexpected death in infancy and childhood. Multi-agency guidelines for care and investigation 2nd edition, November 2016).
[3] Chapter 4

These issues were addressed through multi-agency training and awareness raising, and a full review of the RAG rating system within the Children's Disability Team by the local authority service manager for safeguarding and quality assurance.

4.0 THE REVIEW PROCESS

4.1 The local learning review process was postponed by the partnership in January 2021 due to the Covid-19 pandemic lockdown restrictions and the associated challenges in both responding to the demands of the pandemic and managing the impacts within the workforce. Detailed scoping and planning arrangements were undertaken between March and April 2021 with the aim of delivering an Appreciative Inquiry model of review involving partnership practitioners and managers. Two Appreciative Inquiry Learning Events were scoped, referenced, and put in place with supporting materials to promote strength-based facilitation and learning. Following challenge from key practitioners as to the independence of this process and pressures of meeting timescales, these events were withdrawn by the partnership. However, Appreciative Inquiry information gathering forms aligned to the key lines of inquiry identified within the rapid review (paragraph 4.4), were sent to all involved agencies for completion.

4.2 Additional operational pressures on the partnership further delayed the completion of the review. In October 2021, the three statutory safeguarding partners on the partnership's Child Safeguarding Practice Review Group concluded that a detailed and analytical desktop review of the material available should be undertaken by the independent quality assurance lead for the partnership. This decision was ratified by the partnership's strategic lead partner. It is acknowledged that despite these deferments, learning on issues identified in this case were still being addressed through wider partnership work on the drivers of neglect and sudden unexplained deaths in infants (SUDI)[4]. This work was undertaken through the partnership's quality assurance arrangements, single and multi-agency training, and the embedding of the partnership's ICON package and Dad Pad[5] to support safe sleeping.

4.3 The agencies involved in this review are:

- Plymouth City Council
- Livewell Southwest
- Devon and Cornwall Police
- University Hospitals Plymouth NHS Trust
- Southwest Ambulance Service Trust
- Schools attended by Daniel, Elizabeth, and Susan
- Family General Practitioner.

4.4 Several documents and submissions completed for and after the rapid review process were considered as part of this report:

- Agency Initial Scoping and Information Sharing Forms
- Integrated Multi-Agency Chronologies
- Appreciative Inquiry information gathering forms received from Plymouth City Council – Children's Disability Team, Devon & Cornwall Police and Livewell Southwest. Returns were not received from

[4] This is the preferred term for use in cases in which there is no clear cause of death and there are no features to suggest unnatural death or inflicted injury, but in which the circumstances do not fit the criteria for SIDS (for example, deaths in which the history, scene or circumstances suggest a high likelihood of asphyxia but in which positive evidence of accidental asphyxia is lacking). (The Royal College of Pathologists, Sudden unexpected death in infancy and childhood, Multi-agency guidelines for care and investigation 2nd edition, November 2016).

[5] ICON : Babies Cry, You Can Cope! - Plymouth Safeguarding Children Partnership (plymouthscb.co.uk)

University Hospitals Plymouth NHS Trust, Southwest Ambulance Service Trust, the School, and Family General Practitioner

- National literature, research papers and related evidence.

4.5 Initial draft reports and conclusions based on the desktop review, rapid review and consideration of national literature and learning reviews were submitted to the partnership between December 2021 and March 2022.

4.6 Whilst valid, these reports highlighted several gaps in the information and knowledge of the partnership that could only be meaningfully addressed directly with practitioners and managers involved with providing a range of services to the family during the review period. Consequently, the partnership arranged for a reflective learning workshop to be held with practitioners and managers in April 2022 facilitated by an independent consultant with a professional background in social work. Seven professionals attended the in-person workshop, representing the following agencies:

- Devon and Cornwall Police
- University Hospitals Plymouth NHS Trust
- Schools attended by Daniel, Elizabeth, and Susan
- Plymouth City Council - Children's Disability Team
- Livewell Southwest.

The review author also attended as did members of the PSCP Business Unit.

4.7 In preparation for the event, thematic lines of inquiry were identified, which the attendees were asked to reflect upon during the workshop. Questionnaires were also circulated to attendees prior to the workshop which sought specific information in the areas of supervisory support arrangements for practitioners, the specific nature of agency involvement with Isla and her family, definitions of home visits and policies that influenced the need to undertake virtual or physical home visits during the response to Covid-19. The event was run as a plenary session and included agencies being asked to reflect on the risk factors associated with issues of neglect which may have impacted on family members and the home environment. These risks were documented on pro-forma questionnaires by the attendees and subsequently shared with the report author.

4.8 The review covers the period between September 2019 and September 2020 and focuses on the themes identified within the rapid review, which form the scope of this review:

- Identifying risks around past and present substance misuse and parenting.
- Identification of family and environmental factors which may contribute to neglect.
- Risk of SUDI and provision of safe sleeping advice.
- Effectiveness of agency assessments, risk management, decision making and professional rigour.

5.0 FAMILY ENGAGEMENT IN THE REVIEW

5.1 Karen and Colin were keen to contribute to the review and did so through a meeting with the review author. This meeting offered an opportunity for both parents to ask questions on the review process, including the purpose of the review and outcomes arising from it. The issues of review publication and the anonymisation of the review were also discussed. The meeting started with Karen and Colin giving the pen portrait of Isla, captured at paragraph 1.2 above. They offered, on more than one occasion, self-reflections on what they could have potentially done differently which may have prevented their tragic loss. The following paragraphs present their feedback and considerations which they wish to be included and recognised as part of this review.

5.2 Karen shared her deep anxieties and concerns with her pregnancy given her complex and long-standing health conditions (including heart conditions, emphysema), sustained use of medication and use of drugs (past and present). Karen's age was also a worry for her. The family report that these uncertainties led to Karen having several scans throughout the pregnancy at times once every 7 to 10 days. These scans were undertaken in a private facility at the parents' expense, prioritised within the family budget. Karen carried a pervading sense that she would miscarry as the odds were stacked against a healthy baby being born.

5.3 The restrictions in place because of the Covid-19 pandemic created what Karen describes as a surreal pregnancy for her. She advised that most of her clinical appointments were undertaken alone, without the support of Colin or via Zoom or telephone calls. When discharged from hospital, Karen felt very unsure of how to manage the transition to her home environment with Isla. Karen feels an unfounded and unrealistic confidence was placed on her abilities to be a good mum by healthcare workers when she returned home. Karen felt that she had been left and was isolated. To illustrate this Karen highlighted the fact that Isla's index finger on her left hand was red, swollen and contained pus but, according to Karen, no medical interest was shown in this.

5.4 During the reflective learning workshop, health professionals believed that there was a close working relationship with Karen during and after her pregnancy. Midwifery and health visiting services visited the home. They recognised the extremely complex nature of Karen's health conditions and vulnerabilities that arose from this and felt they invested a prominent level of care in this regard. They stated that Karen was engaged and communicated well with the multi -disciplinary team supporting her.

5.5 In terms of Isla's swollen finger, health professionals were confident this had been picked up in hospital and identified as 'paronychia', a bacterial infection of the nail bed that is common in babies as result of a break in the skin around the nail. However, health professionals were unable to confirm this as Isla's medical notes were not available to them at the time of the workshop.

5.6 Colin recognised he had a key role in co-parenting and supporting the family, a role which he undertook willingly. Despite the complex family background and context, he reports that he was offered no specific parenting support, guidance, or advice.

5.7 At the reflective learning workshop, midwifery services advised how they were encouraged by the way Colin attended a number of Karen's appointments and indicated that Colin was present when safe sleeping advice was offered and discussed. They also noted that Colin visited the maternity unit and discussions were also held with him there.

6.0 FAMILY COMPOSITION

The names of those involved in this case have been changed to ensure their anonymity and the privacy of individuals and wider family members.

Family Member	Relationship	Ethnicity
Baby Isla	Baby the focus of this review	White British
Daniel	Brother	White British
Elizabeth	Sister	White British
Susan	Sister	White British
Karen	Mother	White British
Colin	Father	White British

7.0 BACKGROUND HISTORY

7.1 Isla was born in July 2020 and was of a low birth weight, remaining in hospital for a period of days for neonatal abstinence syndrome observations (symptoms of opiate withdrawal) due to Karen's prescribed medication history. Fortunately Isla did not require any treatment for neonatal abstinence syndrome. Isla is the fourth child of the family.

7.2 Karen has a complex physical and mental health medical history, which has included historic drug use. Karen was prescribed opiate-based medication, for pain relief and anxiety, respectively. Karen also reported that she smoked 1 to 3 joints of cannabis a day to aid pain relief, as well as smoking tobacco.

7.3 During a search of the home address on the morning of Isla's death, police officers located a quantity of cannabis within the property. The quantity was assessed by the police as commensurate with personal use.

7.4 Colin's medical records indicate one historic episode of him experiencing mental ill- health. There is nothing of significance in other agency records.

7.5 Daniel was Isla's eldest sibling. Daniel himself has complex needs, including autism and severe learning difficulties. Daniel attends a local school which specialises in meeting the needs of children with such complex needs and is under the care of the local hospital's Child Development Centre and children's social care, Children's Disability Team.

7.6 One of the sisters has developmental delay and complex needs.

7.7 The family lived in an area which scores 35.8 on the overall IMD2010 deprivation[6] scale. 34.9% of the private sector housing stock was classed as non-decent homes in 2010, above the city averages of 33.3%.[7]

7.8 Prior to Isla's birth the family had arranged for support from paternal grandmother and paternal sister and adult nephew. At the point of Isla's birth, the paternal grandmother was ill in hospital, but the paternal sister and adult nephew stayed in the family home, for a brief period, to offer support. Neither the paternal sister nor adult nephew was staying at the family home at the date of Isla's death. The adult nephew continues to offer day to day support for the family.

8.0 CONTEXTUAL INFORMATION AND SUMMARY

8.1 This section provides a summary of the family's engagement with services from the perspective of the agencies involved in providing those services, as set out below:

- Hospital Child Development Centre
- Elizabeth's and Susan's School
- Daniel's School
- General Practitioner
- Public Health Nursing Health Visitor
- Hospital Midwifery
- Children Social Care

[6] Deprivation measures attempt to identify communities where the need for healthcare is greater, material resources are less and as such the capacity to cope with the consequences of ill-health are less. Areas are therefore deprived if there is inadequate education, inadequate housing, unemployment, insufficient incomes, poor health and low opportunities for enjoyment. A deprived area is conventionally understood to be a place in which the residents tend to be relatively poor and are likely to suffer from misfortunes such as ill-health.

[7] Neighbourhood Profile; Public Health, Plymouth City Council (January 2020)

- Devon & Cornwall Police
- Southwest Ambulance Service Trust

8.2 The family were known to children's social care (Children's Disability Team) in respect of a child in need plan to provide family support for the complex needs of Daniel. In 2017 and 2018 respectively single assessments were carried out. The former following concerns for Daniels's development delay, Karen's use of cannabis, Daniel's dental decay and lack of nursery attendance; resulting in a common assessment framework and no further intervention from children's social care. The latter followed an episode of a lack of parental supervision, resulting in a strategy meeting and single assessment. This led to early help interventions for the family, but no further intervention from children's social care.

8.3 A further referral was received by children's social care in 2019 from ALHELP[8] following parental requests for support for Daniel. Concerns had also been raised by Daniel's school and Children and Adolescent Mental Health Services (Severe Learning Disability) team about Daniel's behaviour which included hitting his sisters to wake them up. A single assessment was carried out for Daniel regarding his specific needs in December 2019 and he was held on a child in need plan, as agreed with the family, with a review every 12 weeks.

8.4 From December 2019 onwards none of Daniel's siblings were supported under a child in need plan. Social workers did consider and approach the parents to undertake single assessments for both Elizabeth and Susan, but the parents did not consent to this process.

8.5 The last child in need home visit, prior to Covid-19 lockdown restrictions, took place on 26 February 2020, and the social worker engaged carefully and fully with Daniel, Karen, and Colin to provide further support for them all. At this point the family home is described as, '*Home remains at good enough level. There is some clutter at the front door of the house. Home is adequately furnished and general cleanliness good enough standard. The home is tired in places.'*

8.6 The family shielded at the point of Covid-19 lockdown in March 2020, due to Karen's vulnerability arising from her physical health conditions.

8.7 Due to Covid-19 the visiting of the family was 'RAG' (red, amber, green) rated green by children's social care. Virtual visits took place during the period of March to September 2020 in lieu of scheduled face-to-face visits as the family were self-isolating. There was a doorstep visit in June 2020 to deliver a laptop, but the children were only seen briefly by their social worker. The issue of RAG ratings and their application in this review are further analysed in the next section of the report under the heading– Impact of Covid-19 and organisational demands.

8.8 In addition to telephone contacts, the health visitor visited the family on three occasions, in July and August 2020, and there are five midwifery home visits following Isla's discharge from hospital. Susan's school did offer her a place at the school, but this was declined by the family due to Karen's physical health. Both Daniel's, Elizabeth's and Susan's schools made regular telephone welfare calls. Any school concerns regarding Daniel, e.g., behaviour and Karen's drug misuse, mental health, and anxieties, were appropriately notified to Daniel's social worker. There were no school concerns indicated about Elizabeth or Susan resulting from the welfare calls.

[8] Aiming High Enhanced Lead Professional: Early Help level support for children with special educational needs who do not meet the threshold for statutory assessment. Introduced via the Family and Children Act 2014

8.9 During March 2020 the family advised the hospital's Child Development Centre that Daniel is having some difficulties, including sleeping, and could be awake 4 to 5 hours per night, being very loud and waking the family.

8.10 At the end of March 2020 agencies became aware that Karen was pregnant. Karen had a specialist midwife who communicated effectively with the health visitor who recorded risk factors including the previous history of drug misuse, prescribed medication, and use of cannabis for pain management. The review did not identify, through written records or in discussions with practitioners, any wider communications between agencies at this point or any escalation of risks based on the family context or the history of any individual family member.

8.11 During June 2020, Karen reports to Daniel's school her concerns as to Daniel's behaviour (acting out like a baby), and her concern that Daniel may unintentionally hurt the new baby if she were to fall asleep. These concerns were raised by the school with children's social care. The documents reviewed do not offer explicit information on any response by children's social care to these concerns, but there is evidence that the school undertook to create a social story for Daniel on babies crying and keeping babies safe.

8.12 Between June and September 2020 several virtual and face to face (socially distanced) visits occurred either to the family home, or at an agency venue. The last visit by children's social care took place, virtually, in early September 2020, and Daniel is seen on video. The midwife and health visitor visit the family home to see Karen in July and August 2020, and the health visitor further contacted the parents by phone in September when a home visit is arranged to take place two days later, which was the date of Isla's death. Records indicate that the practitioners had no safeguarding concerns during this visit with no professional referrals or concerns being logged with children's social care.

The subject of home visits and in particular the kind of activity undertaken during a home visit are pertinent to this review and are further analysed in the next section of this report under the heading- Identification of family and environmental factors which may contribute to neglect.

8.13 In July 2020 a child in need meeting for Daniel is convened and the safeguarding midwife shared information regarding delivery planning and known risks regarding Karen's health relating to the delivery and impact of medication. Karen and Colin were considered to be seen to be working well with services such as the safeguarding midwife, health visitor, and the school. Practitioners reflected that Colin and Karen engaged well with services throughout her pregnancy, appearing attentive and keen to support the best care for both Karen and Isla. A referral had been made for support from a children's centre, together with a plan for family support. This was not progressed due to the restrictions of Covid -19. A pre-birth assessment was not considered by any agency at this stage.

8.14 Following attendance at the property, in September 2020, as an emergency response to Isla's condition, both the police and the Ambulance Trust commented on the poor condition of the home. It is recognised that the paramedics who attended the property were focused on resuscitation attempts, but two clinicians commented on the house being cluttered and unclean, whilst the police hypothesised that the house had been in a neglectful condition for a period of time stating that there were inadequate sleeping arrangements, a very cluttered household with unusable parental bedroom and family bathroom, as well as a garden without space in which children could play. The police shared this hypothesis with children's social care.

8.15 A multi-agency strategy discussion followed, and a section 47 enquiry (Children Act 1989) was opened in response to the concerns raised around potential neglect within the home. The family were visited by the social worker that day and immediate advice was given to address the condition of the family home.

A further visit was undertaken on the 22 September to consider the family support needs and review the condition of the home again. Single assessments commenced for all the children and children in need visits were undertaken. The home conditions are then reported as improving with an ongoing plan in place for this.

9.0 ANALYSIS BY THEME

The rapid review submitted to the Panel on 26 October 2020, highlighted four themes as lines of enquiry. Following a desktop review of the information provided by the agencies, the review author concludes that these lines of enquiry remained appropriate, with no additional lines to be added. As such the following themes are identified and subsequently analysed:

- Identifying risks around past and present substance misuse and parenting.
- Identification of family and environmental factors which may contribute to neglect.
- Risk of SUDI and provision of safe sleeping advice.
- Effectiveness of agency assessments, risk management, decision making and professional rigour.

9.1 Identifying risks around past and present substance misuse and parenting

9.1.1 Case reviews highlight professionals often focus on the issues faced by parents who abuse substances without considering the impact on their children. Substance misuse by a parent or carer is widely recognised as one of the factors that puts children at greater risk of harm. The biggest risk posed to children is that parents, when under the influence of drugs or alcohol, are unable to keep their child safe (including overlay through co-sleeping, and accidents caused through lack of supervision).[9] From a review of the information available, there is evidence of a multi-agency focus upon Karen's and Daniel's needs. This specific focus potentially impacted agency understanding of the level of parental care and protection afforded to all the children resulting from maternal drug use (illicit and prescribed), and the sufficiency of subsequent planning and assessment.

9.1.2 On 18 December 2019 a single assessment commenced to consider Daniel's needs following a parental request for support for his challenging behaviour and potential respite from this. This single assessment does provide a clear picture of Karen's self-reported drug consumption and usage, and noted parents' statement to children's social care that:

- Karen does not parent alone and Colin is present to ensure basic care.
- Colin is not using substances.
- Family and safe friends provide support when Colin needs to go out.

There is no information available on professional exploration of this statement, or consideration as to whether this parental assertion was realistic, how it occurred in practice, or its effectiveness as a safety plan. Neither is there any assessment of Colin's parenting capacity because Karen was not parenting alone. There is a need for active multi-agency curiosity including with substance misuse treatment agencies, to identify, intervene and provide a child centred response to parenting needs where there is known drug consumption and usage.

9.1.3 The single assessment concluded on 29 January 2020. Between the period December 2019 and 29 January 2020 Karen advises the Children Disability Team that she is pregnant.

[9] NSPCC (2013), *Parents who misuse substances: learning from case reviews.* Available at Learning from case reviews briefing: parents who misuse substances (nspcc.org.uk) (Accessed: 22 November 2021)

9.1.4 The reviewer has noted that Karen's GP did discuss with Karen a potential referral to Harbour[10], (at a date unknown) but this does not appear to have been followed up or further discussed with Karen, or any other agency, during her pregnancy with Isla. It cannot be seen that it translated into the child in need plan already in place for Daniel.

9.1.5 During pregnancy, care was provided by a specialist midwife for women with substance misuse and Karen was seen regularly and monitored closely. There was recognition across midwifery, health visiting and children's social care, that this was a high-risk pregnancy due to the prescribed medication, cannabis use and long-term health conditions. This recognition was highlighted during the child in need meeting of 20 July 2020. A personalised antenatal and postnatal plan was devised by midwifery, and this included a plan for an early help assessment antenatally, but this does not appear to have gone ahead. The recognition of a high-risk pregnancy did not translate into a pre-birth assessment and a referral was not made by any agency into children's social care.

9.1.6 There is the possibility that the agency professionals working with Isla's family trusted the parents' self-reporting of drug (both prescribed and illicit) use, and thus this use was not seen as excessive or problematic. There is no evidence of inter-agency challenge, discussion, or escalation on this point. This optimism or acceptance may have impacted agency decision making as well as their understanding of parenting capacity at the point that Karen's pregnancy became known. Such optimism can impact on professional's ability to fully identify and assess concerns, so that interventions are not effective in minimising risk of harm to children.

9.1.7 All agencies need to work together in tackling any problems caused by substance misuse in families to safeguard the children and promote their wellbeing. Parents who misuse drugs may be good enough parents who do not abuse or neglect their children, and it is important not to generalise or make assumptions about the impact on a child of parental/carer drug and or alcohol use. It is, however, equally important that the implications for children are assessed having full regard to the parents' ability to maintain consistent and adequate care in the environment and changing circumstances in which they live. Regard should be given to each child's level of dependence, vulnerability, and any special needs.

9.1.8 Karen's complex medical history meant that she was prescribed oral morphine for pain relief, and diazepam for anxiety. Clinical advice about the impact of these prescription drugs, and their use with cannabis was not directly sought. Indeed, during the reflective learning event Karen's use of cannabis did not feature prominently as a risk consideration with agencies, despite its reference within the child in need meeting in July 2020. At the reflective learning event, health professionals suggested that there was a high prevalence of cannabis use in the community together with limited research into the harms caused to an unborn baby by smoking cannabis during pregnancy or smoking it in combination with medication. However, the review author notes many NHS trusts publish information about the risks of cannabis use when pregnant and Plymouth Hospital's own antenatal website says, "*Illegal drugs (street drugs), such as cannabis, ecstasy, cocaine, and heroin can harm your baby. If you use any of these drugs, it is important to talk to your maternity team straight away so they can give you advice and support to help you stop.*"

9.1.9 Further sources on this matter include:

www.babycentre.co.uk/x25014277/is-it-safe-to-smoke-weed-during-pregnancy

[10] Plymouth based charity providing drug and alcohol services to people with complex lives

www.mja.com.au/journal/2020/212/11/deleterious-effects-cannabis-during-pregnancy-neonatal-outcomes

www.medway.nhs.uk/services/maternity/Maternity%20Patient%20Leaflets/Cannabis%20and%20Pregnancy.pdf

https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-020-0880-9

9.1.10 It is noted by children's social care that the family general practitioner (GP) was not present at the child in need meeting of 08 July 2020. They note the benefit of having the GP present in the multi-disciplinary discussions to consider the risks associated with the medication and cannabis use. As part of this review no records can be found to evidence whether the GP was invited, if they were invited but could not attend and submitted apologies, or in their absence submitted a written report.

9.1.11 Considering the above, and with knowledge that Karen was pregnant, a single assessment of all the children could have been undertaken to understand their needs and the potential for harm and captured a holistic perspective on the maternal drug use. This would have provided greater information for triangulation and assessment, so that the analysis of the presenting situation could have better supported a multi-agency response/intervention. Assessments must be dynamic rather than static and must be reviewed considering emerging evidence or a change in family circumstances. Except for children's social care (Children's Disability Team), as set out below, it is noted that no agency from within the multi-agency network made a referral for, or otherwise actively sought such assessments.

9.1.12 It is noted that the parents were approached by children's social care (Children's Disability Team) in January 2020, to seek consent to undertake such single assessments. However, the parents declined, and this appears to have been accepted without further discussion with the parents or the other agencies involved in family care. No record has been provided to the reviewer to suggest the contrary. Where a parent refuses to give permission for an assessment further advice should be sought from a manager to consider what, if any, further action should be taken, including consideration of a strategy discussion. Any outcome should be recorded along with the rationale for that decision. This action is not seen within the records provided to the reviewer. It is noted that the Children's Disability Team, within their Appreciative Inquiry return, have acknowledged that because of the parent's lack of consent, a single updated assessment for Daniel should have been undertaken due to the change in circumstances identified. Information gathered from this assessment could have further informed the subsequent child in need meetings in January, April, and July 2020, to assist with an up-to-date analysis of family vulnerabilities and strengths, as well as aiding effective multi-agency decision making.

9.2 Identification of family and environmental factors which may contribute to neglect

9.2.1 The rapid review which led to the commissioning of this local child safeguarding practice review identifies several predisposing factors regarding cumulative neglect. These include, poor parental mental and physical health, parent substance misuse, poor supervision of children, Daniel's previous dental decay and low attendance at school, inadequate housing and a cluttered disorganised home with rooms that could not be effectively used for their purpose. Some of these factors date back to 2017/2018 and in response an Early Help Plan was put in place and the Child Development Centre continued to assess and support Daniel's needs. The assessment concluded that there was no ongoing role for children's social care. The subsequent single assessment (Dec 19 to Jan 20) following the referral from ALHELP for family respite, considered Daniel's needs in detail, as well as family dynamics and functioning, basic care, capacity to meet Daniel's needs, home conditions and housing to evaluate risk. Children's social care state that this assessment did not identify concerns of neglect from the information gathered at the time.

9.2.2 HM Government statutory guidance, Working Together to Safeguard Children (2018) provides a statutory definition of neglect, "*The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of a child's health or development.* ***Neglect may occur during pregnancy as a result of maternal substance misuse.***[11]*Once a child is born, neglect may involve a parent or carer failing to: a. provide adequate food, clothing and shelter (including exclusion from home or abandonment) b. protect a child from physical and emotional harm or danger c. ensure adequate supervision (including the use of inadequate caregivers) d. ensure access to appropriate medical care or treatment It may also include neglect of, or unresponsiveness to, a child's basic emotional needs".*

9.2.3 At the point the agencies became aware of Karen's pregnancy there was no clear co-ordinated multi-agency response to assessing the potential risk of neglect arising from maternal substance use during pregnancy; nor any apparent respectful and professional challenge with the medical profession, or Karen herself, on the continued cannabis use combined with the prescribed medication. A pre-birth multi-agency assessment was neither discussed nor commissioned by any agency involved with the family.

9.2.4 Isla's family lived in a socially deprived area of the city, wherein there are social and environmental risk factors, including poverty, social isolation, and housing difficulties. 24.7% of the children (aged under 16 years) in the area are in low-income families. Neither Colin nor Karen was in paid employment. They were in receipt of benefits including Universal Credit, Disability Living Allowances, and Child Benefit. The family live in a privately rented three bedroomed property, which the health visitor describes as "poor housing." The housing costs are covered by housing benefits. Children's social care supported the family with an application to housing for a four-bed need, and the family were given a Band C priority. In August 2020, Daniel floods the family bathroom, and in September the parents discussed with their health visitor the application for a grant for replacement flooring and furniture damaged during the flood.

9.2.5 Whilst it is recognised that poverty is not the same thing as having a low income[12], it is recognised that this family lived in an area of Plymouth with a higher rate of child poverty, higher rates of universal credit claimants, increased numbers of non-decent homes, and shorter life expectancy[13] than the average for Plymouth. Further, there was knowledge of the parent's mental and physical health, previous trauma, and Karen's use of drugs. These indicators and signs can be causes of poverty.

9.2.6 Whilst the presence, or perceived presence of poverty, does not necessarily equate to the presence of neglect, the increased stress associated with poverty can make coping with the psychological as well as the physical and material demands of parenting much harder.[14] In this respect poverty can add to the likelihood of poor parenting and neglect and be one of the many cumulative adversities a child can experience.

9.2.7 Research has found that professionals who work with children and families sometimes normalise and become 'blind' to poverty in their assessment of risk and need for support. Poverty is often seen as an outcome or co-existing factor rather than a potential cause of a family's difficulties. Poverty blindness may occur where professionals are working in areas of high deprivation and so poverty becomes the

[11] Reviewers' emphasis

[12] Poverty in the UK: a guide to the facts and figures - Full Fact (Accessed 17 February 2022)

[13] Neighbourhood: area profiles | PLYMOUTH.GOV.UK

[14] Brandon M. (2015) In What Ways Might Poverty Contribute to Maltreatment? In: Fernandez E., Zeira A., Vecchiato T., Canali C. (eds) Theoretical and Empirical Insights into Child and Family Poverty. Children's Well-Being: Indicators and Research, vol 10. Springer, Cham. https://doi.org/10.1007/978-3-319-17506-5_16

norm and an associated desensitisation to warning signs of poor hygiene, dirty clothes, and poor dental hygiene.[15] This is further highlighted within learning from previous serious case reviews.[16]

9.2.8 Children's social care contacts with the family were virtual during the period March 2020 to September 2020 (except for a doorstep visit in June). It is seen that the health visitor visits the family on two occasions, in July and August, and there are five midwifery home visits following Isla's discharge from hospital. No concerns were raised regarding the home conditions following these visits although the health visitor reported that she was supporting the parents to obtain grants to replace damaged items. This is explored in the paragraphs below to establish if there was either a degree of normalisation and/or a lack of curiosity and sighting of home conditions by health practitioners who had access to the home.

9.2.9 The reflective learning event offered insight, and in terms of the Children's Disability Team who were supporting Daniel, a RAG rating of amber or red would have necessitated a physical home visit. The green rating applied to Daniel led to virtual visits during the lockdown restrictions which were more difficult to conduct on a room-by-room basis.

9.2.10 Midwifery and health visiting services maintained some face to face visits for some families during the Covid-19 pandemic unless there was a positive Covid-19 test in the home.

9.2.11 When the conduct and practice issues of home visits were explored at the learning event it became clear that health professionals would not generally look around a home unless previous safeguarding concerns had been raised (which was not the case in this review), or the parents invited them into other rooms. In this case, Karen and Isla were always seen by midwifery and health visiting services in the downstairs living room of the home. The impression given to professionals was that Isla was sleeping in a cot in an upstairs bedroom. On the day of Isla's death in the parents' upstairs bedroom, neither the parent's bed nor the cot appeared to have been used.

9.2.12 Police photographs taken on the day of Isla's death were shared with practitioners at the learning event. The ground floor kitchen/dining room where Karen had been sleeping in a chair, beside Isla's travel cot, and upstairs bedrooms were shown as significantly cluttered and chaotic and at best only partially fit for their respective purposes. Some attendees reflected that the conditions of other rooms in the house did not represent the rooms they had been in. However, based on what was seen in the photographs of other rooms in the house, there was a recognition from a health professional that if they had previously seen this on their home visits, they would have made a safeguarding referral which would have generated multi-agency responses and additional considerations.

9.2.13 It has not been possible to establish over what period the home environment deteriorated to the condition it was found on the day of Isla's death. What is clear is that the home environment was not coherently assessed by multi-agency partners in terms of condition, cleanliness, or appropriateness to safely support this family with multiple and complex needs.

9.2.14 In addition to the condition of the home environment, the reflective learning workshop also provided an opportunity for professionals to consider the nature of other risk factors for neglect potentially being experienced by the family. They were asked to complete a pro forma questionnaire of these factors that applied to the family, that they were aware of. A considerable number of predisposing factors regarding cumulative neglect were collectively identified by professionals including:

- Parental depression and other mental health problems including anxiety

[15] SCR analysis 2020 for the education sector: Neglect | SCIE

[16] Poverty a key factor in a third of serious case reviews | CYP Now

- Living in poverty
- Parental misuse of drugs
- Developmental delays with two of the children
- Behavioural difficulties with Daniel
- Inconsistent school attendance often linked to health issues
- Home being described as poor and worn -but tidy in some rooms.

9.2.15 It is considered in light of the above, that the risk factors for and indicators of neglect within this family of complex needs experiencing cumulative adversity, a further child being born into the family, and loss of familial and community support due to the Covid-19 pandemic should have been further explored by the multi-disciplinary teams engaged with the family. The reviewer has also identified other opportunities where the family's socio-economic circumstances and the potential for neglect could have been identified:

- A neonatal team meeting to discuss 'social issues' – it's not clear that all factors were considered when there was a decision taken that "no input" was required; and
- the medical discharge summary for Isla provided little information about the family's social circumstances, or specific concerns about Karen's ability to safely care for Isla alone.

9.2.16 The Department for Education's research report 'Missed Opportunities: indicators of neglect – what is ignored, why and what can be done' (2014), notes there are some characteristics of young children which put them at an elevated risk of neglect. This is especially the case for babies born before term, with low birth weight, or with complex health needs.[17] Isla had a low birth weight and neonatal abstinence syndrome observations (symptoms of opiate withdrawal) due to Karen's prescribed medical history, although she did not require treatment for opiate withdrawal. This information was shared between the midwife and the health visitor, but the reviewer cannot see that the information was shared with children's social care. A single assessment for Isla, at this point, was not considered. Additionally, the report explores that a particularly vulnerable group of young children is those with disabilities like Daniel. Disabled children are more likely to be maltreated than their non-disabled peers and neglect is the most common form of maltreatment they experienced.[18] Practitioners who are cognisant of this learning and risk, and who are supported with effective multi-agency tools and strategies, can apply the same during assessments and multi-agency discussions such as child in need meetings and core group meetings.

9.2.17 In this case practitioners focused on and worked hard to ensure practical support for Daniel and his parents, but this focus meant that the wider multi-agency network was not sufficiently alert to what may be contributing to neglect within the declining family environment, and the children's lived experiences.

9.2.18 The fact that a single assessment was not completed for Daniel's siblings (as discussed in paragraph 8.19) represents a missed opportunity to gain insight to experiences of neglect for Daniel, his siblings and the risk presented for Isla both unborn and as a new-born. This assessment could have considered the impact upon the family, the family history, the wider family network, and the effect that current environmental and Covid-19 factors were having on the parents' capacity to respond to all the children's needs and parental concerns as described in paragraph 7.11, where Daniel is expressed to be a potential risk to a new-born sibling.

[17] (Strathearn et al., 2001).
[18] (Stalker and McArthur, 2012).

9.2.19 To prevent desensitisation to potential signs of neglect, the Plymouth partnership can implement multi-agency group and peer reflective practice models to enable practitioners to identify poverty and work proactively with each other and with families to address its causes and consequences; to improve children's wellbeing and outcomes. The use of such group/peer reflective practice can support practitioners to feel safe and identify and address feelings of desensitisation or poverty blindness when working with neglect. Mutual reflection and group discussion can support individual practice and lead to service improvement. It also differentiates from supervision, which can be vulnerable to tension between practitioner support and performance management.[19]

9.2.20 In terms of supervision, the pre-learning event questionnaires asked several questions on this aspect of practitioner's experience. The health visitor did not take this family for discussion in supervision as she did not identify any safeguarding concerns or any other issues of concern. Health visiting only discuss, in supervision, those families that the practitioner identifies as needing a discussion. Midwifery were able to offer extensive details on the supervision for those working with the family. This identified regular and consistent supervisory discussions with the lead midwife for safeguarding. These discussions were held in a safe space for clinical and relationship-based conversations. This supervision mirrored relationship-based practices with families. The police highlighted consistent but not protected spaces for supervision citing the vagaries of operational demands as limiting their ability to protect these discussions. The Children's Disability Team questionnaire highlighted that the head of service, team manager and social worker involved with the family for most of the review period, no longer worked for the local authority. It was noted that although there was continuity of supervision and meetings (supervision and management observation) were held during the review period the social work records offer no information on the issues discussed, nor the quality and nature of the supervisory arrangements.

9.3 Risk of SUDI and safe sleeping advice

9.3.1 This review formally notes the coroner's findings that due to the possible sleeping circumstances Isla's death would not fulfil the criteria for 'sudden infant death syndrome' or 'SIDS'. The cause of Isla's death is unascertained. As this report forms part of a wider learning opportunity, the awareness of such SUDI or SIDs risk is included.

9.3.2 Agency records demonstrate the following:

Midwifery

- There is clear documentation of discussions about the dangers of co-sleeping in the medical records with specific reference to maternal medication and the infant's prematurity. It is documented that Karen said that there is a separate cot at home. In the midwifery records there were 3 entries stating that aspects of safe sleeping had been discussed and on the day of discharge it is documented that "*travel safety and SIDS were discussed, and a cot-death leaflet given.*"
- Following discharge midwifery home visits were undertaken on five occasions, although Karen and Colin only recall two visits. There was documentation from four visits that safe sleeping was discussed. There was specific documentation on day twenty about co-sleeping issues being discussed and SIDS.
- The reviewer is unable to locate any documentary evidence of whether safe sleeping discussions included both Karen and Colin, particularly in light of Colin being the prime carer.

Public Health Nursing

[19] How reflective practice can help social workers feel 'safe' - Community Care

- Antenatal visit in July 2020 and telephone contact by a health visitor to complete new birth assessment in August 2020. The health visitor discussed infant feeding, all relevant health promotion topics and recorded that Karen was fully aware of safe sleeping advice.
- Seven days' later a home visit is undertaken by the lead health visitor. Whilst there was good engagement with the family including Isla's siblings, there is no record or commentary on sight of the sleeping arrangements, or that safe sleeping advice was given in the environment or context of the family's sleeping arrangements.
- As above, the reviewer is unable to locate any documentary evidence of whether safe sleeping discussions included both Karen and Colin, particularly in light of Colin being the prime carer.

Children's Disability Team

- In July 2020, a child in need meeting was convened, attended by safeguarding midwifery. Information was shared to the multi-agency attendees regarding delivery planning and the known risks for Karen's health relating to the delivery and the impact of medication. However, there was no multi-agency conversation as to the risk of SUDI and the embedding of safe sleep advice with Karen and Colin; particularly as the latter was undertaking prime carer duties.

9.3.3 In conclusion, there is some good single agency advice, and a wealth of information given, but a fundamental absence of a comprehensive multi-agency identification and response to SUDI and safe sleeping assessments. There is no practitioner assurance as to the understanding of both Karen and Colin of the dangers of co-sleeping, and their ability to apply the safe sleeping advice they had been given. Safe sleep advice and risk assessments were not joined up with wider considerations of the safeguarding risks and plans to work with Isla's family to address safeguarding concerns. It cannot be seen that any agency had sight of the family sleeping arrangements either antenatally or postnatally. It is imperative that all agencies, not just midwives and health visitors, are able to see where a baby is sleeping to undertake a safe sleep assessment and give appropriate safe sleeping advice in context. This requires a culture of curiosity and the application of inquisitive practices to be assured that the arrangements are appropriate and safe and are regularly reviewed in this regard, challenging parents where necessary when their good enough is simply not good enough. This underscores the provision of safe sleeping advice and guidance. It is also critical that physical home visits form an integral and rigorous part of the single assessment process.

9.3.4 In consideration of the above, the review author turns to the findings from The Child Safeguarding Practice Review Panel's report 'Out of Routine'[11]. The report asks, "In families with children considered to be at high risk of significant harm through child abuse or neglect, how can professionals best support the parents to ensure that safer sleeping advice can be heard and embedded into parenting practice so as to reduce the risk of SUDI?"

9.3.5 The Panel's report's conclusion reflects the themes identified within the rapid review, and the learning arising from this review. The report's conclusions are replicated below:

- A better understanding of parental perspectives by all professionals enables local areas to adopt a more flexible and responsive partnership with parents, develop supportive yet challenging relationships that facilitate more effective safer sleep conversations, and co-produce appropriate information and support for parents and carers to aid their decision making about the sleep environment.
- There needs to be better links between the work in local areas to reduce the risk of SUDI and wider strategies for responding to neglect, issues related to social and economic deprivation, domestic violence, parental mental health concerns and substance misuse. This work needs to be embedded in multi-agency working and not just seen as the responsibility of health professionals.

- The use of behavioural insights and models of behaviour change should be investigated to explore whether these can support interventions to promote safer sleeping, specifically with this group of families with children at risk of significant harm. Approaches such as motivational interviewing hold out promise, particularly when combined with other strategies for family support and risk reduction. Such an approach could include the use of marketing and social media to influence behaviour change and could be linked to ongoing national work to provide consistent and evidence-based safer sleep messages as part of good infant care and safety.

9.3.6 It is recognised that the Plymouth partnership is putting in place the key recommendations outlined above. It is therefore prudent to ensure that the recommended prevent and protect practice model highlighted by the Panel for reducing the risk of SUDI is expedited to fully transfer the learning into multi-agency practice.

9.4 Effectiveness of agency assessments, risk management, decision making, rigour

9.4.1 The review has identified missed opportunities for effective multi-agency assessments and support, which could have better informed subsequent risk management and decision making. As previously recognised, in the July 2020 child in need meeting, the safeguarding midwife shared information regarding the delivery plan, and the known risks regarding Karen's health relating to the delivery, and the impact of medication and drug misuse. However, this did not result in a pre-birth multi-agency assessment being undertaken which would have provided an opportunity to evaluate and respond to potential risks and impact upon the then unborn Isla and her siblings. This specialist assessment could have enlightened professionals around the family in respect of:

- The increased demands for the family of caring for new-born Isla together with 3 other children, one of whom had complex needs and another with learning needs
- Family housing
- Karen's dependency on high dose prescribed morphine medication and diazepam
- Karen's regular use of cannabis
- Karen's poor physical and mental health
- Colin's prime carer responsibilities and parenting capacity (as Karen was not to parent alone)
- Availability of support from family and community network
- Access to resources and services during Covid-19 pandemic
- The multiple risk factors for SUDI
- Successfully embedding safe sleeping advice.

9.4.2 Understanding what a child sees, hears, thinks, and experiences daily, and the way these factors impact on their development and welfare, is central to protective safeguarding work. The complexity of situations in vulnerable families can lead to a particular focus on parental needs, which can get in the way of professionals understanding risks faced by the children. It is essential to explore the child's experience of living with neglect, and substance misusing parents and to understand how these harms impact on their safety, health, and overall development. The child's views should inform analysis and assessment so that intervention is appropriate to address key concerns and needs.[20] In reviewing the documentation presented, the reviewer is unable to form a picture of the children's daily lived experience, and their voices are not explicitly sighted within agency documentation/submissions.

9.4.3 Single assessments were not completed for Daniel's siblings, and this has limited the consideration of information regarding their lived experience which may have provided additional insight to cumulative neglect and their lived experience of maternal substance misuse. There was significant work by agencies

[20] Child Safeguarding Practice Review Panel Annual Report 2020: Patterns in Practice, key messages and 2021 work programme

to support the family with Daniels' complex needs, but this potentially led to the lived experiences of the siblings and Isla's needs being overlooked as they were not adequately seen.

9.4.4 There is no evidence that the agencies sought to assess and understand Daniel's changing needs in light of Karen's pregnancy, and the impact upon him of having a new baby within the family home. At the point of Karen's pregnancy, and knowledge of her concerns that Daniel may unintentionally harm the baby whilst she was asleep, the assessment for Daniel could have been updated. Daniel's single assessment was not sufficiently dynamic in noting and responding to this change in the family's circumstances and the support Daniel may have needed within this context.

9.4.5 Taking a 'think family' approach to assessment which considered the environment, housing, Colin as prime carer, family history, the birth of Isla, availability of familial support, and the wider social construct, particularly during the Covid-19 period, could have provided a better understanding of links and relationship between risk of poor outcomes, resilience, and the changing patterns within the family parenting over time.

9.4.6 From a partnership perspective, multi-agency access to a shared risk assessment tool for neglect may provide an opportunity to improve the partnership's coordination of risks associated with neglect. The learning event highlighted that there is no single approach for this in Plymouth. There would be merit in researching approaches being utilised in other areas to address this issue. A multi- agency risk assessment tool for neglect, like the NSPCC's strengths-based approach in the Graded Care Profile 2[21] is a useful point of reference. A common assessment tool, shared across partners and regularly updated offers a way of better managing neglect and its cumulative effects, and can help bring about positive changes for families.

10.0 IMPACT OF COVID-19 AND ORGANISATIONAL DEMANDS

10.1 Clearly Covid-19 and the first national lockdown which came into effect on 23 March 2020 are contextually significant. Lockdown and associated measures taken to delay the spread of the coronavirus posed substantial and previously unrecognised challenges for child protection, health and welfare, education, and police. Universal and targeted support services were either closed or their services severely restricted and social distancing meant that social workers and other frontline professionals could not see some children and families face to face. The context of Covid-19 was a significant factor for those attending the learning workshop in terms of the ways it detrimentally affected their normal practices and services. The Covid-19 concerns professionals held in respect of risks to their own and their family's health during this time on an individual basis should not be underestimated.

10.2 With certain caveats, health services continued to undertake some home visits during lockdowns. However, children known to local authority services and schools were re-evaluated (using separate methodologies) because of the Covid-19 restrictions and RAG-rated to inform approaches and methods of working related to visits, contacts, and the frequency of these access points. For the local authority, those marked red were prioritised for face-to-face visits and more frequent contact and those rated amber experienced alternate face to face and virtual visits. The local authority guidance on RAG-rated assessments stipulated that the assessments should be regularly reviewed in light of information from social workers and other agencies.

10.3 As noted above, Daniel was RAG-rated green by children's social care throughout the Covid-19 pandemic and until Isla's death. This meant that face to face visits were not deemed essential and

[21] NSPCC GCP2

consequently only virtual visits took place, with one doorstep visit on 24 June when the children were briefly seen.

10.4 The review author has considered the RAG guidance document used by Plymouth City Council for social work teams, including the Children's Disability Team (V1.2 2020 04 23). The guidance was designed to support social work managers using the RAG system when considering the urgency for visiting children and young people under Covid-19 conditions. The guidance states, "Risk assessment is dynamic, and it will be important for social worker to flag up any new information relating to cases that might indicate a higher or lower risk rating. Risk could be reduced in several ways, for example, if the child is attending school regularly throughout this period this might offer a level of protection." Further, the guidance sets out that, "every case must be given a RAG rating and that the status and rationale must be recorded on the child's file as a management observation. Discussions about RAG ratings will take place in supervision. Red ratings must be reviewed weekly and all other cases at least once a month and immediately if information is received that indicates the risk may have changed."

10.5 Social work case notes within the Children's Disability Team do not identify if any actual risk assessment process was undertaken in respect of the family or Daniel, or the rationale for the appropriateness of a green rating. Between the start of the first lockdown and the time of Isla's death, any discussions or review of the RAG rating were not recorded on the three occasions of supervision (two in April, one in August) or the one occasion of management observation in April. It appears that any concerns raised during this time (by schools or health professionals) did not trigger a review of the social work RAG rating. Similarly, it does not appear that Isla's birth triggered a review of this rating. The RAG rating process and its application, in this instance, did not provide an outcome which proportionately addressed systemic and complex risks arising from the family. It was not subject to continuous assessment, as it should have been, in line with the children's social care policy at the time.

10.6 The reflective learning workshop also highlighted that health professionals were unaware that social workers were not undertaking physical visits to the family's home during this period. This is a significant oversight in communication and risk management during a time of heightened vulnerability for the family.

10.7 Daniels school, using a different RAG rating framework, assessed social care risks to the family as amber and health risks as red. It is instructive to note that in some other local authority areas all school RAG ratings were shared with children's social care, with discrepancies discussed and a rationale identified for the discrepancy if the discussion did not lead to a shared view on risk. According to those that attended the learning workshop, this process in Plymouth was not quite as defined as this and there were times, as in this case, where agencies have different ratings and were not aware that each other had assessed the risk differently. If the RAG rating policy had been followed by the children's disability team; then the rating would have been regularly reviewed, taking into account the information shared by other agencies.

10.8 The necessity to provide a prioritised operational response to service delivery during the pandemic was a national consideration by several agencies and not solely reflected in local practices by local agencies. However, this review highlights the need to ensure a consistent application of any such policy, regularly reviewed in light of changing circumstances and crucially shared and communicated across the partnership. On this occasion, the RAG rating for home visits was based on a single agency assessment and lacked rigour and coherency from a partnership perspective. It is not clear from the guidance or those that have contributed to this review, if the RAG ratings across agencies were consistently based on family needs, parenting capacity, children's needs, or wider risks.

10.9 Whilst acknowledging the restrictive environment and changes to working practices during the Covid-19 response, it is difficult to reconcile why individual agency approaches to home visits were not widely promoted across partner agencies particularly where services are being provided to vulnerable families with complex needs. Further, there is also an opportunity to consider a single, multi-agency approach to such policies or at the very least a process which enables the outcomes of the single agency RAG assessments to be challenged, communicated, and shared with other agencies. Processes should also be established to ensure future adherence to any single or multi agency policy guidance related to home visiting for vulnerable families.

10.10 During the Covid-19 pandemic, schools provided consistent support and Susan's School offered her a place where she could have been professionally sighted. Due to Karen's health circumstances and the risk of Covid-19 transmission to her health, this was declined by the family. From the commencement of the Covid-19 lockdown in March 2020 and until September 2020, the family's children did not attend school. Daniel's school made welfare calls two to three times a week, for the period 23 March until 24 July 2020, with information shared with children's social care. The school periodically dropped schoolwork and other essential items to the family home, but it does not appear from the records that they had sight of Daniel and his presentation/appearance, nor sight of the home conditions. No referrals or concerns were made by either school to children's social care for potential neglect.

10.11 The birth of Isla, a baby of low birth weight, into a family with complex needs and support did not trigger a review of the Children's Disability Team RAG rating, and the family were not prioritised for face-to-face visits and more frequent contact. The missed opportunity of either an updated single assessment for Daniel, or single assessments for Daniel, Susan, and Elizabeth and/or a pre-birth assessment for Isla, also meant that this RAG rating was unable to be reviewed with fully triangulated information and family history. The RAG rating policy in place, at the time, suggests that a review of the risk assessment should have taken place. Further, the six home visits conducted by the health professionals following Isla's birth did not evidence any concerns or trigger a referral into children's social care, which may have led to the RAG rating being reviewed.

10.12 As children's social care contact with the family occurred virtually, the social worker's ability to identify neglect, and visually identify the declining home conditions was limited. This could have been partially overcome by creative engagement with the family and the children to include virtual tours of the house, and in particular sleeping arrangements. The use of a multi-agency protocol or practice guidance for video call/contact and virtual, online home visits, such as that provided in April 2020 by the Principal Children and Families Social Worker Network[22] can help, to an extent, negate any such future limitations. That said, nothing can replicate the full benefit a physical visit can offer to a potentially neglectful home.

10.13 During the period of this review, the Children's Disability Team had also been through a change in team management. A long standing and experienced manager had moved onto a new role. Attempts to recruit to a permanent post had been unsuccessful. Therefore, a secondment was agreed to provide management cover in the interim. The team manager came from adult social care and provided an important contribution through skills and knowledge to the team, with reference to the complex assessment and care planning for young people with learning disabilities and autism, knowledge of the mental capacity act, knowledge of deprivation of liberty. This made a positive impact on the work of the team. However, the incumbent was not experienced in statutory children's social care. The Children's Disability Team have commented as part of this review, that they have considered whether potentially the seconded manager not having an experienced statutory children's social work background impacted

[22] PSW best practice guide for video call and virtual home visit (skillsforcare.org.uk)

on the professional oversight of the case open to Children's Disability Team. The honest answer is they do not know whether this was a factor, or not. This consideration is recognised by the report author. The report author also acknowledges that the family had the support of an advanced social work practitioner, who had access to a full range of child protection measures and the wider children's social work team.

11.0 IDENTIFIED GOOD PRACTICE

11.1 The value of reviews of this nature are widely recognised as an opportunity to learn and signpost improvement to services where necessary whilst also building and enhancing strengths that exist in agency responses. The following aspects of partnership working were presented as strengths in written records and at the reflective learning event.

11.2 The advanced social work practitioner in this case worked actively to build a relationship with Isla's family and engaged with the wider multi-agency network to support Daniel's needs. Karen and Colin would both call the social worker with any concerns, questions, or updates.

11.3 There was specialist midwifery involvement within the Jasmine Clinic (a clinic run for women who have problems with drug use, currently or historically).

11.4 Good and timely information sharing between the midwife and health visitor. Karen and Isla were doing well following the birth.

11.5 Within the hospital midwifery service, the importance of Colin's role in caring for Isla was recognised and enhanced visiting was facilitated postnatally despite the Covid-19 restrictions. There was also a personalised plan of care produced antenatally that detailed medical considerations for Karen and Isla, including the need for monitoring signs of opiate withdrawal.

11.6 Support was being provided to secure new flooring at the home, to try to get the family re-housed and to seek respite care for Daniel.

11.7 The children's schools kept good safeguarding records and provided welfare calls to the family and timely shared information with the social worker, which was followed up, as necessary. There was effective liaison between the siblings' different schools. The school's engagement and levels of support offered to the family were extensive throughout the pandemic, often going beyond what one could reasonably expect.

11.8 The social story provided to Daniel by the school following Isla's birth had a positive impact.

11.9 The initial sharing and information forms, and subsequent Appreciative Inquiry returns for this review, from the hospital and the Children's Disability Team evidence thoroughness and high-quality reflective practice as part of the child safeguarding review process.

12. LESSONS FOR THE PARTNERSHIP

12.1 As with all reviews, there are lessons to be taken from this review by both the wider safeguarding partnership and individual agencies. Significant factors in this case are the effectiveness of agency's assessment, risk management and decision making.

12.2 The undertaking of a multi-agency pre-birth assessment could have been a critical opportunity to enable the multi-agency network of professionals to identify and respond to the potential risks, including substance misuse, cumulative neglect, SUDI, and co-sleeping, for Isla.

12.3 Given the complex family situation and the impact of Covid-19 restrictions on a family already under pressure, there may have been benefit of single assessments being undertaken for all the children. Whilst the parents declined the offer of the single assessment, a strength based, restorative conversation with them could have potentially better informed their decision on consent.

12.4 As identified paragraph 11 there is evidence of good practice to build a relationship with Isla's family and with the multi-agency network work with the family to support them with Daniel's needs. However, this potentially led to the lived experiences of the siblings and Isla's needs being overlooked. Developing a strategic approach to 'think family' is essential in embedding family and significant others into the day-to-day work of agencies across the partnership to ensure family work is sustained and developed. Such an approach can mitigate any tendency to lose balance and focus on parental needs meaning that the child or children are not effectively seen and heard, and their voices not captured.

12.5 Practitioners were aware of the need to improve and consistently maintain such improvement of the home conditions. All practitioners were aware of the complex needs and additional support required for Daniel. When parents and family are this complex, this can be mirrored in professional's thinking as they become overwhelmed by the complexity, nature and often the volume of work, becoming 'stuck' and unable to be proactive about protecting the children.[23]

12.6 It is well recognised that practitioners can become desensitised to levels of neglect particularly when working in areas with high levels of deprivation and this can cause inertia. The chronic and fluctuating nature of neglect can also cause difficulties in deciding at which point to act. Despite the family history, there appears to be a lack of reflective sighting of the home conditions and the sleeping arrangements by agencies who had access to the family home.

12.7 The partnership has published and disseminated its multi-agency neglect strategy alongside a framework and guidance. Whilst referenced and recognised by the Children's Disability Team, it does not appear to be widely known or effectively implemented across the wider multi-agency network. This lack of knowledge and effective implementation affected multi-agency assessment and decision making; their responses to neglect were not made in the children's time. This review welcomes the ongoing activity by the partnership to quality assure its response to child neglect and evaluate alternative potential multi-agency tools to support recognition of child neglect, e.g., Graded Care Profile 2[24] or Signs of Safety.[25]

12.8 Home visiting in the arena of child protection is the accepted norm. Professional and respectful curiosity to family home environments, their community and day to day living informs knowledge of family welfare and support needs. A good home visit supports dynamic risk assessment. Building relationships with a family can support any multi-agency colleague to be able to ask to see the home environment and to see a child's sleeping arrangements. The focus of seeing the child alone, can also be placed on seeing the home environment within multi-agency home visiting practice and culture.

12.9 The partnership has published and rolled out ICON: Babies Cry, You Can Cope programme to help parents and carers manage crying babies. This programme aligns itself to the Lullaby Trust's safe sleeping campaign and initiatives, together with Dad Pad, a free app which provides essential guides for new dads. All these initiatives seek to ensure that parents can support themselves and each other so that babies get the best possible start in life. It remains unclear from this review as to the multi-agency

[23] Brandon M et al Understanding Serious Case Reviews and their impact DCSF Research Report June 2009
[24] NSPCC GCP2
[25] Signs of Safety

awareness of these programmes and initiatives or if they were provided to Colin, as prime carer, or the wider family as a part of parental support.

12.10 Assessments of fathers', including their parenting capacity, protective as well as risk factors, and their resultant needs, should be carried out as robustly as they are for mothers, and services can do more to have fathers within their focus when considering interventions and support.

12.11 With regard to the risk of SUDI and safe sleep advice, it is recognised that the partnership has already undertaken work to put in place the prevent and practice model for reducing the risk of SUDI, recommended by the Panel.[26] The partnership should note that all agencies reflected that a multi-agency system, process and response to this issue is welcomed. Focus should be given to ensuring that the recognition of unsafe sleeping arrangements, and risk of SUDI, are incorporated across multi-agency safeguarding procedures tools for responding to neglect, domestic violence (although not a feature in this case), children of alcohol and substance misusing parents and children at risk where a parent has a mental health problem. The partnership must further assure itself as to the effectiveness of its work to promote safer sleeping and reduce the risk of SUDI. This includes the learning and dissemination of reviews undertaken within the child death review process overseen by the Child Death Overview Panel (CDOP).[27]

12.12 With regard to the key themes of maternal substance misuse, neglect, safe sleeping, and SUDI risks, for many agencies, the use of effective supervision is a means of improving decision making, accountability, and supporting professional development among practitioners. Supervision is also an opportunity to question and explore an understanding of a case. Group supervision and peer reflective practice groups can be even more effective in promoting curiosity and safe uncertainty, as practitioners can use these spaces to think about their own judgments and observations, particularly regarding social deprivation, potential for poverty blindness, and cumulative neglect. It also allows multi-agency teams and disciplines to learn from one another's experiences, with the issues considered in one case relevant to others.

12.13 Karen's cannabis use was not considered a prominent safeguarding risk for some agencies in attendance at the reflective learning event. Whilst there is some empirical research on cannabis use in pregnancy, literature reviews have indicated that there is no known safe level of cannabis use during pregnancy and women should be counselled as to the risk of in utero exposure.[28] Changing cultural acceptance of cannabis, its tendency to be publicly viewed as a safe drug, and increased use of cannabis amongst pregnant women[29] may have lent itself to decreasing agency perception of risk. The Southwest Child Protection Procedures highlight drug misuse as a risk factor for unborn babies, and its use in pregnancy as an indicator of neglect.

13. CONCLUSIONS

13.1 The purpose of this review is to identify improvements to be made to safeguarding and promoting the welfare of children. Understanding whether there are systemic issues, and whether and how policy and practice needs to change, is critical to the system within the local area being dynamic and self-improving. It is not surprising to find that the learning from this review echoes, in many respects, the findings of national reviews and other reports that have considered safeguarding practice.

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[26] Child Safeguarding Practice Review Panel, (2020) *Out of Routine: A review of sudden unexpected death in infancy (SUDI) where the children are considered at risk of significant harm;* Figure 6.

[27] Working Together to Safeguard Children (2018) Chapter 5

[28] Badowski S, Smith G. Cannabis use during pregnancy and postpartum. *Can Fam Physician*. 2020;66(2):98-103.

[29] Gabrhelík R, Mahic M, Lund IO, et al. Cannabis Use during Pregnancy and Risk of Adverse Birth Outcomes: A Longitudinal Cohort Study. *Eur Addict Res*. 2021;27(2):131-141. doi:10.1159/000510821

13.2 Practitioners from agencies who have contributed to this review demonstrated their wish to offer the best possible service and protection for children. However, the intention of individual workers and agencies were not sufficient to counter some of the barriers which inhibited practitioners' ability to effectively safeguard Isla.

13.3 Whilst practice within children's social care is for child in need single assessments to include all children living within the household, the single assessment conducted in December 2019/January 2020 by the Children's Disability Team focused on Daniel's complex needs. It did not include Elizabeth or Susan or their needs and was not reviewed and updated when Karen's pregnancy with Isla first became known. The reviewer is aware that this matter has been addressed as immediate learning and qualitative audit activity was undertaken to provide reassurance. There was an absence of curious and inquisitive conversations with health clinicians and drug misuse professionals to understand the impact of the cannabis misuse with high levels of prescribed medication and whilst it was recognised that Karen was not to parent alone, there was no clear assessment of Colin's parenting capacity and his role within the family.

13.4 No agency sought a referral for or recommended a pre-birth assessment. This is despite the following known circumstances which can increase risk to an unborn child/new-born child:

- Karen's pregnancy with Isla was understood by all agencies to be high risk due to the prescribed medication, cannabis misuse and chronic health conditions.
- There was already a child within the family on a child in need plan
- Daniels' child in need plan required Colin to be always present to provide basic care to the children.
- Working Together 2018 contains the statutory description of neglect, which includes the statement that 'neglect may occur during pregnancy because of maternal substance misuse'.
- Karen's concerns that Daniel may unintentionally hurt the baby whilst she is asleep.

13.5 The findings of the rapid review regarding the impact of Covid-19 upon families, and what was in effect socially distanced child protection are repeated here. Covid-19 meant that the family were shielding, due to Karen's health conditions, for a considerable period, resulting in limited access by professionals for face-to-face visits. It is considered that the home conditions had declined since those visibly seen and noted by the social worker in February 2020. Improvements to, and sustained maintenance of home conditions were not adequately evaluated and addressed. Visiting for Daniel was 'RAG' rated green by the Children's Disability Team, meaning only virtual visits took place, with one doorstep visit on 24 June when the children were briefly seen. Health visiting and midwifery undertook home visits, but there does not appear to be a recognition of the condition of the home environment or sight of the family sleeping arrangements. Health professionals were unaware that children's social work was not visiting the house.

13.6 Practitioners can ask for physical and virtual tours around homes, to see fridges and cupboards, bedrooms and sleeping arrangements. With planning practitioners can be directive about which parts of the home they need to see physically or virtually, and which children. Engagement with children, via play, can be adapted to the online world, via short quizzes or games.

13.7 Lastly, there should have been a review of the Children's Disability Team green risk rating following notification of Karen's pregnancy and the birth of Isla, as well as when Karen and Colin expressed concerns to the school, social worker, and health practitioners that they were finding it difficult to cope, and the family presence for support had ended. The RAG rating process should have been co-joined between agencies and clearly communicated to all lead practitioners.

13.8 In summary, there are several shortcomings and much learning that has arisen in areas of both practice and strategy from this tragic incident. The learning points were reflected on at the learning workshop, and in the written submissions from agencies that formed part of this review. However, what is now clear is that deficiencies in several areas combined to inhibit positive safeguarding activity and outcomes, including:

- The ineffectiveness of holistic assessment and planning to fully understand the children's lived experience and potential risk to Isla as both unborn and new-born.
- No formal assessment of Colin's parenting capacity and his role within the family nor of availability and capacity for support from parents' wider familial network.
- A lack of a 'think family' approach and response when supporting families with a child or children with complex needs.
- A poor response to the factors that contribute to the effects of neglect be they cumulative or otherwise.
- Potential challenges with professionals' alertness to desensitisation when working in areas of high levels of deprivation and increased levels of need or at least an absence of curiosity in this regard.
- A lack of a multi-agency strategic approach and practice to risk of SUDI and provision and assuring the application of safe sleeping advice.
- A lack of awareness, understanding and application of the partnership's current neglect strategy.
- The absence of a coherent, clearly communicated multi-agency risk assessment strategy for home visits to safeguard children and promote their welfare during occasions of restrictive lockdowns in response to Covid-19.
- A perceived tacit acceptance of the use of cannabis in pregnancy and reticence to reinforcing the dangers of cannabis use pre and post birth, challenging parents with medical, evidence-based research where appropriate.
- A benign culture and practice for agency home visits which detracts from developing a shared understanding across agencies on the condition and appropriateness of individual rooms, wider neglect factors as well as sleeping arrangements for children.

14. LEARNING INTO PRACTICE CONSIDERATIONS

14.1 The Plymouth Safeguarding Children Partnership (PSCP) to be assured that its work is addressing the following identified core practice and strategic issues.

Drug misuse and parenting

a. The PSCP promotes collaborative assessment, information sharing and clear pathways between both systems and services to ensure families experiencing drug (or alcohol) problems receive holistic, child and whole family approaches.[30]

b. The consequences and risks associated with using cannabis during pregnancy and post birth are widely promulgated within the PSCP, challenging any potential complacency in practice due to common use of this drug.

Risks of SUDI and safe sleeping advice

[30] Public Health England *Guidance: Parents with alcohol and drug problems: adult treatment and children and family services* (May 2021): https://www.gov.uk/government/publications/parents-with-alcohol-and-drug-problems-support-resources/parents-with-alcohol-and-drug-problems-guidance-for-adult-treatment-and-children-and-family-services#system-and-service-level-requirements: Accessed 25 March 2022

c. The PSCP supports multi-agency practitioners with skills and tools to enable confident and courageous conversations with parents on difficult topics such as neglect, SUDI risk and safe sleeping.

d. The PSCP ensures that the findings and learnings of its current evaluation of the multi-agency strategic response to the risk of SUDI and provision of effective and embedded safe sleeping advice is fully considered in the context of the findings documented in this report.

Family and environmental factors of neglect

e. The PSCP ensures its multi-agency practice tools are well understood and used effectively so that they actively support practitioners to identify and respond to child neglect. Options such as the NSPCC Graded Care Profile 2 should be considered in this respect.

f. The PSCP embeds in practice demonstrable engagement of children and their understanding and experience of living with or at risk of being affected by neglect; thereby strengthening a think family approach to child safeguarding.

g. The PSCP explores ways of improving leadership and practitioner understanding of cumulative neglect, identification and impact of poverty, and possible desensitisation to the warning signs of neglect.

h. The PSCP supports its multi-agency work force to undertake both effective child centred virtual and physical visits to family homes using processes and guidance such as that provided by the Principal Children and Families' Social Worker Network.

i. The PSCP considers opportunities for practitioners to have informal multi-agency space to think reflectively on practice themes, such as neglect, fathers in safeguarding, and think family approaches.

Agency assessments, risk management and decision making

j. The PSCP identifies options to improve the quality of multi-agency assessments (including specialist) where children and unborn children are experiencing neglect or are at risk of neglect.

k. The PSCP works collaboratively with other partnerships to address the recommendations of the CSPR Panel Report "The Myth of Invisible Men." The reviewer acknowledges that the premise of the report considers safeguarding children under 1 from non-accidental injury caused by male carers, but its recommendations on service design apply equally to the context of this case and the findings of this review.[31]

l. The PSCP seeks assurance on the RAG Rating system of all statutory agencies, to ensure that they are effective and provide an appropriate, timely and joined up response to changing safeguarding needs and risks experienced by families. The outcomes from this process should be widely communicated across the partnership organisations.

15. ACKNOWLEDGEMENT

15.1 The sudden and unexpected death of an infant is one of the most devastating tragedies that could happen to any family. It is also recognised that the impact of a child death, and resultant inquires, on safeguarding professionals can have a negative psychological and emotional impacts. The independent review author would like to take this opportunity to express his thanks to the Plymouth Safeguarding Children Partnership, safeguarding professionals and practitioners in supporting this local learning review. He would particularly like to put on record his appreciation for the contributions of Karen and

[31] The Child Safeguarding Practice Review Panel. (September 2021) "*The Myth of Invisible Men", Ch*18, pp57-59

Colin who made this review ‘real’ by the compelling way they shared their lived experiences and that of Isla’s profound legacy.