Surrey Safeguarding Children Board

Report of the Serious Case Review regarding Child A:Executive Summary

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Initiation of the Serious Case Review

This case was initiated by Surrey Safeguarding Children Board (SSCB) as a result of the death of Child A who died in April 2017 aged 4 weeks, the Coroner concluded death was due to SUDI[1] associated with co-sleeping. The Police, having conducted their enquiries passed their file to the Crown Prosecution Service who refused a charge due to lack of evidence of suffocation.

The Children

There were three children in this family unit. Child A, the primary subject of this review, was a very young baby at the time of death and as a result there was limited information held by professionals. Child A's pregnancy was unplanned. Mother attended ante-natal appointments and there were no concerns regarding Child A during the pregnancy.

Child A was born by caesarean section at full term, weighing 2810 grams which was within the normal range. There were no concerns regarding Child A whilst in hospital. Child A and Mother were discharged at 3 days in line with usual practice. The relationship between Mother and Father 1 ended within days of Child A's birth meaning Mother was a single parent to all three children. The only concern raised by Mother and professionals, related to Child A's weight gain and feeding.

Child A's 2 older siblings had experienced domestic abuse in infancy via their father. There was no Children's Services (CS) involvement at the time of Child A's death. Both sibling's attendance at school was good. Sibling 1 was described as academically bright and Sibling 2 of average ability. Sibling 2 was described as a "very happy child". Their teacher described both children as "lovely."

In 2015 Mother was concerned about Sibling 1's behaviour and sought assessments for ADHD; Sibling 1 was diagnosed with ADHD in December 2015. Mother reported Sibling 2 was a "nightmare" to get to bed, who struggled to shut off at bedtime. Mother sought an assessment for ADHD, however Sibling 2 did not meet the criteria for assessment. Father 2 was absent from the children's lives.

Siblings 1 & 2 and Mother were reportedly well supported by Mother's parents both emotionally and financially.

[1] Sudden unexpected death in infancy, or **SUDI**, is a broad term that covers both sudden infant death syndrome, or SIDS, and fatal sleeping accidents. Most **SUDI** deaths occur in a sleeping environment.

Summary of the Case

The period covered by this serious case review covers 24 months from May 2015 until the death of Child A. At the beginning of the review period school had concerns regarding Mother's alcohol use impacting particularly on Sibling 1, and referred the case to Children's Services (CS). A Child and Adolescent Mental Health Service (CAMHS) assessment recognised that Sibling 1 was finding it difficult to cope emotionally and contain frustration, anger and anxiety. Siblings 1 and 2 had experienced estrangement from their father, domestic abuse and were further impacted by Mothers work patterns meaning their care was shared between Mother and Maternal grandparents, across two separate households. CAMHS reported Mother was finding it difficult to cope at times as a single parent. Strategies were recommended to school and a recommendation made that Mother attend a formal parenting class. A child and family assessment was conducted by CS; Mother indicated she was no longer drinking. The need for support around Sibling 1's behaviours lead to the case entering Child in Need (CIN).

The agreed actions from the CIN meeting centred on Sibling 1's behaviours; there were no specific actions to address Mother's alcohol or parenting issues. Sibling 1 continued to have behavioural issues. A decision was made to transfer the case from CS to the Extended Hours Service (EHS) as the more appropriate service to address the breakdown in relationship between Sibling 1 and Mother. One worker from EHS was to work with Mother and the Grandparents and another was to work with Sibling 1 to build / strengthen the relationship with Mother and work on Sibling 1's sense of self-worth and self-esteem. Sibling 2 did not feature in plans.

Behaviour Support intervention commenced. Progress around actions was noted however, there was no direct work taking place between the EHS worker for Mother and the Maternal Grandparents. Sibling 1's behaviour continued to be of concern.

At the end of December Sibling 1 was diagnosed with a severe degree of ADHD and placed on medication. At a CIN/ re-integration meeting held early in the new term (January) Mother indicated she was now eligible for ongoing support through an ADHD nurse and was aware of support groups for parents. The family reported they were seeking behaviour therapy privately.

In March the last and final CIN meeting took place. Mother gave a positive outlook in relation to Sibling 1 and the significant improvements that had been made. EHS ended their involvement with the family. School stated that they would start to incorporate ELSA[2] support (a new service) for Sibling 1 to receive support for the emotional and learning

[2] ELSA - An educational psychology led intervention for promoting the emotional wellbeing of children and young people.

aspects of Sibling 1's time spent at the school. It was reported by the school that there was no further report of Sibling 1 wandering around the school and that Sibling 1 was far less disruptive in classroom settings; recent incidents were not shared within the meeting. Within weeks of CIN closure, Mother took Sibling 2 to the GP requesting an assessment for ADHD. A SNAP[3] assessment was arranged.

In April 2016 Sibling 1 disclosed to school staff a row with Mother the previous night. Mother had left Sibling 1 home alone whilst she went to see a friend with Sibling 2. Sibling 1 had begun to worry how long Mother would be. At 9.45pm Mother still wasn't home so Sibling 1 climbed out of the window and went to Mother's friend's house. Sibling 1 and Mother argued and Mother slapped Sibling 1 round the face. Mother pushed Sibling 1 against a wall banging Sibling 1's head. Sibling 1 indicated Mother had drunk a whole bottle of wine. School did not make a referral to CS.

In July Sibling 1 again arrived at school very upset. Sibling 1 disclosed a row with Mother the night before; Mother had said she would send Sibling 1 to live with Father 2 and get a dog instead. Sibling 1 shared his worries; Sibling 1 hadn't seen Father 2 for 4 years, Father 2 used to lock Mother in the kitchen, Father 2 had nearly killed Sibling 1 when Sibling 1 was younger and hadn't fed Sibling 1 on court order day visits. School rang Mother to discuss and she spoke to Sibling 1 who was reassured by her. School did not make a referral to CS.
In August Mother attended a maternity booking appointment, she was 10 weeks pregnant. Routine questions were asked around CS involvement, Domestic abuse and substance misuse. No disclosures were made. Mother reported consumption of alcohol pre pregnancy as 4 units per week and current units as 0. Mother attended all appointments and ultrasound scans throughout the pregnancy occasionally accompanied by Father 1.
In September Sibling 1 attacked Sibling 2 on the school playground; Sibling 1 was very violent and aggressive towards Sibling 2. Sibling 2 gave no response and put up no defence. Staff were shaken by the incident but Sibling 2 indicated all was fine.

In November Mother attended an appointment with the GP to discuss Sibling 2 as she remained concerned that Sibling 2 had ADHD, a school questionnaire did not reveal anything abnormal. Mother was requesting a paediatric referral as CAMHS had not been helpful in diagnosing Sibling 2. GP records indicate Paediatrics triaged the referral to CAMHS who felt Sibling 2 did not meet criteria for ADHD. Self-support advice was given to the family and the case closed.

In March 2017 Child A was born by planned caesarean section. Mother and Child A remained in hospital for 3 days. Following Child A's birth both community midwives and the HV carried out routine visits in line with normal practice. The only concern noted was Child

[3] SNAP – Special Needs Assessment Profile

A's faltering growth. Child A's weight was monitored by midwifery services and the feeding and well-baby clinic. When satisfactory weight gain was not achieved, Child A was reviewed twice by the GP and twice by Paediatricians on the request of midwifery, in twenty days. The HV carried out a new birth home visit seeing Mother and Child A. Mother became tearful when talking about the relationship with Child A's father. Mother indicated Father 1 had not been supportive through the pregnancy and had left the family home the week before so Mother was coping with 3 children on her own. Mother reported she could cope as she had good support from her family. Mother was given appropriate feeding information and advice. Health promotion advice was given including risk of cot death-safe sleeping positions.

When Child A was two weeks old Sibling 2 disclosed to school staff worries about how she would sleep during the forthcoming Year 5 residential. Sibling 2 disclosed struggling with sleep and reported Mother had given her some of Sibling 1's sleeping tablets to help. Staff told Sibling 2 not to worry as they would be so busy that sleep would not be a problem. School did not make a referral to CS.

Child A was reviewed regarding weight gain by the Paediatrician. Two days later, Child A was found unresponsive by Mother and an ambulance called. CPR was commenced however was unsuccessful. Ambulance staff reported a Sudden Unexpected Death in Infancy to the Police. Mother indicated she had been drinking alcohol at lunchtime and then again in the evening with a friend; totalling approximately two whole bottles of wine.
Mother stated that her children did not have any contact with Child A after Child A was put into the crib that night however Sibling 1 gave an account of attending to Child A twice as Sibling 1 was unable to wake Mother, feeding Child A from a bottle on the first occasion and placing Child A on Mother's chest to feed on the second.

Summary of findings/learning

The tragic death of Child A, the subject of this review, was unexpected and could not have been predicted by the professionals who had been working with the family. There is no certainty that any of the findings below would have made any difference to the tragic outcome in this case. At the time of the death there was no CS involvement.

Finding 1: Within the school there was lack of clarity about what constituted a safeguarding concern. This coupled with over optimism and a lack of support and supervision for staff, lead to lack of challenge of professional's thinking. Ultimately this led to an inconsistent approach to making referrals, resulting in some safeguarding concerns not being referred. Learning: The school was not sufficiently skilled or supported to fulfil their safeguarding responsibilities.

Finding 2: CAMHS decision to cease their involvement with Sibling 1 whilst a Child and Family assessment was in progress was flawed. Attendance at and contribution to the CIN plan prior to closure was essential to ensure their recommendations were taken forward by appropriate services. When Sibling 2 was referred, CAMHS did not fully link Siblings 1 & 2's shared experiences of trauma and behavioural issues or consider referral to CS.
Learning: The importance of thinking about the children within the context of their family and what is known is crucial. Services should be mindful of repeat patterns of behaviour within families.

Finding 3: Mother's view of the cause of Sibling 1's behaviours appears to have been given more credence than the findings of the Child and Family Assessment. The lack of inclusion of fathers within assessments is reducing professionals understanding of the issues within families and the family's functioning. The allocated worker was deflected from exploring Mothers alcohol use and parenting having accepted that a diagnosis of ADHD was responsible for all Sibling 1's behaviours and didn't consider the impact of Mother.
Learning: Both parents/members of a child's household need to be consulted as part of assessments in order to gain a more holistic understanding of the family. Whilst parents are to be listened to and supported it is essential professionals across all agencies confidently and competently exercise a strategy of "high support; high challenge" when engaging with adults. Professionals must be respectfully uncertain in their interactions, and recognise when deflection may be creating risk for a child, and ensure the adult does not obscure a rigorous focus on the identified issues.

Finding 4: The lack of recognition that the children were at risk of harm coupled with a misinterpretation of information sharing guidance, meant professionals did not consistently share information when there were indicators of abuse.
Learning: This case brings into sharp focus the importance of both recognising indicators of abuse and understanding when to share information. Whilst it is clear the concerns did not meet the criteria for s47 there was a risk to the children. Whilst parents can choose not to consent, professionals need to understand when they can override parental consent otherwise children will not be adequately protected.

Finding 5: Resource issues in the form of an over stretched CS CIN service, and a lack of school nurses, and process issues in the form of, IT system issues, notification of children on CIN plans, and sharing of minutes for children experiencing domestic abuse, coupled with a lack of professional curiosity meant the multi-agency approach to safeguarding children who were not deemed as "needing protection" was not robust.

Learning: Children and their families who needed “Early Help”, were not receiving the right help early enough. This resulted in the statutory system becoming overwhelmed. CSC have embarked on a programme of transformation named ‘Family Resilience’ which clearly articulates the levels of need. This was signed off by SSCB in November 2018.

Finding 6: Aspects of the family and its functioning impacted on professional practice. The adults within the family presented a ‘forceful’ and ‘united front’ which deflected professionals from fully addressing the impact of Mother’s behaviours on the children and considering the potential risks to the children.
Learning: Working with articulate and confident families presents challenges akin to those posed by violent families; it can make professional wary and tentative in their interactions with family members. The importance of reflective supervision and managerial oversight when working with families is crucial to maintaining focus on the child.

Finding 7: Whilst it is clear who prescribed Sibling 1’s medication and what is less clear is the robustness of dosage monitoring. In addition, there is no evidence available to the Lead Reviewer to indicate medication safety was discussed.
Learning: Private prescribing is becoming increasingly common with families seeking private care for their children. Incidental learning within this review has uncovered current guidance does not cover the scenario in this case.

Finding 8: Sibling 1 was viewed as a young carer by school when Mothers emotional needs placed Sibling 1 in that position. Sibling 1’s carer role should have featured within the CIN plan and stopped if Mother’s behaviours had been addressed.
Learning: When a child takes on a caring role professionals need to question whether this is as a result of parent’s lifestyle choices. If so steps to address the root cause must be taken as part of a safeguarding plan.

Finding 9: No professional involved in the care of Child A could have prevented Child A’s death had they acted differently. Mother was given appropriate advice regarding co-sleeping. Co-sleeping was specifically discussed with Mother on a number of separate occasions, including at the new birth visit.

Finding 10: Sibling 1 and 2’s voices were lost when professional attention was deflected onto Sibling 1’s behaviours.

Learning: Maintaining focus on the child features as an issue in many serious case reviews. When working with parents and carers professionals need to keep in mind what the child is saying. When there is disparity between parent’s views and those of their children, or

deflection, professionals must maintain focus on the child. Plans must include all issues raised by children and should not be considered complete until interventions have been completed. Managers overseeing plans must ensure actions are completed before cases are closed

Recommendations

1. SSCB should review the training and supervision provided to schools, to ensure school staff have knowledge of the indicators of abuse and have the competencies and confidence to act to safeguard children through support and supervision. An audit of Education referrals and associated school records will provide the SSCB with an understanding of whether full and contemporaneous referrals and records are being made and whether the issues in this case are isolated to this school or reflective of all schools across the locality.
2. No service, which has been made aware of CS involvement, to discharge a child from their care whilst a Child and Family assessment is in progress without providing a written report of their involvement and recommendations for on-going work.
3. The SSCB to seek assurance from CS that there is now robust managerial oversight, that ensures fathers and household members have been consulted, and all identified issues have been addressed prior to closure of cases being managed within CIN.
4. SSCB to ensure all safeguarding and information sharing training and guidance includes a clear directive that, when parents/carers do not give permission to share information, further consideration is given as to whether the child is at risk of harm, before a decision not to share information is made.
5. The LSCB to ensure that all agencies, have robust plans and are taking action to address the resource and process issues identified in this case. SSCB to request quarterly reports from all agencies to oversee progress with a focus on outcomes for children and young people.
6. SSCB to seek assurance from children's services that all actions on CIN plans incorporate all of the children's expressed concerns and have been completed prior to case closure.

What will the LSCB do in response to this?

Surrey SCB has prepared their own document which describes the actions that are planned to strengthen practice in response to the findings and recommendations of this serious case review.