CONFIDENTIAL

Surrey Safeguarding Children Partnership

Child Safeguarding Practice Review

Child "ROWAN"

Lead Reviewer

Moira Murray

March 2023

TABLE OF CONTENTS

1. Introduction: Background Information to the Review 3
2. Terms of Reference, Methodology and Scope 4
3. Key lines of enquiry 4
4. Involvement of family members in the review 5
5. Background History: including information outside the time period for the review 6
6. Rowan's lived experience in the family environment 10
7. Key Lines of Enquiry 13
7.1 What was the quality of assessments of Mother and Father as children who were in need of help and protection? 13
7.2 What was the quality of support for Rowan's mother and father as young parents? Did their needs and vulnerabilities overshadow professionals understanding of his needs as a child in need of protection? 16
7.3 How was Father's capacity as a young father assessed and supported? 19
7.4 How well was the parenting capacity of both these parents and their wider families understood, assessed and supported? 21
7.5 How effective was the multi-agency work in providing and reinforcing safer sleeping advice? 23
8 Findings and Lessons Learned 25
8.1 The importance of parenting assessments, including pre-birth assessments 25
8.2 Recognising that the parents were themselves children 26
8.3 Support to young parents 27
8.4 Child Protection Planning 28
8.5 Professional Advice on Safe Sleeping 28
8.6 Risk-factors identified in the *Out of Routine* Report and presenting Issues in this case 28
9. Good Practice 29
10. Conclusions 29
11. Recommendations 30
Appendix 1 32
Terms of Reference 32

1. Introduction: Background Information to the Review

1.1 Rowan was found unresponsive by his mother at home in his cot in a morning in Spring 2022. He was four months old. Mother said that on the previous evening she had fed Rowan and placed him on his back in his cot, although he preferred to sleep on his front. Mother reported that this was the first occasion that Rowan had been put in his cot at night to sleep, as they usually co-slept. Fearing that Rowan might wake up, Mother remained awake until 00:30 and then fell asleep. On waking the next morning, Mother was concerned that Rowan had not woken for his feed and found him unresponsive, lying face down in his cot.

1.2 An ambulance was called, and CPR was administered until Paramedics arrived. Sadly, the Advanced Paramedic who attended the home, determined that there was no chance of Rowan being successfully resuscitated. Mother accompanied Rowan to hospital where he was pronounced deceased.

1.3 At the time of his death, Rowan was subject to a Child Protection Plan, under the category of Physical Abuse. This was because of the contextual safeguarding risks associated with his father, which resulted in threats being made to Mother and her family. Surrey County Council initiated Care Proceedings in respect of Rowan, with an Interim Supervision Order being sought. Because of the young age of the parents, the Public Law Outline was determined not appropriate and in accordance with case law guidance, it was proposed that the matter be dealt with by a High Court Judge.

1.4 Both parents were children themselves at the time of Rowan's birth. Mother was 13 and Father was 14 years old. Mother had been subject to a Child Protection Plan prior to Rowan's birth. Father lived outside Surrey and there were concerns about physical abuse in the home as well as his association with youth violence. Because of these concerns, both Father and his sibling were subject to Child Protection plans at the time Rowan was born. Statutory agencies in the local authority where Father and Paternal Grandmother lived considered them to be at risk of harm.

1.5 At the time of death, Rowan and Mother were living in the home of Maternal Grandmother, together with three of Mother's five siblings. Mother's family had been known to Surrey statutory agencies since 2014 due to concerns about domestic abuse, Maternal Grandmother's aggressive behaviour towards her children, and the violent behaviours of Mother's older siblings.

1.6 A post-mortem found that Rowan died as a result of Sudden Unexpected Infant Death Syndrome (SUDIS).

1.7 Given the involvement of agencies with both families, consideration was given by Surrey Safeguarding Children Partnership (SSCP) as to whether the case met the

criteria for a Child Safeguarding Practice Review under Working Together to Safeguard Children, 2018. It was decided at a Rapid Review meeting on 13 May 2022 that the case met the criteria for a Local Child Safeguarding Practice Review, which was commissioned on 1 August 2022.

2. Terms of Reference, Methodology and Scope

2.1 Full details of the terms of reference and methodology for the review can be found in Appendix 1, as can details of the agencies involved, and the Lead Reviewer.

2.2 An online, multi-disciplinary Reflective Learning Workshop for practitioners was held in January 2023. Thirty two professionals attended the event, representing all of the agencies involved with the families. Discussion and reflection of the practice issues arising from the review proved extremely helpful to the Lead Reviewer and are reflected in this report. The Lead Reviewer would like to thank all those who attended the event and to the Surrey Safeguarding Partnership Team for organising and contributing to its success.

2.3 **The time period for the review is from January 2021,** when Mother came to the attention of services following a domestic abuse incident perpetrated against Maternal Grandmother by Maternal Grandfather and her older sibling, until **the date of** Rowan's death. Additional information relevant to the review, but outside the time period has been included in this report.

3. Key lines of enquiry

3.1 What was the quality of assessments of the parents as vulnerable children who were in need of help and protection?

3.1.1 What was the quality of the pre-birth assessment: assessment is a live and on-going process; each assessment should reflect the specific characteristics of each child within their family and community context; this includes drawing upon relevant family history and family functioning; as well as the risk factors for Sudden and Unexpected Death in Infancy identified in the Child Safeguarding Practice Review Panel's Out Of Routine report published in 2020.

3.1.2 Did assessments focus sufficiently on the needs of Rowan as a child who needed to be safeguarded.

3.2 What was the quality of support for Rowan's mother and father as young parents?

3.2.1 The Rapid Review noted that when parents have a range of vulnerabilities, these must be addressed, whilst maintaining focus on the child. In this case, did the needs and vulnerabilities of Rowan's very young parents overshadow professionals' understanding of his needs as a child in need of protection?

3.2.2 How was Father's capacity as a young father assessed and supported? The role of fathers: Father was the focus of significant concern; however, it is less clear regarding the work that was done to support him as a parent, including joint work with both sides of Rowan's family. This should be considered against the findings and recommendations of the Child Safeguarding Practice Review Panel's report, *the Myth of Invisible Men*, published in September 2021.

3.2.3 How well was the parenting capacity of both these parents and their wider families understood, assessed and supported? The risk to Mother and Father were known, however, there needed to be a greater focus on how these risks impacted on their ability to act as consistently good enough parents for Rowan. Related to this was the need for a clear assessment of the impact of the vulnerabilities of the Maternal and Paternal Grandparents for Rowan.

3.3. How effective was the multi-agency work in providing and reinforcing safer sleeping advice?

3.3.1 As identified in the Surrey SUDI thematic review and the Child Safeguarding Practice Review Panel's *Out of Routine* report, this case highlights the need for all agencies to play a role in communicating safer sleep advice and safe sleep assessment to form part of all child and family assessments.

4 Involvement of family members in the review

4.1 Both Mother and Father were invited to contribute to the review, but this has not proved possible. Paternal Grandmother was also invited to meet with the Lead Reviewer, and although initially indicating that she would like to do so, a meeting did not materialise.

4.2 The Lead Reviewer and a Nurse from the Child Death Overview Panel met with the Maternal Grandparents at their home in January 2023. The Lead Reviewer would like to thank the Maternal Grandparents for agreeing to meet with us to discuss the tragic death of their grandson and to express their views on their experience of agency involvement during the time period of the review. Their views have informed the review and are referenced in this report.

5 Background History: including information outside the time period for the review

5.1 Rowan was of White and Black British heritage, and lived with Mother, Maternal Grandmother and Mother's siblings. At the time of his death, Father and Paternal Grandmother were not in contact with Rowan following an argument in early January 2022, which had resulted in Father allegedly pushing Mother whilst she was holding Rowan.

5.2 Mother's family had been known to Surrey Children's Services since March 2014, with input from Early Help and Social Care. Following an incident of domestic abuse between Maternal Grandparents in January 2021, a child protection investigation was initiated. During the three months between January and March 2021, Mother was thrown out of the family home on several occasions by Maternal Grandmother and was sent to stay with her paternal grandparents. Such action on the part of Maternal Grandmother was to be repeated during the time Mother was pregnant and was said by her older siblings to be a pattern of behaviour exhibited by Maternal Grandmother, which they had also experienced. At this time, Mother was 12 years old, and her parents knew that she was involved in a relationship with a boy (Father) from another area, although they said they were not aware that the relationship was sexual.

5.3 Since September 2020, Mother had been permanently excluded from mainstream school, following a physical assault on another pupil and a member of teaching staff, and had been attending a Short Stay School. The Short Stay School provided education to those children who were unable to attend a mainstream school because they had been permanently excluded or were experiencing emotional or behavioural difficulties. This was not a permanent placement and Mother was expected to return to mainstream education. During the period of national lockdown because of the Covid Pandemic, Mother would have had a place available at the Short Stay School.

5.4 During the time period of the review, five Child and Family Assessments were undertaken concerning Mother and her siblings. Safeguarding concerns about the younger children being subject to physical violence, domestic abuse, Maternal Grandmother's mental health, the impact of the Maternal Grandparents separation and Mother being 'beyond parental control' emerged during the assessments. In addition, it became known that Mother, aged 12, was sexually active, when she consulted the GP Surgery as to whether she might be pregnant in mid-March 2021. During the consultation, which she attended alone, Mother disclosed that she had been involved with a 13 year old boy for eight months. The GP provided sexual health and contraception advice, and as it was too early to ascertain whether Mother was pregnant, advised a pregnancy test should be done in one week's time. The GP made a safeguarding referral to Children's Services, and informed Maternal Grandmother of the situation.

5.5 As a result, a strategy discussion was convened to consider Mother's ability to consent to sexual activity and to investigate whether sexual offences were being committed by Father. A Police investigation was undertaken, and a decision made that given the nature of the relationship and the closeness in age, a criminal prosecution was unlikely to succeed. Mother was placed on a Child in Need plan at the end of March 2021. It is noted that Child in Need Plans are not routinely shared with GP Practices, although a policy was in place at the time, which stated that they should be made aware. Thus, the GP did not know of this decision or the background information leading to it. This issue is discussed in the Findings and Lessons Learned section of this report at para 8.4.2.

5.6 In April 2021, a Strategy Discussion was held in relation to Father, after his arrest for possession of a firearm. Father had been out of school for over 18 months. Father and his sibling were both subject to Child Protection Plans under the category of physical abuse. This was as a result of an escalation of arguments between Paternal Grandmother and Father over the Christmas period in 2020, leading to Paternal Grandmother physically assaulting Father, for which she was arrested. It was also the case that Father was at risk because of his involvement in Gang and County Lines activity and being at risk of Child Criminal Exploitation (CCE).

5.7 In May 2021, Mother was placed on a Child Protection Plan under the category of Neglect, until January 2022. In June 2021, Maternal Grandmother informed Children's Services that Mother was pregnant, and had booked an appointment for a termination of pregnancy. Information provided to the review states it was Maternal Grandmother who wished for Mother to have a termination, but that Mother was unsure. There was uncertainty as to when Mother may have become pregnant, but confirmation of the pregnancy was passed to a Social Worker who at the time was covering the case on behalf of the allocated Social Worker.

5.8 A Strategy Discussion held in mid-June 2021, shared information that Mother was visiting and staying with Father, who because of threats of violence had been moved out of area with Paternal Grandmother and his family. It was agreed that the threshold was met for a single Section 47 child protection investigation to be commenced in respect of Mother.

5.9 By the beginning of July 2021, Mother confirmed that she had decided to keep the baby, and the first antenatal appointment was booked at the hospital. Mother was under the care of *Willows*[1], a specialist midwifery team working with young mothers. Maternal Grandmother attended the appointment and stated she would be supportive. This was despite her initial reaction to the news, which according to Mother was that she would not support her as she had children of her own. (Source: Combined Chronology Education entry).

[1] Willows has now been disbanded

5.10 The Midwifery Team was aware that Mother was on a Child Protection plan and made a safeguarding referral to Children's Services. A referral was also made by the Health Visiting Service to the Family Nurse Partnership (FNP). It was not until early September 2021 that a first visit was successfully made by the Family Nurse to Mother, who welcomed FNP engagement.

5.11 Following confirmation of the pregnancy, Mother's allocated Social Worker was commissioned to undertake a Pre-birth Assessment. At the time, the current Surrey Pre-birth Assessment Policy was not in place, which states that such an assessment should be undertaken by a Social Worker from the Family Safeguarding Team (FST).

5.12 When the Pre-birth Assessment had been completed (the assessment was allocated to the Social Worker for the family on 20 July 2021 and information was still being collated on 8 December 2021. Source: Combined Chronology) it was planned that the case would progress to a Strategy Discussion and with an Initial Child Protection Conference convened concerning the unborn baby. During her pregnancy, in accordance with Child Protection Procedures, Mother was visited regularly by her Social Worker. The home situation was considered to be stable with Maternal Grandmother offering support with fewer arguments taking place between the Maternal Grandparents. It would appear that Maternal Grandfather was still a member of the household, at this time, although following arguments with Maternal Grandmother, he was often requested to leave. Mother continued to be on roll at the Short Stay School during her pregnancy, with a place being held for her at a mainstream school after the baby was born.

5.13 In early August 2021, Mother and her family moved to different accommodation believed to be because of risks presented by gang members associated with Father. Later that month following management oversight by the Independent Reviewing Officer (IRO) the pre-birth assessment was reallocated to a Social Worker in the FST, with a recommendation that a Strategy Discussion be convened within 48 hours. A Strategy Discussion took place in early September 2021, with a recommendation for an ICPC in respect of the unborn baby.

5.14 During September Father was threatened with violent assault from gang members and went missing for 2 days. This caused the ICPC in relation to the unborn baby to be postponed due to Mother's anxiety for Father's welfare. On his return, Father had sustained an injury to his hand and he and his family continued to receive threats of violence. At the beginning of October 2021, a Strategy Discussion was convened. Father remained allocated to the Adolescent Team in Children's Services, but was open to the Child Criminal Exploitation Police Team as a consequence of the risks posed to him by his involvement in youth violence. Father continued to be associated with gang culture, and he and his family were once again moved to a safe place.

5.15 In October 2021, unborn Rowan was made subject to Child Protection Plan, under the category of Physical Abuse. This was on the basis of Father's continued association with criminal gang activity and the risk posed to Mother, her family and the unborn baby. The plan was for Maternal Grandmother to supervise any contact between Mother and Father. Mother's school attendance at this time continued to be 100%, she was attending antenatal appointments with the support of Maternal Grandmother and was engaging with the FNP.

5.16 In mid-November Father was arrested for suspicion of knife point robbery, which was to result in no further action. In early December 2021, Father, Paternal Grandmother and other members of the family moved to permanent accommodation, out of area, which was funded by Children's Services.

5.17 The review has been informed that information was still being gathered in December 2021 for a Pre-birth Assessment. Rowan was born in December 2021. Maternal Grandmother was in attendance at the birth. Rowan remained in hospital for a further period because of jaundice. Whilst in hospital Mother had tested positive for Covid. On his discharge, both Mother and Rowan resided with Maternal Grandmother, and were under the care of Community Midwives and the FNP. Health and Children's Services professionals continued to visit the family home at this time, and throughout the Pandemic. As part of the discharge plan, support was offered by Maternal Grandmother. The Maternal Grandparents home was considered appropriate for the needs of Rowan and Mother.

5.18 Mother's care of Rowan was considered to be good. He was gaining weight and Mother kept appointments with the FNP. Safer sleeping information was reiterated by the Community Midwife and the Family Nurse, but it is known that Mother co-slept with Rowan. On the advice of the midwife, Mother and Maternal Grandmother attended hospital A&E in late December 2021 with concerns about a lump on Rowan's head. This proved to have resulted from his forceps delivery, and the injury had not been noted on his discharge notes to the Community Midwives.

5.19 It is not clear to the review as to how much contact Father had with Rowan, following his birth. When we met with the Maternal Grandparents, we were told that Father was at the hospital when Mother was in labour but once she was diagnosed with Covid he was required to leave. Father did have some limited contact with his son when Mother and baby returned home from hospital. It is known that in early January 2022 there was an incident involving both parents with an alleged physical assault by Father towards Mother whilst she was holding Rowan. Police and Children's Services were informed, resulting in a Strategy Discussion and Section 47 investigation. Paternal Grandmother made allegations that Maternal Grandmother smoked cannabis and drank alcohol, which she claimed Maternal Grandmother gave to Mother and Father. These allegations were denied by Maternal Grandmother, and following an investigation by Children's Services, no evidence could be found to substantiate such allegations. Following this incident, Children's Services attempted to facilitate contact

between Father and Rowan, but it appears from this point onwards contact ceased.

5.20 Mother was no longer subject to a Child Protection Plan, as at a Review Child Protection Conference in December 2021 a unanimous decision was made by professionals that the case should be stepped down to one of Child in Need. In early February 2022, a Legal Gateway Meeting was held in respect of Rowan, and a second meeting took place later that month. In mid-February, Maternal Grandmother informed Children's Services that she no longer wished to be responsible for Mother and Rowan's care and suggested that Maternal Grandfather should take responsibility, which he refused to do. Children's Services agreed to find a foster placement for Mother and Rowan. However, when Mother said she wished to live with Maternal Grandfather, arrangements were put in place to assess the feasibility of this proposal. By the end of February 2022, it was evident that such an arrangement would not work, and when Maternal Grandmother said that Mother and Rowan could remain in the family home, an agreement was put in place between Mother, Maternal Grandmother and Children's Services as to the expectations for the care provided to Rowan. It was made clear that if the agreement was not adhered to, Rowan would be removed.

5.21 During March and early April, arrangements were being made for Mother to return to fulltime education. Rowan was thriving and considered to be making good progress. Efforts were being made to arrange supervised contact between Father and Rowan, although concerns continued about his gang association and issues had been raised as to whether he was a victim of modern slavery. The Maternal Grandparents agreed to attend relationship counselling and attempts were made to reduce their significant rent arrears.

5.22 In April 2022, Surrey County Council delivered letters to both parents of their intention to issue to Care Proceedings in respect of Rowan. An application was listed for a hearing in April, but sadly, Rowan died before the hearing.

6 Rowan's lived experience in the family environment

6.1 Rowan was a baby born to parents who were themselves children, both of whom experienced emotional trauma and had witnessed and suffered physical violence. In the case of Father, it was evident that his involvement with gang related violence and criminality resulted in risk of serious harm to himself, Mother, Rowan and extended family members. This in turn meant that attachment to his son could not develop due to the severe restrictions in place concerning Father's contact with Rowan, because of the risk posed by his behaviour.

6.2 Mother came from a home where there was marital discord, domestic abuse, and physical harm and neglect. She was on occasions told to leave by Maternal Grandmother. Because of aggressive outbursts at her mainstream school, Mother was permanently excluded, but it is to her credit and that of the staff at the Short

Stay School that she began to fully engage in education, achieving 100% attendance prior to Rowan's birth.

6.3 Mother became sexually active from a very young age, and it is evident that she and Father were involved in a sexual relationship when she was 12 and he was 13 years old. According to his expected date of delivery, Rowan was born 4 weeks prematurely, however, there is some uncertainty as to the date of his conception. Although Maternal Grandmother appeared to try and influence Mother's decision as to whether she should continue with the pregnancy, Mother decided that she would.

6.4 During her pregnancy, Mother regularly attended antenatal appointments and once engagement with the FNP was established, a good relationship developed with the Family Nurse. Rowan's birth weight was 3080g (6lbs 12 oz) and he continued to gain weight appropriately. Although Rowan had not been vaccinated during his short life, Mother's care of him was assessed as being appropriate and she was seen to be a caring and loving mother. Her concern for Rowan's wellbeing was demonstrated by her pointing out the lump on his head to the Community Midwife, which was found to be caused by his forceps delivery. Mother and maternal Grandmother acted immediately on the Midwife's advice and took Rowan to A&E.

6.5 Rowan was a wanted and loved child, whose care professionals considered good. His lived experience, however, was that of a child born to extremely young parents, who were dependent on the support offered by Maternal Grandmother who was caring for her other children, whose mental health was volatile, and who consistently used cannabis to 'self-medicate' her mood. In addition, the added pressures and risks to both families brought about by Father's involvement in youth violence meant there was a lack of stability in the home environment in which Rowan was living.

6.6 When the Lead Reviewer met with the Maternal Grandparents they were able to provide some insight into Rowan's lived experience. He was described as a beautiful, smiley baby, who fed and slept well. He was much loved by Mother and all the family. He was described as a 'strong baby' who could 'roll over.' He did co-sleep with Mother, but Maternal Grandmother said that this began because there were problems with the heating at their previous address where Rowan lived when he was first brought home from hospital.

6.7 Maternal Grandmother described how under the terms of the Child Protection Plan she was required to support and supervise her daughter's care of Rowan. According to both Maternal Grandparents, in essence this meant that Mother and Rowan could not leave the family home unaccompanied because of concerns about the threat presented by Father's involvement with gang related violence. The Maternal Grandparents also alleged that Father was threatening Mother, and that the family was in fear of him and his associates. Their relationship with Paternal Grandmother was described as difficult, and according to Maternal

Grandmother, Paternal Grandmother had only limited contact with her grandson and had never held him. Following Father's alleged aggressive behaviour towards Mother in January 2022 whilst she was holding Rowan, he had not been allowed to have unsupervised contact with his son.

6.8 When asked about their experience of agency involvement, both Maternal Grandparents expressed concern about a lack of communication with them as a family, as well as a lack of communication between agencies, especially Children's Services and Police. They felt that there could have been more liaison between these two agencies concerning the risk presented by Father, which in turn should have been communicated to them. From a review of Child Protection Conference minutes and from other documentation provided to the Review, this appears not to be the case.

6.9 Maternal Grandmother considered there was little support offered either by the FNP or Children's Services to her or Mother. She also stated that Children's Services had said that Mother and Rowan would be split up in different foster placements if they no longer resided with her. This view contradicts the information supplied to the review by these agencies. Maternal Grandmother did praise the support, care and concern consistently shown to Mother by the Senior Pastoral Worker, Short Stay School.

6.10 It was not possible to speak with Mother, to confirm the views expressed by Maternal Grandmother, and the above account is a reflection of the Maternal Grandparents discussion with the Lead Reviewer. Maternal Grandmother went on to describe how Mother's pregnancy was normal but following a 16 hour labour Rowan's birth was traumatic, requiring a forceps delivery. Maternal Grandmother also stated that Mother experienced discrimination from some maternity staff on the post-natal ward due to her age. Because of the treatment she experienced Maternal Grandmother complained to the Unit Matron on her daughter's behalf and received an apology. Maternal Grandmother did praise the Teenage Pregnancy Lead, who showed empathy and understanding towards Mother. Maternal Grandmother said that not only was she with Mother when she gave birth to Rowan, she stayed on the ward with her for four days.

6.11 Maternal Grandmother wanted to emphasise that despite her young age, the care given by Mother to Rowan could not be faulted and his death was devasting for her.

6.12 Although there was a cot for Rowan in Mother's room, she was co-sleeping with him, until the night before he was found unresponsive the following morning. On several occasions, both the Community Midwife and the Family Nurse discussed with Mother the risks of co-sleeping and provided her with information about the dangers of doing so. Mother was also given advice as to how Rowan needed to be placed on his back to sleep.

6.13 The information provided to the Child Death Overview Panel, following Rowan's death, resonates with the risk factors associated with Sudden Infant Death, as manifest in the Child Safeguarding Practice Review Panel Report '*Out of Routine'* published in July 2020, concerning Sudden Unexpected Death in Infancy (SUDI).[2] The report found that almost all of the 14 tragic incidents of sudden unexpected death (SUDI) in infancy examined included risk factors such as co-sleeping, domestic abuse, mental ill health, secondary smoking, and substance misuse. Whilst Mother was seen to be a loving and caring parent to Rowan, it is apparent that some of the findings of the '*Out of Routine'* Report concerning the risk factors prevalent in the sudden unexpected death of an infant did feature in Rowan's home environment.

6.14 The report is one which Surrey Safeguarding Children Partnership has taken seriously and has implemented measures to improve outcomes for infants at risk of sudden unexpected death.

7 Key Lines of Enquiry

7.1 What was the quality of assessments of Mother and Father as children who were in need of help and protection?

7.1.1 As is evident from the narrative section of this report, Mother's family had been known to statutory agencies during the period under review and for several years previously.

7.1.2 Information provided by Surrey Police to the review states that between January 2021 and April 2022 Police had direct contact with Mother's family on twenty one separate occasions. The primary source of these contacts arose from relationship breakdowns between Maternal Grandparents and conflict between Maternal Grandmother and her older children, especially Mother when she became involved in a sexual relationship with Father, with the added stress of the threat of violence towards Mother from criminal gangs. Police involvement with the family was shared with other agencies at numerous Strategy Discussions and Child Protection meetings.

7.1.3 Mother experienced periods of rejection by Maternal Grandmother, said to be because of her behaviour, at several times resulting in her being ejected from the family home and living instead with Maternal Grandfather's parents. Such incidents happened when Mother was 12 and 13 years old, including one occasion in March 2021 when she was thrown out of the house at midnight, in her pyjamas, was collected by Maternal Grandfather and driven to his parents' home. On another occasion, when aged 12, Mother was known to be out of the home, not returning until 11:30pm during a period of lockdown.

[2] https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

7.1.4 During the period under review, there were five Child and Family Assessments. In relation to Mother, the first assessment in March 2021 discovered that the Maternal Grandparents had recently separated, there were concerns that Mother was '*beyond parental control'* and that she was sexually active. Maternal Grandmother maintained that as part of a safety plan Mother and Father were not left alone and at that time Mother had been sent to live with her grandparents after being '*disrespectful*.' The Maternal Grandparents said they were worried about Mother's sexual activity but had not acted to ensure that she was provided with sexual health advice or long acting reversable contraception. Clearly the arrangements put in place by the Maternal Grandparents to ensure that Mother and Father were not left alone were unsuccessful, given that Mother spoke to the Social Worker during the assessment visit about having sex, going to the GP for a pregnancy test and being worried about the test being positive. Mother also disclosed her ambivalence about what to do if she was pregnant. (Source: Children's Services report to the review).

7.1.5 It is apparent that Mother was seeking help to discuss her situation and could have been referred to a professional for advice and guidance as to her choices. The author of the Children's Services report asks the question as to whether there may have been a role for the School Nursing Service to assist at this time. This suggestion is one with which the Lead Reviewer agrees. Also, it was known that Mother had visited the GP to discuss her fears about pregnancy and the GP had acted with concern and compassion. The outcome of the assessment was for Mother to be placed on a Child in Need plan. There is no indication, however that consideration was given to proactively seeking professional support to assist Mother with her relationship with Maternal Grandmother, her sexual activity and the fear that she may be pregnant. She was 12 years old when she became sexually active, and as such should have been considered a vulnerable child, living in a home environment which was not sympathetic to her health and wellbeing.

7.1.6 Mother's ongoing association with Father resulted in a Child Exploitation Risk Assessment being undertaken in late April 2021, which resulted in Father being seen as a risk to Mother. The Children and Family Assessment was updated, and a Strategy Discussion considered that Mother may be pregnant and questioned the capacity of Maternal Grandmother to put in place effective boundaries and effective parenting. During this time, Mother had been '*kicked out'* of the family home by Maternal Grandmother and sent to stay with grandparents in another part of the country. In addition, on one occasion Maternal Grandfather and Mother presented as homeless. No information has been provided to the review to indicate that there was any assessment made of the impact of Maternal Grandmother's rejection of her daughter, or action taken to ameliorate the situation, apart from a referral to *Talking Teens*, a parenting course for parents of teenagers.

7.1.7 The risk of significant harm to Mother culminated in her being placed on a Child Protection Plan in May 2021. Further assessments followed, during her pregnancy and prior to Rowan's birth. The author of the Children's Services report supplied to the review reaches the conclusion that *"the ongoing assessment and support*

planning for Mother demonstrated a thorough and strength based approach to understanding and improving her lived experience." Whilst the report goes on to state that Mother's allocated workers knew her well and had built a good relationship with her, which helped to advocate for and support her in the midst of a '*sometimes chaotic and rejecting relationship with Maternal Grandmother',* there is little information to evidence what this support consisted of and what improved outcomes were achieved.

7.1.8 Mother became pregnant when she was possibly still 12 or just 13 years old. Annual statistics gathered by the Census 2021 for England and Wales concerning conception rates by age groups including women aged under 18 years in 2020, show that the rate of teenage pregnancy had been decreasing, especially in the under 16 age range:

"*There was a 16% decrease in the under-16 age group conception rates, from 2.5 conceptions per 1,000 women aged 13 to 15 years in 2019 to 2.1 in 2020. This is the largest annual decrease seen since 2016*."[3]

7.1.9 These figures show that Mother is in a very small minority of children who conceived a child, although the figures do not indicate how many went on to give birth. For professionals working with these young parents, the impact of Mother becoming pregnant and giving birth to Rowan needed to be seen first and foremost in the context of both parents being children. Support by health professionals during Mother's pregnancy and postnatally was manifest in the GP Surgery who continued to maintain Mother and Rowan as patients at the Practice after they had moved out of area, the Young Mums Midwifery Team, the FNP and the Community Midwives. In addition, Children's Services were involved given that Mother, Father and subsequently Rowan were subject to Child Protection Procedures. However, the voice of Mother and indeed Father is not apparent in the information provided to the review.

7.1.10 It is clear that Mother wished to continue with her pregnancy despite Maternal Grandmother's opposition. The review has received no information to indicate that she received guidance or counselling to make an informed decision as to the choice she made. When the Lead Reviewer met with Maternal Grandparents, Maternal Grandmother expressed her concern and frustration that Mother was allowed to make her own decision as to whether she should continue with the pregnancy, given she was only 13 years of age. We briefly discussed the concept of Gillick Competency[4] and Maternal Grandmother contrasted this with the right of Mother to make her own decisions, compared with the action taken by Surrey County Council to invoke care

[3] https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/bulletins/conceptionstatistics/2020

[4] Gillick competency is often used in a wider context [to that of Fraser Guidance] to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.
https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines#skip-to-content

proceedings, given that both parents were considered children themselves and too young to care for a baby. Maternal Grandmother said she failed to understand how Mother could be treated as 'an adult' in certain circumstances and as a child in others.

7.1.11 Recent research[5] shows that the brain continues to develop through childhood and adolescence, even into the late 20s and 30s in some brain regions. White matter increases, grey matter decreases. These changes are thought to be caused by important neurodevelopmental processes that enable the brain to be moulded and influenced by the environment. When a risk is taken the brain's positive reward system gets activated. In adolescents, that activation is higher during risk taking than in adults. It is important for professionals to be aware of research findings concerning the workings of the adolescent brain if an informed understanding is to be developed and maintained of the additional risk posed to young parents themselves and, more importantly to their babies and children.

7.1.12 These findings are particularly relevant to Rowan's parents, as not only were they both extremely young, their engagement in a sexual relationship without use of contraception, as well as Father's involvement in gang activity and its consequences for his safety and that of Mother and Rowan epitomize the influence of environment on adolescent brain development. Mother lived in an unstable family home situation, where frequent parental discord was prevalent, physical violence, unpredictable rejective and abusive behaviour by Maternal Grandmother, regular cannabis use, difficulties with school and a previous history of self-harming behaviours.

7.2 What was the quality of support for Rowan's mother and father as young parents?

Did their needs and vulnerabilities overshadow professionals understanding of his needs as a child in need of protection?

7.2.1 Mother's support before and after the birth of Rowan came from a variety of professionals. When she transferred to the Short Stay School, she received continuous support and advice from the Senior Pastoral Worker who saw her in school and at home and intervened in times of crisis. The Senior Pastoral Worker was able to engage with the Maternal Grandparents to ensure that Mother needs were recognised and addressed as far as was possible, whilst at the same time maintaining Mother's trust. The Senior Pastoral Worker liaised with Social Workers allocated to Mother and Rowan, and as the Designated Safeguarding Lead acted appropriately, immediately bringing to their attention safeguarding concerns. Because Mother's pregnancy had not been confirmed and she was anxious as to whether she was pregnant, it was the Senior Pastoral Worker who discussed with the School Nurse whether it was possible for Mother to undertake a pregnancy test at school. She was advised that under Gillick Competence this could be offered, and the test was carried out at school.

[5] Blakemore Sarah-Jayne *Inventing Ourselves: The Secret Life of the Teenage Brain, 2018*

7.2.2 In July 2021, Mother told the Senior Pastoral Worker that she wished to visit a Mother and Baby Unit. This request was passed on to Mother's Social Worker but seemingly the visit did not materialise. At that time Mother also had a Targeted Youth Support Worker. Once her pregnancy was confirmed and she was booked into the hospital, Mother was under the care of the Teenage Pregnancy Unit. The Safeguarding Midwife made an appropriate referral to Children's Services. During the antenatal period Maternal Grandmother supported her daughter with antenatal clinic visits, scans and was with her during labour and when Rowan was born.

7.2.3 Support was also offered to Mother by the FNP, the Community Midwifery Team and Social Workers allocated to the family and Rowan. Once engagement with the Family Nurse was established, a good relationship developed with Mother and Rowan's development was appropriately monitored, he was recorded as gaining weight and reaching milestones. During the visits by the Family Nurse, no evidence was apparent that Mother was smoking or using alcohol, although Maternal Grandmother stated that she (Maternal Grandmother) used cannabis for 'medicinal use'.

7.2.4 The Family Nurse was concerned when she visited in late January 2022 that Mother was at increased risk of postnatal depression and social isolation due to not being permitted to leave her home unsupervised and planned to closely monitor this at future contacts. It was also noted that Rowan had not been brought to his scheduled hip scan appointment, which Maternal Grandmother said she would rebook. Additionally, Mother did not attend her six week check with the GP, nor did she take Rowan for his immunisations appointment. The Family Nurse reinforced the importance of doing so, and for Mother to seek contraception advice. She also discussed safer sleeping arrangements, which is detailed below at Section 7.5.

7.2.5 The Family Nurse became increasingly concerned about Mother's emotional wellbeing after the incident involving alleged abusive behaviour by Father at the beginning of January 2022. A decision was made by statutory agencies that Father should not have unsupervised contact with Mother or Rowan, and resulted in maternal Grandmother removing Mother's mobile phone. This action caused Mother to feel angry and isolated as not only could she not make contact with Father, she could not contact or see her friends. Maternal Grandmother was also expressing her desire for Mother to move to her father's home (Great Grandfather) in another county. During a visit in late February 2022, the Family Nurse described Mother's mood as 'flat' and her feeling increasingly isolated due to having no mobile phone. However, Mother's interaction with Rowan was described as loving and affectionate. Mother reiterated several times that she did not consider Father to be a risk to Rowan. After the visit, the Family Nurse learned from Maternal Grandmother that she had discovered that Mother had been in contact with Father via a laptop and as a result she had removed all devices from Mother and had changed the passwords.

7.2.6 Following this visit, it was good practice on the part of the Family Nurse to contact the GP requesting to discuss Mother's emotional health as her mood assessment had indicated low mood and anxiety. It is evident that the Family Nurse persevered to establish a positive relationship with Mother (and Maternal Grandmother), and closely

monitored Rowan's development and Mother's interaction with her baby. She showed good awareness of the impact of removing a teenager's mobile phone and what this meant in terms of Mother feeling isolated, which could in turn lead to the development of postnatal depression. It should be noted that in the past Mother came to rely on Father and Paternal Grandmother, when the situation became difficult at home, and at times was allowed to stay at their home. Thus, for her to be denied contact with him, however well-intentioned Children's Services and Maternal Grandmother's actions may have been, meant in reality Mother was left cut off from the father of her child and a person she loved.

7.2.7 Events already documented in this report, exemplify how Maternal Grandmother's behaviour towards her daughter was a reflection of her reaction to her children as they got older, resulting in them being forced out of the family home. Such a pattern of behaviour was confirmed by one of Mother's older siblings who expressed fears for Mother's safety to Children's Services, explaining that Maternal Grandmother's actions in requiring Mother to leave the family home was an experience which all three older siblings had been subjected to. In addition, on numerous occasions, Maternal Grandmother left the family home, taking the two younger children with her and went to stay with her father, leaving the older children, including Mother, dependent on her estranged husband to care for them.

7.2.8 Mother's attendance at mainstream school was characterized by aggressive behaviour, resulting in frequent suspensions, and culminated in permanent exclusion when she was 12 years old. Mother was also subject to serious bullying on social media from other students, which increased her vulnerability. It was not until she arrived at the Short Stay School that Mother began to engage more fully in secondary education and was described by the Senior Pastoral Worker and Deputy Designated Safeguarding Lead (DDSL) at the school as "*a lovely bright girl with ambition for her life with Rowan not to be the same as her mother's."* The Short Stay School informed the review that "*not enough weight had been given to the impact Maternal Grandmother's inconsistent parenting has had on Mother. Whilst acknowledging that Maternal Grandmother could be very supportive sometimes, however at other times when for example she had thrown Mother ou,t this has had a very negative impact on Mother."*

7.2.9 It is also important to note that it was when Mother was due to return to school after the birth of Rowan that Maternal Grandmother stated her unwillingness/inability to care for her grandson and requested that Mother leave. It was at this point that Children's Services began to seek a foster placement for Mother and baby. Maternal Grandmother then changed her mind and allowed them to remain in the family home.

7.2.10 It is acknowledged that the account given to the Lead Reviewer by Maternal Grandmother differs to the information provided to the review by agencies. Having read documentation related to the Strategy Meeting held in February 2022, in relation to Maternal Grandmother saying that she was no longer willing to support Mother and Rowan living with her, it is evident that there was no suggestion that Mother and Rowan would be in placed in separate foster homes. The Chair of the meeting was

recorded as stating that a request for a foster placement had been made, and it had been stipulated that '*they must not be separated.*'

7.2.11 The anxiety caused to Mother, then aged 13, and the resulting vulnerability of both her and her baby, caused by the uncertainty and precariousness of where she and Rowan would live, cannot be underestimated. The incident in February 2022, presented Children's Services with an opportunity to remove Mother and Rowan to a safe environment where explorative work could have been undertaken with Mother to reflect on her own childhood experiences of parental rejection. It could have also enabled her to care for her baby in an atmosphere of stability, where she could enjoy being a child, as well as a mother, by continuing her education and receiving continued support to improve her own parenting skills.

7.2.12 It is evident that Rowan was considered vulnerable, both prior to and after his birth, as reflected in recognition by statutory agencies of the need for him to be subject to a Child Protection Plan. Indeed, the fact that Mother was seen as a child in need of protection, and then as a Child in Need herself is an indication that her baby could also be considered to be at risk of significant harm, heightened by Father's involvement in youth violence. The decision of the Child Protection ICPC and subsequent Review Conferences that Maternal Grandmother would be an appropriate person to protect and support Mother and Rowan required a more rigorous assessment than appears to have taken place.

7.2.13 Given the incidents of domestic abuse, Maternal Grandmother's own mental health needs, her volatile behaviour towards Mother and her siblings, her parental responsibilities towards her younger children, and the requirements to support Mother and Rowan, it was over optimistic that Maternal Grandmother could fulfil the requirements of the Child Protection Plan. The family history of safeguarding concerns was known to those agencies involved in the child protection process relating to Rowan. The Senior Pastoral Worker and DSL for the Short Stay School, who was closely involved with Mother and Maternal Grandmother expressed her concerns about the expectations placed on Maternal Grandmother, given the numerous incidents which had occurred, resulting in Mother being thrown out of the house.

7.2.14 The incident in February 2022, when Mother and her baby were requested to leave, provided statutory agencies with an opportunity to remove both Mother and Rowan from an unstable environment and to place them together in foster care. Unfortunately, once Maternal Grandmother changed her mind and said that her daughter and grandson could remain, the placement was not pursued, which was a lost opportunity to hear Mother's voice in her own right and to make suitable provision for her needs and those of Rowan.

7.3 How was Father's capacity as a young father assessed and supported?

7.3.1 Father's experience of childhood had featured physical abuse from Paternal Grandmother, (Police Officers had been called on 13 occasions in a 13 month period

because of conflict between Father and Parental Grandmother), lack of school attendance for over 18 months, involvement in criminal activity, resulting in him being assaulted and at serious risk of significant harm from rival gangs.

7.3.2 The University of Bristol's research findings on violence in teenage relationships6 undertaken between 2005 – 2009 clearly show that physical, sexual and emotional forms of teenage partner violence constitute a major child welfare issue. Such research resonates with Father's increasingly volatile behaviour, and his limited threshold for impulsive, aggressive behaviour, as illustrated when he was arrested for being in possession of a firearm and for allegedly being involved in a robbery at knife point. Most concerningly he allegedly pushed Mother when she was holding Rowan, which led to a curtailment of contact with her and his son.

7.3.3 It is also important to note that Father was considered to have difficulties with his emotional regulation and expressive language and had been assessed by a Speech and Language Therapist. It was recommended that Father "*receives a follow up, in depth assessment of his language skills to establish support needs for educational settings. Professionals should be mindful of checking his understanding of information by asking him to explain in his own words what he has understood."* (Source: Combined Chronology). This assessment of Father was part of the Youth Offending Service Speech and Language Team's specialist caseload and was undertaken to ensure that Father would receive follow-up assessment and input as required. It was part of the service offered to any young person referred to the Youth Offending Service on a Youth Offending Order, as was the case for Father at that time. It is not known to the review as to whether any further assessment and input took place, given the family moved out of area.

7.3.4 It is evident that the Children's Services Adolescent Team responsible for Father did their utmost to engage with him and Paternal Grandmother and attempted to protect him and his family from the significant harm they faced because of his involvement in youth violence. Little is known to the review about Father's interaction with his son; as due to the risk presented by his association with gang members and the very real threat to his safety and possibly that of Mother and Rowan, his feelings towards his child and the situation he found himself in were not known to the practitioners attempting to engage him.

7.3.5 The Terms of Reference for the review request that consideration should be given to the '*The Myth of Invisible Men'*[7], the third review commissioned by the National Panel focusing on the circumstances of babies under one year old who had been killed by their fathers or other males in a caring role. Rowan was found to have died a result of

---

[6] Conducted by Christine Barter (Senior Research Fellow 2005-present), Professor David Berridge (Professor 2005-present), Dr Melanie McCarry (Research Associate/Lecturer 2004-2013), Ms Marsha Wood (Research Associate 2003-present) and Ms Kathy Evans (Research Associate 2006-2009).

[7]https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1017944/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf

SIDS, and there is no suggestion that either parent was responsible for his tragic death. The findings of the National Panel review concerning background information of the men involved in the study resonate to some extent with the circumstances of Rowan's father.

7.3.6 It is, however, crucial to recognise in this case, Father was himself a child. The findings relevant to this review are as follows:

- There was a history of adverse childhood experiences
- Substance misuse (Father was known to use cannabis)
- Problems with anger and frustration
- Fathers were too often 'excluded' from child protection assessments and work with families
- Men are often only 'partially seen' and subject to 'shallow' assessments – it is unclear as to whether Father was involved in any pre-birth/parental assessments
- Failures to seek information proactively – it could be said that an opportunity was missed by practitioners in Surrey to communicate earlier with colleagues working with Father in the local authority where he lived
- Fathers/men's role in families are often not understood – it is difficult for this review to comment on the role of Father in case, because of his lack of contact with Rowan
- The importance of practitioners acknowledging and exploring how ethnicity, race, and racism affect parenting, and a need to understand every individual within the context of their own histories, backgrounds and culture.

7.3.7 The above considerations, including the research findings referenced above, highlight the need for professionals working with young teenage parents to not only focus on the child protection needs of the infant, but to also recognise the complexities of their own experience of parenting, the influence of their lived environment on behaviour and most importantly that the parents are children themselves. This is not always easy, given the difficulty, which is so often encountered when attempting to engage with young people. However, if these fundamental principles are not embedded in professional practice the risk to the babies and children of young parents is severely heightened and can lead to tragic consequences.

7.4 How well was the parenting capacity of both these parents and their wider families understood, assessed and supported?

7.4.1 The review has been informed, and practitioners attending the Reflective Learning Workshop confirmed that Mother had a loving, caring relationship with her son. Rowan was well looked after, he gained weight and was a thriving, happy, healthy baby. Mother was however 13 years old when she gave birth and just 14 when Rowan died. To consider her parenting capacity, the necessity to take into account that she was a child herself, only just entering adolescence, was paramount. Those practitioners involved with Mother did understand this and commented that they

were surprised at how devoted she was and how well Rowan was looked after. Yet, because she was only 13 years old, Mother had to rely on support, advice and material assistance from the Maternal Grandparents.

7.4.2 This report has detailed the history of safeguarding concerns, the volatility of the Maternal Grandparents own relationship, which impacted their approach to parenting, and the involvement of statutory agencies over a period of seven years at the time of Rowan's birth. Given this history, the reliance by agencies on Maternal Grandmother to undertake responsibility for supervising the care of her grandson, the contact between Mother and Father, whilst continuing to parent Mother and her younger siblings was over ambitious. Agencies were aware of the difficult relationship between Mother and Maternal Grandmother, of the precarious situation concerning the family facing homelessness due to rent arrears and of the two younger children being subject to Child Protection plans because of physical abuse by Maternal Grandfather.

7.4.3 Yet, despite knowing this information, the outcome of the Initial Child Protection Conference was that Maternal Grandmother could be considered appropriate to offer protective oversight of Mother and Rowan. From information provided to the review there appears to have been little consideration given to seeking Mother's views as to whether she wished to pursue alternatives to returning to the family home after Rowan's birth. It is known that whilst pregnant she discussed the prospect of going to a Mother and Baby Unit with the Senior Pastoral Worker, but this does not seem to have been pursued. Similarly, there was an opportunity for Mother and Rowan to go to a foster placement, but once Maternal Grandmother changed her mind and said her daughter and grandson could stay at the family home, consideration of this option was discontinued.

7.4.4 It is evident that greater thought should have been given by agencies to alternative placements for Mother and Rowan. Maternal Grandmother was seen as the 'go to option' and whilst in principle families should be kept together wherever possible, the underlying factors of poor parenting capacity of the Maternal Grandparents required greater professional scrutiny before making such a decision.

7.4.5 As has already been discussed, Father did not feature in the care of Rowan. The pre-birth assessment was completed by the Social Worker allocated to Mother and there were concerns about the quality of this assessment. Father was not involved in any parenting assessment. Practitioners involved with him have told the review that he was pleased to be a father and loved his son. However, his contact and interaction with Rowan was limited because of his involvement with youth violence and gang related crime. Communication for arrangements for supervised contact between Father and Rowan were required go via Paternal Grandmother. At the Practitioners Event, it was said that Paternal Grandmother did not allow such arrangements to be made, as she was of the view that contact did not require supervision. Practitioners discussed how much the restrictions on

visiting and appointments impacted on relationship building between Father and Rowan, which was considered to be significant.

7.4.6 Father was fearful for his safety, as was Paternal Grandmother. The seriousness of risk to life faced by Father and his family was manifest in the action taken by the local authority to permanently rehouse them out of area. Given this situation, it was difficult, if not impossible, for Father to be engaged with the care of Rowan. It was further compounded following his alleged outburst towards Mother at the beginning of January 2022, which resulted in Father having no contact with Rowan prior to his death. However, the turmoil and distress experienced by Father following this incident is captured by the author of the Children's Services report provided to the review, and highlights his own vulnerability as a child:

"The reports of him having to get out of Mother's house on 2 January 2022 paint a picture of a boy who was also caught up in the domestic abuse incident, trying to leave the house and crying in the street and needing to be collected by a family member. He had stayed overnight against the safety planning agreed with Mother and Maternal Grandmother. A more controlled and measured introduction to his son, supported by Surrey County Council and [his local authority] may have prevented this extended visit from taking place at a time when family life was already heightened, and alcohol was likely to be consumed during the New Year celebrations."

7.4.7 Little is known of the views of Paternal Grandmother concerning her involvement with her grandson. What is apparent is that the relationship between the Maternal and Paternal Grandparents was difficult with assertions made on both sides concerning inappropriate behaviours. Following the incident in January 2022, Paternal Grandmother raised concerns about how Rowan was being parented. It is unfortunate that Paternal Grandmother has chosen not to meet with the Lead Review, as her views could have been further explored, and included in this report.

7.4.8 It is also known that Paternal Grandmother was deeply worried and was said to be overwhelmed by anxiety about her son's safety and his involvement with youth violence. At the Practitioners Event on 5 January 2023, those who knew Paternal Grandmother and who had engaged with her said that she was very positive about having a grandson and openly expressed the view that she and Father wished to be more involved. However, given her concerns for Father's safety, Paternal Grandmother struggled to engage with services to try and resolve the situation and this in turn limited Father's engagement with services. It is unfortunate that Paternal Grandmother was unable to engage with the review, as her views would have been valuable in informing this report.

7.5 How effective was the multi-agency work in providing and reinforcing safer sleeping advice?

7.5.1 One of the recommendations from the '*Out of Routine'*[8] report produced by the National Child Practice Safeguarding Review Panel, July 2020 was that:

"the Department of Health and Social Care works with key stakeholders to develop shared tools and processes to support front-line professionals from all agencies in working with families with children at risk to promote safer sleeping as part of wider initiatives around infant safety, health and wellbeing".

7.5.2 A similar recommendation was identified in the SUDI thematic review undertaken by Surrey Safeguarding Children Partnership, with learning disseminated by the Partnership in the publication of a 7 minute briefing in November 2021. It is unclear as to how this learning was embedded in Partner Agencies, for whilst it is apparent from report provided to the review detailing the involvement of the FNP that the Family Nurse reiterated the importance of safe sleeping, it is evident that this was not the case from the review of Social Care records. The author of the Children's Services report makes the point that Maternal Grandmother was overseeing the care of Rowan but he was sleeping in the same room as Mother, thus it was not clear who had the final say over co-sleeping or the positioning of baby in his cot. It is not evident from Children's Services casefile records that this key area of parenting was explored with Mother or Maternal Grandmother. Risk assessments were not evident on the casefile to determine the factors that increased the risk of SUDI to Rowan, which may have prompted wider discussion and safety planning as part of the child protection process.

7.5.3 The Lead Reviewer agrees with the Children's Services report author that there is a need to consider all the risks to vulnerable children and not just those of a child protection nature. As previously indicated in this review, Rowan would have been considered at higher risk of SUDI due to the factors in his family and environment at the time. Whilst it may be difficult for practitioners to explain to parents and carers that their baby is at risk of SUDI, a previous Child Safeguarding Practice Review[9] undertaken by the Surrey Partnership has highlighted that speaking to parents in plain language about the risks of unsafe sleeping arrangements is important and welcomed.

7.5.4 The report of FNP involvement with Rowan states that safe sleeping and sudden infant death were discussed with Mother at the new birth visit on 5 January 2022. Maternal Grandmother was in the next bedroom as she had tested positive for Covid. These issues were discussed again during two visits in January 2022, when Mother told the Family Nurse that Rowan slept on his tummy. The Family Nurse reinforced the importance of him sleeping on his back and the associated risk of sudden infant death syndrome for Rowan sleeping on his front. Maternal

[8] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

[9] CSPR Acer

Grandmother was seemingly only in attendance during one visit in January 2022, for some of the time.

7.5.5 It was known by the Family Nurse that Maternal Grandmother was using cannabis to 'help her sleep' and the Family Nurse sought confirmation from Maternal Grandmother that she had signed a safety plan drawn up by the Social Worker confirming she was not using cannabis around Rowan. When the Family Nurse visited the home in

7.5.6 Ashford and St Peters Hospital and West Middlesex March 2022, Mother and Rowan were present, but Maternal Grandmother was only in attendance towards the end of the contact. During this visit, Rowan was '*sleeping in his cot with cot contents observed by the Family Nurse. Safer sleeping was discussed with [Mother] advising that the cot is clear during the night and when Rowan is alone in his cot with correct feet positioning*.'

7.5.7 From the above account it is clear that the Family Nurse was diligent in ensuring that Mother was told of the risks of SUDI and the need for Rowan to be in a safe sleeping position. What is not clear is whether Maternal Grandmother was present when this advice was being given. Maternal Grandmother had overall caring responsibilities for Rowan, however, it was known to agencies that she was using cannabis at night to 'help her sleep.' This raises the question of whether Maternal Grandmother would have woken up if an issue had arisen with the care of Rowan, and if she had, would she have been capable of reacting appropriately to ensure his wellbeing. By entering into an agreement with Maternal Grandmother that she would not use cannabis in the presence of Rowan, Children's Services acknowledged that she was using an illegal substance whilst being responsible for the care of her grandson. If such an agreement had referred to the use of alcohol, it would not have been considered appropriate. The need for practitioners to be aware of the effects that cannabis use can have on the capability of parents/carers to look after children appropriately is a finding of virtually every Child Safeguarding Practice Review, and is a lesson learned from this review.

7.5.8 In addition, it needs to be acknowledged that practitioners can advise parents of the risks to infants of unsafe sleeping arrangements, but it is the decision of the parent as to whether such advice is followed. Sadly, in the case of Rowan the advice of the Family Nurse was not followed.

8 Findings and Lessons Learned

8.1 The importance of parenting assessments, including pre-birth assessments

8.1.1 The pre-birth assessment of Rowan was completed; however, the assessment should have been assigned to a Social Worker, who was not already involved with the family.

Given that Rowan's parents were possibly some of the youngest parents that agencies involved with them had encountered, it was crucial that a thorough pre-birth assessment was undertaken if the unborn child was to be protected. This was even more pressing because of the known child protection concerns for both Mother and Father. The pre-birth assessment should have been assigned to a social worker who was not already involved with Mother's family, and this did not happen. A Social Worker was allocated to Rowan, but this practitioner did not complete the assessment.

8.1.2 Changes have been put in place by Surrey Safeguarding Children Partnership to improve practice concerning pre-birth assessments since Rowan's birth. This is manifest in the *7 Minute Briefing: Learning from Pre-Birth Assessments, January 2022*, as well as other policies and procedures[10] which have been implemented. The 7 Minute Briefing sets out the learning from an audit of pre-birth assessments undertaken in 2021, the areas of practice requiring development and provides clear guidance as to timeframes and action required for pre-birth assessments. Such revisions to policy and procedure are welcomed by the review, and should be recommended reading (or revisiting) for those practitioners involved in this case. **Recommendation 1(a)**

8.1.3 Given that it was agreed at the ICPC prior to Rowan birth that Maternal Grandmother would have overall responsibility for his care, an assessment of her parenting skills should have been undertaken. It seems that the decision to place Rowan on a Child Protection Plan was influenced by the risk presented by Father's involvement in youth violence. There is little evidence that Maternal Grandmother's parenting capacity was assessed. This was a missed opportunity, given the history of relationship breakdown between the Maternal Grandparents, between Mother and Maternal Grandmother, and the fact that Mother and the younger children were made subject to Child Protection Plans in May 2021. It would have also provided an opportunity to explore arrangements for Rowan's day to day care. **Recommendation 1(b)**

8.2 Recognising that the parents were themselves children

8.2.1 The need to protect Rowan from significant harm was of paramount importance. However, it was also important for all those involved with Mother and Father to recognise that they were themselves children and extremely young. It is possible that for Father, his involvement in youth offending and connection with gang criminality, became the main concern for those practitioners involved with him and his family, and the fact that he had fathered a child as a child, was a secondary concern. Clearly, the risk presented to Father's life was considered to be very real, but his vulnerability as a child is discernible in the description of his distress following the incident of alleged domestic abuse in January 2022.

[10] 5.20 SSCP: Pre-birth Child Protection Procedure (revised October 2022); Pre-birth assessment and intervention timeline; Pre-Birth Policy: under 16 year olds, 16-18 year olds, LAC and Care Leavers

8.2.2 To become pregnant at 12 and give birth to Rowan at 13 years old was a traumatic experience for Mother. The birth itself was lengthy and difficult and resulted in a forceps delivery. Although the GP had referred her to the Perinatal Mental Health Team in October 2021 to address Mother's anxieties about the threat posed by Father's involvement with gangs and how she would cope as such a young mother, the referral was rejected due to her age and a referral to CAMHS was suggested. The GP report submitted to the review stated that no correspondence could be found relating to a subsequent referral to CAMHS.

8.2.3 Maternal Grandmother has stated that Mother faced discrimination whilst in hospital after giving birth to Rowan. The Lead Reviewer has seen no evidence to support this, and it may be something which needs further exploration outside the remit of this Child Safeguarding Practice Review. However, given Mother's age it is understandable that she may have felt under scrutiny whilst in hospital, and such feelings could have compounded her experience of abusive telephone calls and messages on social media whilst pregnant.

8.2.4 That Mother had aspirations to continue her education are apparent from her desire to return to school, which she did briefly on a part-time basis after Rowan's birth. This decision can be linked to the support, care and understanding offered to her by the Senior Pastoral Worker and the teaching staff at the Short Stay School. The tragic death of Rowan interrupted not only Mother's education but severely impacted her childhood. **Recommendation 2.**

8.3 Support to young parents

8.3.1 Not only were both parents very young, they were also subject to child protection procedures, as was Rowan, during their short period of parenthood. The need for support from professionals was engrained in the child protection process and this was evident during the time frame of this review. Mother was well supported by the Family Nurse Practitioner, her Social Worker, the GP and the Senior Pastoral Worker. She could have benefitted from intervention from the Perinatal Mental Health Team, but this was not available. **Recommendation 3**.

8.3.2 Mother's main support came from Maternal Grandmother. This report has highlighted that such support was inconsistent and was dependent on Maternal Grandmother's frame of mind and the state of relations between her and her daughter. The issues raised by the decision to task Maternal Grandmother with the responsibility of the overall care of Rowan and to ensure that no contact, supervised or unsupervised could take place between the parents have been already addressed in this report. Of further consideration is the effect on Mother's mental health and wellbeing of the removal of her phone and other means of communication, in addition to not being permitted to see friends outside the home unsupervised. The Family Nurse recorded her concerns about Mother's low mood and general anxiety, and appropriately brought this to the attention of the GP. Such actions instigated by Children's Services and implemented by Maternal Grandmother placed an unrealistic expectation on a 13 year old, and

needed careful consideration as to the consequences of leaving Mother feeling isolated, as well as the impact on her relationship with Maternal Grandmother. The need to take account of the needs of young parents who are children is a lesson arising from this review, as reflected in **Recommendation 2.**

8.4 Child Protection Planning

8.4.1 The importance of taking full account of family history and consideration of the consequences of requiring a family member to take responsibility for ensuring a safe environment and supervise the care of an infant cannot be overestimated. It can be concluded that given Mother's family history and the dynamics of her relationship with Maternal Grandmother, there was misplaced optimism on the part of practitioners that the specifications of the Child Protection Plan would succeed. Child Protection planning was needed from the outset and should have been the focus of the pre-birth assessment, which proved not to be the case, and is a lesson learned. **Recommendation 1(b)**

8.4.2 In addition, the review has noted that GPs are not routinely informed of when a child is subject to a Child in Need Plan. This practice is considered to be a gap in information sharing and should be reconsidered by the Partnership. **Recommendation 4.**

8.5 Professional Advice on Safe Sleeping

8.5.1 The review has evidenced that frequent advice was given to Mother, and possibly Maternal Grandmother by the Family Nurse about the importance of safe sleeping to avoid risk of harm to infants. It is apparent that although such advice was given, Mother and Maternal Grandmother did not necessarily follow it. One of the issues discussed at the Practitioners Event was that whilst such information is delivered to parents by professionals, documentary evidence by midwives and health visitors when undertaking home visits, as to where a baby is actually sleeping can be missing. Whilst in this case the Family Nurse did see where Rowan was sleeping, the importance of all professionals asking to see where a baby sleeps is crucial and could potentially save lives. **Recommendation 5(b)**

8.6 Risk-factors identified in the *Out of Routine* Report and presenting Issues in this case

8.6.1 It is apparent that the risk-factors identified in the *Out of Routine* report resonate with the presenting issues in this case. One of the most important findings of the Report, was that the risk of SUDI should not be seen in isolation from other risks present in the home environment. Of equal importance, as has already been discussed was the need to not see assessment of the risk of SUDI as solely the responsibility of health professionals. Practitioners in all agencies working with children at risk, need to develop an evidence-based understanding of the decisions parents make in relation to their child/ren's sleeping environment and where there are concerns, consideration given to what could be put in place to achieve change.

8.6.2 The need to develop a framework for practitioners from partner agencies working with families where young infants are at risk because of unsafe sleeping arrangements, as stated at Recommendation 3 of the Out of Routine Report, was a finding of the previous review undertaken by Surrey Child Safeguarding Partnership referenced at para 3.4.3 and is a finding of this review. **See Recommendation 5(a)**

9. Good Practice

9.1 The GP Practice offered exceptional care to Mother and showed good awareness of Safeguarding Children.

9.2 The Short Stay School provided a safe, caring environment for Mother that continued during her pregnancy and after Rowan's birth. The duty of care shown by the Senior Pastoral Worker and DSL was exceptional.

9.3 The Family Nurse was exemplary in her care and support to Mother and Rowan.

9.4 Community Midwives, the Family Nurse and Children's Services continued to visit the family during the Covid Pandemic.

9.5 The local authority responsible for Father did their utmost to engage him and to ameliorate the risk of significant harm, culminating in the funding of a permanent move for the family out of area.

10. Conclusions

10.1 This review is one which unusually focuses on the death of a baby born to extremely young parents. It has considered the impact on and outcomes for parents who themselves are children, and how their needs, as well as those of their baby have to be taken into consideration by professionals involved in child protection procedures. The dangers faced by children involved in youth violence and gang criminal activity have also been addressed, as have the risks posed to vulnerable babies of Sudden Unexpected Death in Infancy.

10.2 This report has shown there was good professional practice by many of those practitioners involved with this family and in this context, it is perhaps worth considering a comment arising from the Practitioners Event when concluding this review. Those attending the Event recognised the death of Rowan was a tragedy, but it was suggested that it was not as a result of any one individual or professional practice. This assertion is one with which the Lead Reviewer agrees. Rowan was a much loved, healthy and well cared for baby, by a mother who was still a child herself. The impact of such a loss on a such young parents is incalculable.

10.3 It needs to be recognised that the positive support Mother received from the Short Stay School was a model of what can be achieved when children are on the brink of

exclusion from mainstream education. It enabled her to develop aspirations to have a different life for her and her son. It is to be hoped that Mother will be able to renew and re-engage at some point with some of those visions for herself.

11. Recommendations

The following recommendations are for consideration by Surrey Safeguarding Children Partnership (SSCP).

Recommendation 1: (a) The SSCP to disseminate the 7 Minute Briefing: Learning from Pre-Birth Assessments, January 2022, with a requirement that it is recommended reading for all practitioners working with parents and children. (b) If a vulnerable baby is living in the care of grandparents (with or without the presence of their parent), an assessment of their parenting capabilities and skills should be a pre-requisite before any such placement is made; especially if the child is subject to a Child Protection Plan, which is reliant on the care offered by the grandparents.
Recommendation 2: Partner agencies are to be reminded that when parents are children themselves, their needs and wellbeing should be recognised, and considered a priority, together with that of the need to safeguard their child.
Recommendation 3 Consideration should be given to exploring the possibility of young, teenage mothers being offered the services of the Perinatal Mental Health Team when it is evident that their health and wellbeing is at risk, and sufficient support for their mental health cannot be provided by the services of the FNP (Family Nurse Partnership).
Recommendation 4 As required by existing SSCP policy, GP Practices should be informed when a child is subject to a Child in Need Plan, to ensure that information relevant to safeguarding is shared.
Recommendation 5 **(a)** The SSCP to seek reassurance that the framework concerning safe sleeping is embedded for use by practitioners working with families where young infants are at risk because of unsafe sleeping arrangements. **(b)** Such a framework should include a requirement that professionals visiting the home should ask to see where a baby is sleeping to seek assurance that the arrangement is safe.

Appendix 1

Terms of Reference

SCOPE OF THE REVIEW
Time Period to be Considered by the Review: **1 January 2021** when Mother came to the attention of services following a domestic abuse incident at the family home until the date of Rowan's death**.** Relevant historical information related to Rowan's parents can be included as background information in the form of a summary, highlighting significant events and key practice episodes. **Key Lines of Enquiry to be Addressed by the Review:** The case has identified the following areas of key lines of inquiry: **1. What was the quality of assessments of Mother and Father as vulnerable children who were in need of help and protection?** ▪ What was the quality of the pre-birth assessment: assessment is a live and on-going process; each assessment should reflect the specific characteristics of each child within their family and community context; this includes drawing upon relevant family history and family functioning; as well as the risk factors for Sudden and Unexpected Death in Infancy identified in the Child Safeguarding Practice Review Panel's Out Of Routine report published in 2020. ▪ Did assessments focus sufficiently on the needs of Rowan as a child who needed to be safeguarded? **2. What was the quality of support for Rowan's mother and father as young parents?** ▪ The Rapid Review noted that when parents have a range of vulnerabilities, these must be addressed, whilst maintaining focus on the child. In this case, did the needs and vulnerabilities of Rowan's very young parents overshadow professionals' understanding of his needs as a child in need of protection? ▪ How was Father's capacity as a young father assessed and supported? The role of fathers: Father was the focus of significant concern; however, it is less clear regarding the work that was done to support him as a parent, including joint work with both sides of Rowan's family. This should be considered against the findings and recommendations of the Child Safeguarding Practice Review Panel's report, *the Myth of Invisible Men*, published in September 2021. ▪ How well was the parenting capacity of both these parents and their wider families understood, assessed and supported? The risks to Mother and Father were known, however, there needed to be a

greater focus on how these risks impacted on their ability to act as consistently good enough parents for Rowan. Related to this was the need for a clear assessment of the impact of the vulnerabilities of the Maternal and Paternal Grandparents for baby Rowan.

3. **How effective was the multi-agency work in providing and reinforcing safer sleeping advice?**

    - As identified in the Surrey SUDI thematic review of and the Child Safeguarding Practice Review Panel's *Out of Routine* report, this case highlights the need for all agencies to play a role in communicating safer sleep advice and safe sleep assessment to form part of all child and family assessments.

PLANS TO INVOLVE CHILDREN AND FAMILY MEMBERS

The Parents and the Paternal and Maternal Grandparents and relevant extended family will be invited to participate in the review process.

METHODOLOGY

Throughout the review process the well-being of the workforce will be a priority – the review panel will be mindful of staff well-being throughout

The review will include individual agency reports and chronology of key practice episodes from relevant agencies and services including:

- Surrey County Council Children's Social Care
- A London Borough Children's Social Care
- Surrey County Council Education Department
- Ashford and St Peters Hospital
- West Middlesex Hospital
- The Midwifery Service
- Community Health Teams
- Surrey Police and the Metropolitan Police

The review process will be collaborative which means the Independent Review author and the Panel will listen to and involve practitioners.

LEGAL CONSIDERATIONS

Parallel Investigations:

There are no parallel investigations related to the death of this child.

Legal Advice:

Legal advice will be provided to the Panel by Surrey County Council Legal Department who will act on the behalf of the SSCP.
OTHER CONSIDERATIONS
The impact of COVID-19 was discussed at the Rapid Review and not felt to be significant to practice and system learning.

The Lead Reviewer

Moira Murray has been an independent reviewer since 2010 and has undertaken numerous SCRs, Learning Reviews and Safeguarding Children Practice Reviews. She has been involved in safeguarding audits for the NHS, the voluntary sector and local authorities, and co-authored HM Government *Safeguarding Disabled Children Practice Guidance, 2009* whilst Head of Safeguarding at the Children's Society. Moira was a non-executive board member of the Independent Safeguarding Authority for 5 years, and was Safeguarding Manager for Children and Vulnerable Adults, London 2012 Olympic and Paralympic Games. She has also undertaken a review for the Foreign & Commonwealth Office, reviewed safeguarding at the BBC post Jimmy Savile and undertaken safeguarding reviews of Premier League Football.