Dudley Safeguarding People Partnership

Serious Case Review

Child: Child L

3rd September 2018

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1. Framework of the review:

1.1 Working Together to Safeguard Children 2018 contains the statutory guidance for undertaking Child Safeguarding Practice Reviews (CSPRs) when a serious child safeguarding cases has been reported. These are cases in which:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

1.2 Meeting the criteria does not mean that safeguarding partners must automatically carry out a local child safeguarding practice review. It is for them to determine whether a review is appropriate, taking into account that the overall purpose of a review is to identify improvements to practice.

1.3 Issues might appear to be the same in some child safeguarding cases but reasons for actions and behaviours may be different and so there may be different learning to be gained from similar cases. Decisions on whether to undertake reviews should be made transparently and the rationale communicated appropriately, including to families.

1.4 Some cases may not meet the definition of a 'serious child safeguarding case', but nevertheless raise issues of importance to the local area. They might, for example, include where there has been good practice, poor practice or where there have been 'near miss' events. Safeguarding partners may choose to undertake a local child safeguarding practice review in these or other circumstances. In this case, the rapid response meeting (RRM), which is a multi-agency meeting which takes place immediately after a child dies, concluded that the circumstances of the case should be referred to the Serious Case Review (SCR) panel. Scoping work was undertaken, which was presented to the panel. The panel concluded that the threshold was met for a SCR to be undertaken. The Independent Chair of the Local Safeguarding Children Board agreed with the decision of the panel.

1.5 The decision of the Independent Chair was presented to the National Panel, who agreed for a single agency review to be commissioned, however felt that the case fulfilled the criteria for a SCR as laid out in Working Together 2015 and, as the borough were in transition to the new arrangements, a SCR has been undertaken.

1.6 Child L died on 3rd September 2018. It has been established that the medical cause of death, as detailed in the report produced by the pathologist[1], is 'best regarded' as 'airways obstruction in the context of co – sleeping'. She had been sleeping with her parents and sibling on the sofa. Parents provided blood samples for the purpose of toxicology tests, however the tests did not prove that they were significantly impaired by alcohol or drugs at the time of her death. There was evidence of recent usage of alcohol and drugs by both parents. They were cautioned for child neglect and drug possession offences. This was in relation to the home conditions at the time of Child L's death and the substances found[2].

1.7 From the scoping information provided to the SCR panel it was evident that there had been information which indicated that Child L may be at risk of abuse or neglect, and there were concerns about how the agencies had worked together. The information which the panel considered as relevant is documented as follows[3]

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[1] Report provided by Dr Alexander Jan Oldrich Kolar 14th March 2018

[2] Information provided by the Police Senior Investigating Officer

[3] Minutes of Extraordinary Meeting SCR panel 14/09/2018

- The home conditions at the time of Child L's death as stated in the referral document to the SCR panel[4].
- Potentially, there were missed opportunities for engagement with the parents in a more proactive and supportive way to assist them in caring for their children.
- A referral had not been made to children's services about the home conditions.
- Evidence of substance misuse had been found within the premises, and there was information that the parents may have had convictions for offences involving drugs and alcohol. The use of these substances may have had a detrimental effect upon their ability to care for their children.
- The parents had provided different accounts in relation to where Child L had slept the night before. Her mother had stated she had put Child L to sleep in the moses basket. Her father had stated that he fell asleep with her on the sofa, which indicated that there was evidence of co-sleeping.
- There was a lack of information in respect of an older half sibling and the reasons why she lived with her maternal grandmother. If this had been explored it may have indicated that there were concerns in respect of Child L's parents' ability to care for her.
- Child L's father had a history of depression and anxiety.
- A sibling who also resided with Child L had a child protection medical and was found to be dirty and unkempt. A child protection medical in respect of the sibling living with maternal grandmother did not give any cause for concern.

These concerns did not appear to have been shared by agencies, and formed the basis of the requirement to carry out a SCR.

2. Process for the case review

2.1 The independent author met with the Safeguarding Board representatives and agreed the terms of reference, agencies involved and the scoping period.

2.2 **Agencies involved and reports and chronologies required**

Three agencies have been identified as having contact with Child L and her family during the period of the review –

Dudley Clinical Commissioning Group (CCG) – GP services.

Black Country Partnership NHS Trust (BCPNHST) – Family Nurse Partnership, including the health visiting team.

Dudley Group NHS Foundation Trust (DGNHSFT) – midwifery, acute paediatrics, and accident and emergency.

Individual Management Reports (IMR) were requested from each of the above agencies. Each agency was also asked to record individual contacts during the scoping period with the family on a chronolater document. These documents, together with the information shared at the

[4] DSCB Referral form dated 05/09/2018 submitted to the SCR panel

RRM and the additional scoping information collated for the SCR panel have been utilised to compile this report.

2.3 An author's briefing event was convened, where the three IMR authors presented their agencies respective reports, which were subject of discussion and clarification.

2.4 The parents and maternal grandmother were made aware that the SCR was taking place, and were invited to meet with the independent author. They did not respond to the invitation. It would have been useful to have had this opportunity to gain an insight of the family and their experiences of the professionals involved.

3. Scoping period

3.1 The scoping period commences in January 2016, which is the approximate date when mother would have conceived Emily, Child L's elder sibling. This period is necessary in order to understand the issues relevant to the pregnancy and the antenatal and postnatal period of Emily, and how they may have influenced professionals when the second pregnancy was reported.

3.2 The scoping period concludes on 3rd September 2018, the day Child L died.

4. Background to the Case Review

4.1The persons subject of the SCR are listed below. Their names have been changed in order to ensure anonymity is maintained as far as possible.

Child L – aged under 3 months
Jane - Mother, aged between 25 – 30 years
John - Father, aged between 35 - 40 years
Emily - Sibling, aged under 2 years

Beth - daughter of Jane and half sibling of Child L and Emily, aged under 10 years, residing with Ann
Ann – maternal Grandmother

4.2 Child L lived with her mother, father and elder sibling, Emily, in a two bedroomed terraced house. Her older sibling, Beth, resides with maternal grandmother, Ann. John is not the father of Beth and her father has not been subject of this review. Following Child L's death, both Emily and Beth underwent Child Protection medicals. There were no concerns in respect of Beth, however Emily was found to be dirty and unkempt. The home address of Child L and her family was visited on the day she died by the Police and the lead nurse for child death. The following concerns were jointly documented by both professionals[5] -

[5] DSCB Referral form dated 05/09/2018 submitted to the SCR panel

- No evidence of baby feeding bottles and the sterilising unit was dry and had black mould within it
- Home was very chaotic and cluttered and several doors were obstructed with clutter
- The front room had floor to ceiling clutter, there were old clothes all over the room
- There was little food in the kitchen, with a bag of mouldy food on the floor
- The kitchen was cluttered and dirty
- There was drug paraphernalia around the house
- The beds were dirty with no bed covers
- There was cigarette ash on the floors with broken bottles and cups

From the information gathered, it appeared unlikely that the home conditions deteriorated to this extent in a short period of time, and the home had been visited by both the Community Midwives (CMW), on 27thJune 2018, 1st and 5th July 2018, and a Health Visitor on 5th July 2018, 6th August 2018 and 16th August 2018, the last visit being 17 days before Child L died.

4.3 Prior to her death, Child L was assessed by the health visitor on 16th August 2018, and was seen to interact positively with Jane with good eye contact[6]. She demonstrated good interaction with her family. West Midlands Police investigated the circumstances surrounding the death of Child L and the involvement of Jane and John. Both parents have admitted the criminal offences of possession of cannabis and child neglect[7] and have received criminal cautions for both offences.

5. Summary of Facts

5.1 Child L was found unconscious at home on the morning of 3rd September 2018. Parents called for an ambulance at 06.18hrs; however death was confirmed at Russells Hall Hospital at 06.44hrs[8].

5.2 When Jane and John were interviewed by West Midlands Police they admitted to taking drugs and alcohol during the evening before Child L died. They stated that Child L had been sleeping on the sofa with mother, father and older sibling rather than in the moses basket. When John woke up, he found that Child L was trapped between his body and the sofa. However, from the RRM it was established that when they were initially spoken to by health professionals and the police, they stated that Child L had been put to sleep the night before her death in a moses basket and they maintained this account until presented with the additional medical evidence below (point 5.3). The Senior Investigating Officer has described

[6] Chronolator document

[7] The definition of neglect is outlined in section 1(2)(a) of the 1933 Act. The offence is committed if a parent or the legal guardian, or other person legally liable to maintain a child or young person has wilfully neglected the child in a manner likely to cause injury to health by failing to provide adequate food, clothing, medical aid or lodging or, if having been unable to provide such items, they fail to take steps to procure them.

[8] Dudley CCG IMR

the investigation as 'challenging' because of the inaccurate accounts provided by the parents initially[9].

5.3 At the post death examination by police and the paediatrician, several parallel linear marks were noted on Child L's wrists and side, and there was a scratch to the back of the leg. Rigor mortis was well established on arrival at hospital. The marks were later considered to be consistent with overlay whilst on the sofa.

5.4 Child L's older sibling, Emily, was found to be dirty and unkempt, however in good health. The home conditions at the time of Child L's death were concerning, and subsequently deemed to constitute criminal neglect. Both parents have accepted that this was the case as they have accepted a criminal caution for the offence of neglect.

5.5 The following periods have been identified as being significant in respect of professionals involvement with the Family, and **references made have been drawn from agencies IMR's, the combined chronolator document and from the author's briefing event.**

5.5.1 January 2016 – January 2017, which is the period of antenatal and postnatal care in respect of Emily.
5.5.2 January 2017 – November 2017, which is the period prior to the pregnancy of Child L
5.5.3 November 2017 – June 2018, which is the period of pregnancy in respect of Child L.
5.5.4 June 2018 – September 2018, which is the postnatal period in respect of Child L up to the day she died.

<u>5.5.1 January 2016 to January 2017</u>

Jane, John, and both Child L and Emily received primary care services and have been registered with the same GP practice in Dudley since 2016.

In July 2016 Mother booked her pregnancy at Russells Hall Hospital with Emily. Her pregnancy was advanced at 17 weeks at booking and she delivered prematurely at 31 weeks. Emily weighed 1540grams. Emily was cared for on the neonatal unit (NNU) for four weeks.

Because Jane booked late into her pregnancy and delivered prematurely, her potential care contacts with maternity services was limited to six. Just two of these contacts would have been with her Community Midwife.

On 7th November 2016 health visitor A arranged a primary birth contact to the home address. Emily was not at home as she was still being nursed in the NNU. Jane was present. The home conditions were noted to be a concern. There was a shopping trolley in the hall, no wallpaper on the hall walls, the living room was cluttered, and there was an ash tray full of roll up cigarettes observed. Pets were seen in the house, and there were no carpets. During interview for the purpose of the SCR, health visitor A stated that she had told Jane that the property needed to be tidied up before Emily came home. This was not documented in the health visitor record but was a verbal account provided to the IMR author. Details were taken about family members and the school was recorded for Beth (older half sibling). Jane referred to Beth being tearful and wanting her little sister home. When interviewed for the purpose of this review, health visitor A self-reported that this disclosure caused her to make an

[9] Information provided by the Police SIO by e mail 17/10/19

assumption that Beth lived in the family home. Jane was noted to be low in mood, and tearful when the home clutter and smoking cessation was discussed. Health visitor A offered support and advice. There is no record of consideration being given to submitting a multi- agency referral form (MARF).

On 28th November 2016 health visitor A was made aware of financial concerns by staff on the NNU. It was disclosed that in heavy rain Jane had put bin bags over her shoes and legs to keep them dry when she had visited the NNU. NNU staff also reported that there were concerns around the frequency of parental visits, and that there had been a period of four days when they had not attended. Jane had further disclosed that she did not have bottles for her baby and that the maternal grandmother, Ann, would be buying them. Health visitor A shared information about the home conditions observed on 7th November 2016 with the NNU, and a joint home visit was arranged for the following day. There is no record of consideration being given to submitting a multi-agency referral form.

On 29th November 2016 health visitor A and a NNU nurse undertook a joint visit to the family home. Both parents were present. A cot and pushchair had been purchased by Ann, the maternal grandmother, and she was noted to be supportive of the family. The home environment was found to be tidy and uncluttered, the hallway was cleared, and no smell of a dog or of dampness was recorded. Carpets were in place. The temperature of the house was discussed, as it was felt to be cold. Health visitor A was asked about the dog during interview for the purpose of the review and she remembered seeing it in the garden but could not remember if it was discussed with the parents. The health visitor stated that she asked Jane about the use of bin bags on her feet and legs, and was told it was a long walk and she wanted to keep dry. Benefits, home safety, safe sleeping and support from the Children's Centre and community services were recorded in the record. A local church was to donate a Christmas hamper. The property was deemed suitable for discharge home.

Emily was discharged from hospital on 1st December 2016.

A community neo-natal nurse visited the following day and again on 9th December 2016 and no concerns were noted.

On 13th December 2016 Health visitor A and community nursery nurse A conducted a home visit for the purpose of the new birth contact. The joint visit was part of the nursery nurse orientation into her post. Emily, Jane and John were present. The home was noted to feel very warm, however John checked the temperature gauge and the temperature was within normal limits. The landlord had repaired the boiler. Jane and John were sleeping downstairs as their bedroom was being decorated. Child L was sleeping in a moses basket, also downstairs. The house was noted to be clean, and the clutter in the hallway was baby equipment. No reference is made to Beth in the record of the visit. Health visitor A stated at interview that she addressed the subject of the referral to a local food bank and John said he wanted to them to manage independently. The referral to the Children's Centre was not discussed as health visitor A said she had been told the family were not eligible prior to the contact. The information about the food bank and the Children's Centre was not recorded in the health visitor records.

A community neo-natal Nurse visited on 23rd December 2016 and no concerns were noted[10].

[10] Chronolator - DGNHSFT notes

5.5.2 January 2017 to November 2017

On 2nd February 2017 a letter was received by the health visiting team informing them that Jane did not take Emily for an appointment with a dietician, however had made a telephone call to rearrange.

On 16th March 2017 a visit arranged by the health visiting team was cancelled due to sickness and an attempt was made to contact Jane, but the mobile was switched off and a message could not be left. A letter was sent to rearrange the visit for 4th April 2017.

On 21st March 2017 it is recorded that Emily was not brought to a dietician appointment

On 4th April 2017 community nursery nurse A conducted a home visit and Jane, John and Emily were present. The focus of the visit was a developmental review. Positive interactions between baby and parents were noted. It is recorded that Emily was sleeping in a cot. The family were signposted to playgroups and to a clinic for advice and growth monitoring. Jane stated that the dietician appointment had been missed and she was advised to try and rebook.

On 4th May 2017 health visitor A had contact with Jane and Emily in clinic for a weight review. Jane disclosed that she still did not have a new dietician appointment, and the health visitor called the dietician to rearrange.

On 13 June 2017 the dietician appointment was attended.

On 3rd October 2017 community nursery nurse A completed a 9-12-month developmental review for Emily at a nursery venue, with Jane. The Standard Ages and Stages Questionnaire (ASQ) assessment tool was used and it was noted that gross motor development required further assessment. Jane stated that Emily had an appointment with the paediatric consultant and dietician on the 05/10/2017. She raised concerns about Emily having 'sweaty feet' and referred to a skin condition that John had and a possible link. Advice was given about skin temperature. The information from the contact was discussed with health visitor A.

On 5th October 2017 Emily was taken to the neo-natal clinic appointment, and no concerns were noted.

5.5.3 November 2017 to June 2018

On 29th November 2017 Jane booked her pregnancy with Child L appropriately in the first trimester and accessed care throughout her pregnancy. She was booked for consultant led care due to her previous premature delivery of Emily. It is recorded that she disclosed that she smoked, however declined the offer of smoking cessation.

A dating scan took place on 6th December 2017 and antenatal blood screening tests were completed on 18th December 2017.

On 4th January 2018 community nursery nurse A tried to call Jane to review Emily's gross motor development, however there was no reply and a message was left. This appointment took place on 18th January 2018 at a nursery venue. Community nursery nurse A saw Jane and Emily and Jane asked for support in the form of foodbank vouchers, citing the fact that all their bills had come at once. This was referred to health visitor A. There is no reference

made to the gross motor development. On 23rd January 2018 Health Visitor A attempted to call Jane and there was no reply and no facility to leave a message.

On 1st February 2018 community nursery nurse A attempted to call Jane and John answered. He stated that Jane was out and requested a call back later or the next day to speak to Jane. No reference was made to the request for a food bank referral during the call. During interview for the purpose of the SCR community nursery nurse A stated that she felt the financial situation was personal to Jane and she did not feel she wanted to discuss the food bank with John.

On 8th February 2018, 21st February 2018, and 4th April 2018 community nursery nurse A attempted to call Jane. However, the calls were not answered and she could not leave a message. A letter was sent to Jane on 5th April 2018. A call was made on 12 June 2018 by community nursery nurse A as neither parent had responded. John was spoken to, and a telephone review of Emily's progress was conducted, based on the responses provided by John.

On 9th April 2018 Jane attended antenatal clinic where her carbon monoxide levels were found to be high and growth of Child L was just above the 10th centile. She was advised of the risks of smoking to her unborn child. She declined a referral for smoking support.

On 30th April 2018 health visitor B made a home contact for an antenatal visit. The home was described as 'cluttered but minimally acceptable'. This was explained in interview for the purpose of the SCR as meaning the home was not in good repair. The front room was cluttered with toys and household objects, but had a safety gate across the doorway. The second downstairs room was described as 'not excessively cluttered' and no safety issues were identified. A record was made of a previous history of paternal cannabis use and the health visitor stated that she would have asked about drug usage and there was no disclosure of current use. Family members, including Beth and Emily, were recorded on the antenatal record, along with the school for Beth. There is no further information regarding whether Beth was resident at the home and health visitor B has stated that they felt reliant on a disclosure of the information from the family. John's history of a skin condition was recorded on the health records and the health visitor stated he disclosed that information and how it affected him. It was concluded that the condition would have no impact on the baby.

On 9th May 2018 Jane attended for an antenatal appointment. A routine enquiry in respect of domestic abuse, in line with the procedures for antenatal appointments[11], was made, which was negative. She was advised of the effects of smoking whilst pregnant. Routine growth scans took place on 14th May 2018 and 4th June 2018. Child L was a breech presentation and an attempt to change the presentation on 7th June 2018 was not successful. On 20th June 2018 Jane attended for an antenatal appointment. A routine enquiry in respect of domestic abuse was made, which was negative. She was advised of the effects of smoking whilst pregnant.

[11] DGNHSFT antenatal appointment procedures

5.5.4 June 2018 to September 2018

Child L was delivered at term in June 2018. She was intra- uterine growth restricted, weighing 2.710kg, consistent with a mother who had smoked during pregnancy[12].

On 27th June 2018 the community midwife (CMW) visited the home address as Jane and Child L had been discharged from hospital. The only detail recorded is that safe sleeping and a smoke free home were discussed. The CMW has been spoken to as part of the review and confirmed that the kitchen and the baby's room would have been accessed. Feeding equipment was seen and the preparation of feeds was discussed. The moses basket was seen and checked, and it was confirmed that Child L should sleep in the parents' room for a period of six months.

On 28th June 2018 health visitor C contacted John by telephone to make an appointment for the new birth visit. As Jane was not present, John requested that a call be made the following day. There was no reply to this call, therefore a letter was sent arranging the visit for 5th July 2018.

Child L was not brought to a new born screening appointment on 30th June 2018. As this appointment was due at the weekend, the parents were required to bring her to the hospital. If it had been due on a weekday, then it would have taken place at home.

The appointment was carried out as a home visit by a CMW on 1st July 2018. The CMW has been spoken to as part of the review. Her recollection of the visit is described as being very clear and she does not recall seeing any concerning home conditions. She accessed the kitchen to wash her hands and can recall that the back door was open leading into the garden. She has described the kitchen as untidy, and there were about two days worth of dirty dishes.

On 5th July 2018, at midday, health visitor C attended the family home for a primary birth contact. The contact was made after a failed contact at 1040 hours, which was followed up by a telephone call to John. He explained that the family had been asleep. Health visitor C completed the primary birth contact in line with the relevant procedures[13]. The health visitor could not remember if she had the details of the antenatal contact made by health visitor B on 30th April 2018. During the contact both Jane and Emily were present. Child L was seen in her moses basket. Emily was reported by Jane to be asleep upstairs and she woke and came downstairs during the contact. Emily had a full nappy and was not dressed. The health visitor described the day as hot, and was not concerned about Emily being undressed or the full nappy as she had been sleeping. The assessment for safe sleeping with Child L was conducted upstairs and health visitor C noted that Emily's room contained a mattress on the floor. The mattress was stripped of bed linen, despite the fact that Emily had been asleep. Clothes were on the bedroom floor in Emily's room. Jane explained that she was buying a new bed frame and that was why the mattress was on the floor. The home was described by health visitor C as 'cluttered'. There was food debris on the floor underneath Emily's feeding chair. A cigarette lighter was observed on the floor. Jane stated she had not had time to tidy up, as she had been sleeping. A used feeding bottle was noted and health visitor C advised on the safe use of feeding bottles. There was evidence of smoking in the home and health visitor C addressed

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3881126/

[13] Standard Operating Procedures (SOP) for Healthy Child Programme Universal Service offer

this with Jane. It was noted that a safety barrier was in place to prevent entry into the kitchen and the bathroom. It does not appear that John was present.

A further home visit was conducted by a CMW on 5th July 2018. The records are brief, and there is no mention of the home conditions or siblings. Of note is the fact that the health visitor had visited earlier that day. The CMW has been spoken to as part of the review by the DGNHSFT IMR author and has provided further detail. She can recall that it was a very hot day and that Emily was asleep upstairs. Jane spoke with the CMW from an upstairs window, and then took about ten minutes to come downstairs and open the front door. She had both children in her arms and they sat in the living room. The room was dark as the blind was lowered. The room is described as minimally furnished, and the available furniture was 'cluttered together'. The CMW was shown the photographs taken by the Police following the death of Child L, and has stated that the clutter did not reflect the images shown in the photographs. She did not consider the room to be dirty. She did not access the kitchen as she used hand gel and didn't need to clean her hands, and she did not access the bedrooms. Child L was examined from top to toe and both Jane and Child L were discharged from maternity care.

The following day, 6th July 2018, health visitor C made a telephone call to Jane to reiterate home safety in respect of the cigarette lighter she has observed on the floor. During interview for the purpose of the SCR by the IMR author, the health visitor stated that she had reflected overnight and felt she needed to reinforce the risks and ensure that Jane took action.

On 7th July 2018 Child L's hearing test was completed at Russells Hall Hospital.

On 7th August 2018 health visitor C attended the family home for the 6-week assessment. There was no reply. A calling card was left and telephone contact was attempted, but there was no reply. A letter was sent to rearrange the visit.

On 16th August 2018 health visitor C had a home contact for the 6-week assessment. Present were Jane, John, Emily and Child L. Parents stated that they had the wrong date for the previous contact, as they were expecting a visit on 6th August 2018. It is recorded that health visitor C apologised, although it is not clear from the records which party had made the mistake. It is reported that Emily was happy and smiling and appropriately dressed and that Jane had good interaction with Child L. She had a small lump to the side of her neck and parents were advised to consult with the GP. Jane stated that there was no evidence of low mood. The home was described as cluttered but tidier than the previous contact on 5th July 2018. During interview the health visitor stated that she was in the living room for the contact and there was no evidence of food on the floor. Parents stated that they attended play group with Emily and they were invited to attend the health visiting clinic.

Child L died on 3rd September 2018, 17 days later.

6. Analysis

6.1 How effective were the professionals involved with the family in assessing the home conditions and parenting ability, and taking appropriate action.

6.1.1 The family received Universal Services, which are the services provided to all children, young people, and their families. None of the professionals referred to in this report considered completing a Graded Care Profile 2 (GCP2)[14], a Multi-Agency Referral Form (MARF), or offering Early Help in this case. At the time of Child L's birth Emily was just 20 months old and, given that she was premature at 31 weeks gestation, would have been significantly dependent on her parents. Early Help is taking action early and as soon as possible in order to provide support where problems are emerging for children, young people and their families, or with a population most at risk of developing problems.

The GCP2 has been promoted widely within Dudley since 2016 following a number of cases in which neglect was a feature. However, in this case none of the professionals have documented that they considered neglect was a feature, and anecdotally[15] it does not appear that it was utilised very frequently. There is also no documented evidence that a Multi-Agency Referral Form (MARF) was considered, due to the concerns raised regarding parenting ability, financial circumstances and sub optimal home conditions, at any point during the scoping period. GCP2 is triangulated with Dudley's neglect strategy. A number of practitioners have completed GCP2 train the trainer training and training for frontline staff is offered via the DSCB on a regular basis.

Training on the GCP2 is available for all midwives and health visitors and would give guidance through assessment of evidence of neglect at home. It was not utilised in respect of any of the visits conducted to the family home. If it had been, it would have indicated the requirement to submit a MARF.

6.1.2 Currently there is an antenatal home visit conducted by health visiting services in the second trimester of pregnancy. There is no procedure for antenatal midwifery services to conduct a home visit in place at present. Some visits may take place on an adhoc basis. It would be good practise for midwifery services to perform a routine antenatal home visit. Parents may be more at ease in their own environment as opposed to a clinical surrounding, and will be more likely to engage and disclose to a midwife when there is engagement for a length of time. Professionals are able to assess home conditions and ensure preparations are made for the new born. Any concerns could be raised and discussed with the health visitors, who do conduct an antenatal home visit. Monthly meetings take place between the health visiting team and the midwifery team and consideration could be given to conducting a joint visit in certain cases.

6.1.3 The antenatal contact with DGNHSFT was a good opportunity to assess the level of health visiting support the family were likely to need, and to review the previous history. This

[14] The GCP2 is a widely used assessment tool designed to help professionals identify when a child is at risk of neglect. It assists professionals to measure the quality of care being given to a child in respect of physical care, safety, love and esteem on a graded descriptive scale, and is designed to give a representative overview of the current level of care. The grades are based on observations and good quality evidence gathered.

[15] IMR authors meeting 09/10/2019

would have indicated they were going to need more support than Universal Services. There was a history of paternal drug use, maternal low mood, financial difficulties, a cluttered home environment and an older sibling being cared for by a relative.

6.1.4 No health visitor antenatal visit took place in respect of Emily because she was born 9 weeks prematurely. However, Emily was in the NNU at the time the primary birth contact was due and the health visitor completed a home contact prior to her discharge home, on 7th November 2016. It is probable that only Jane was present, as there no reference to John. This was good practice and meant that the health visitor could make an assessment before the discharge from the NNU. The health visitor identified cluttered and unhygienic home conditions and discussed them with Jane, arranged a follow up contact and a joint visit with a neonatal nurse. It was noted that home conditions improved before the discharge home was agreed for Emily. The maternal grandmother had gifted baby equipment to the family.

6.1.5 A joint visit took place on 29th November 2016, where both parents were present. The GCP2 was promoted widely in the borough at this time. Jane consented to a referral to the Children's Centre. A Children's Centre, sometimes called a Sure Start Centre, is a place where parents, carers or families with children under 5 years old can go and use play facilities, join in groups and receive support. Of note is the fact that there was no consideration of the living arrangements for Beth, the older sibling, despite the fact that it was presumed that she lived with the family. She was not to taken into consideration again until after the death of Child L.

A number of concerns had been highlighted, including home conditions, financial concerns, and infrequent visits to Emily. Emily was also a premature baby, and it was assumed that there was a 7 year old sibling residing in the premises. Of note is the fact that Jane had been tearful when clutter was discussed on 7th November 2016. It was an omission by the health visiting team and the NNU staff to make a referral to social services at this point, and enable an Early Help Assessment to be offered and considered.

6.1.6 Further home visits took place on 13th December 2016, by health visitor A, and 4th April 2017, by community nursery nurse A. Both parents were present. In respect of the first visit, whilst it is highlighted that there was good delivery of the SOP, particularly in relation to safe sleeping and smoking, there was no follow up of the referral to the Children's Centre, or discussion around the family finances, apart from a reference to food banks. There is still a reference to clutter.

Whilst it appears that the family were coping, the impression is that they would have benefitted from further support, and the offer of Early Help should have been made. A MARF should have been submitted,

In respect of the second visit, the focus is primarily on the development of Emily, which was positive. However, two dietician appointments had been missed and there appears to be no urgency on the part of parents to rebook.

6.1.7 An antenatal visit for Child L was undertaken by health visitor B on 30th April 2018, where it is reported that the property was cluttered and that the parents were smokers. There was an awareness of paternal cannabis use, and dirty sofas and carpets. The property is described as cluttered but 'minimally acceptable'. Bearing in mind the visit was anticipated, and some attempt could have been made to improve the premises, this description is concerning. To have not made a referral to the Multi Agency Safeguarding Hub (MASH) was not acceptable.

It is not clear whether both parents were present. Referrals had also been made to the Children's Centre, but were declined, and there had been signposting to a playgroup and some community charitable services. The fact that parents did not appear to be engaging with additional support which was available should have been an additional factor.

Taking into consideration the information already known about the family and the home conditions, a referral should have been made to social services at this point. If the home was minimally acceptable, the family were unlikely to be in a position to improve it with the additional responsibility of a new baby. Mother had also asked about food banks, so there was unlikely to be additional financial support. There was a pattern of missed appointments developing, which would suggest they were struggling to meet the demands of caring for Emily, which was not likely to improve with the arrival of a new baby. Both parents were smokers, and had declined the offer of cessation support on a number of occasions. Use of the GCP2 tool would have made it clear to health visitor B that a referral was required.

6.1.8 Three visits were undertaken by the CMWs to the home address on 27th June 2018, 1st July 2018, and 5th July 2018, following the birth of Child L. Three different CMWs attended. The purpose of the visits was to check on the progress of Child L and Jane. However, there is an expectation, as professionals with safeguarding training, that they should be professionally knowledgeable regarding the home conditions, particularly with what was known about the conditions following the birth of Child L. There is no reference made to home conditions in the records. The CMWs have been spoken to as part of the review process by the DGNHSFT IMR author and confirmed that only the position of the moses basket, the living room and the kitchen would have been accessed. Clutter and dirty dishes were noted, however not to the extent recorded in the Police photographs. All of the midwifery staff involved had received their level 3 safeguarding children training and were knowledgeable in safeguarding risk assessment and referral processes However, the DGNHSFT report author has identified a potential gap in training in respect of professional knowledge regarding what is a safe home environment.

6.1.9 Health visitor C also undertook a new-birth visit to the family home on 5th July 2018. It appears that only Jane, Emily and Child L were present. Again, it would appear that there was no reply on initial attendance, and the visit was rearranged for later that day. It is not possible to ascertain whether Jane made an attempt to improve the home conditions. It was reported that the house was cluttered and there was food on the floor. A telephone call was made to Jane the following day as a lighter had been found on the floor. There was no bed frame for Emily and Child L said that she was buying a new bed, but there is no evidence of a follow up to ensure that a bed had been obtained. The bed did not have bed linen and the child was observed to have woken from sleep, with a full nappy, so the indicators were that, on this occasion, she was sleeping on a mattress without a cover. This was a potential sign of neglect that should have resulted in a referral to social services. If the GCP2 had been completed then this would have confirmed that it was required.

6.1.10 During the home visit undertaken on 16th August 2018 both parents were present, and it is documented that parents stated they had expected a visit on 6th August 2018. The house was reportedly 'still cluttered but appeared cleaner'. The fact that the parents had been expecting a visit earlier in the month could have provided them with an opportunity to improve the usual conditions, but this is supposition.

6.1.11 The GCP2 was not used at any of the contacts with the family, by either the CMWs or the health visitors. It is reported that one health visitor stated when interviewed that they did not consider the home conditions to be any worse than other premises they visited in the area[16]. The GCP2 tool would have provided an indication that the family should have been offered Early Help. Opportunistic contacts were not considered which may have given more information about the daily living activities, and signs of neglect, such as the lack of a bed, were not always followed up after they were identified. The BCPNHST report stated that health visitors said that the GPC2 was not easy to use without electronic access, however the report author said that there was no evidence of this being the case[17].

Initial contact failed for the visits in July and August 2018, and were rearranged for later that day. There is also an indication that, when John was present for the visits, there is evidence of disguised compliance. For example, only Jane was present for the visit on 7th November 2016 and she became tearful when discussing the home conditions. In July 2018 she attempted to explain the clutter by saying that she was tired and had been sleeping, and that she had been caught unawares.

Community referrals were made to the Children's Centre to a Family Support Worker and to local charitable groups for food and gift funding. The referrals were appropriate but lacked follow up to establish if the family were accessing the support, and if not, why not?

6.1.12 It was noted during initial contacts that the family had with the health visiting team that maternal grandmother, Ann, was a 'very big support' for them, and it is documented that she helped financially. In respect of the antenatal and post-natal contacts for Child L, there is no mention of her role and, importantly, whether she was still providing support. This is a factor which should have been considered when ascertaining the parents' ability to care for Emily and Child L, bearing in mind a second child would presumably require additional support.

6.1.13 The health visiting team and the CMWs were all up to date with their mandatory safeguarding children training. Staffing levels have been identified as appropriate throughout the scoping period.

6.1.14 There is no indication within the GP records that the family's home was visited during the scoping period by any members of staff from the practice. There is no information to suggest that an Early Help Assessment, MARF or GCP2 should have been considered during either of the pregnancies for Child L and Emily. Whilst Jane attended for antenatal appointments at the GP practice with the community midwife, there is no reference to poor home conditions in the antenatal recordings within primary care.

6.1.15 Reports of the home visits refer to clutter. The NHS advice[18] in respect of clutter relates to hoarding and identifies it as a problem when

- the amount of clutter interferes with everyday living – for example, the person is unable to use their kitchen or bathroom and cannot access rooms

[16] BCPNHST IMR
[17] Minutes of SCR panel 07/11/2019
[18] www.nhs.uk/conditions/hoarding-disorder

- the clutter is causing significant distress or negatively affecting the quality of life of the person or their family

The Clutter Image Rating Scale (CIRS) is a tool aimed at assisting professionals in identifying the impact hoarding, and the resulting clutter, can have on a person and their family. There is no indication that the home conditions were as a result of either Jane or John hoarding items, however the tool could have been used to assist professionals in identifying how the clutter was contributing to the general neglectful conditions.

6.2 What enquiries were made to identify the sleeping arrangements, particularly as it was assumed that three children were residing in the premises?

6.2.1 Co-sleeping has been identified as a feature in a number of child deaths in the borough and the Dudley Child Death Overview Panel (CDOP) have supported the development of campaigns and leaflets to raise the risks of co-sleeping with parents. Safe sleeping practices are discussed with parents by the CMW and the health visitor in the antenatal and postnatal periods. This was recorded within the Health Visitor records for all of the home visits undertaken, in line with SOP. The parents were clearly aware that Child L should have been sleeping in the moses basket, as they maintained that they had put her to sleep in the basket until they were presented with medical evidence to the contrary.

6.2.2 Good practice was noted in identifying that the premises were unsuitable for a new born on 7th November 2016. During the second visit on 29th November 2016, a new cot for Emily was observed. It was good practice to arrange for the parents to stay in the ward flat with Emily the night before her discharge. There is also reference to noting the temperatures of the rooms during the visits on 29th November 2016 and 13th December 2016, and noting attempts to make sure this was remedied. On 13th December 2016, it is recorded that Emily was in a moses basket. On 4th April 2017 it is recorded that Emily was in a cot. Community nursery nurse 1 discussed safe sleeping at the 9 -12 month review with Emily. It was discussed during the first home visit by the CMW on 27th June 2018.

6.2.3 There is no record of it being discussed during the antenatal visit conducted by health visitor B on 30th April 2018, where the house was described as minimally acceptable, and there is no reference to where Emily was sleeping.

6.2.4 Following the home visit on 5th July 2018 by health visitor C, it is recorded that Jane had been sleeping downstairs as they had had a bad night sleep. Emily had been asleep upstairs, but it is recorded that there was no bedding on her mattress as Jane said that it had been removed for washing. Safe sleeping was discussed. Child L was in a moses basket.

6.2.5 It is clear that safe sleeping was discussed with the family. However, the fact that Emily had been sleeping on a mattress without bedding was not discussed further and should have been checked at the following visit on 16th August 2018. There is no reference to safe sleeping being discussed at this visit in the record of the visit. No mention is made of the parents sleeping arrangements and the bedrooms in general. This can often provide a clearer indication of where family members are sleeping and ensure there is no disguised compliance when speaking with professionals. No mention is made of considering where Beth was sleeping during any of the visits, despite the fact that an assumption had been made that she

was living with the family in November 2016 when Emily was born and that the house only had two bedrooms.

6.3 Professional Curiosity around Beth living with maternal Grandmother, Ann.

6.3.1 Following the death of Child L, it was identified that Jane left Ann's home, when Beth was 5 months old, to live with John. Beth remained with Ann. The reason for this has not been identified in any of the records examined for the purpose of this review. Within the GP records from this time there is no reference to the fact that the child no longer lived with her mother. This may be due to the fact that professionals were unaware despite maternal grandmother being awarded a residence order in 2012. There appears to have been a lack of professional curiosity around the reason for Beth remaining with Ann. It was not explored by professionals during the scoping period. In subsequent pregnancies, the pregnancy with Beth is recorded but there is no indication within the GP records that Beth's place of residence was questioned.

6.3.2 It is recorded within the maternity records initially that Emily was Jane's first pregnancy. However, records later indicate that she was seen visiting the ward when Emily was born, and professionals were aware of her.

6.3.3 Little was known about Beth and she remained invisible to the health visiting team. There was no recognition that she was living outside of the family home because questions were not asked at contacts about her, other than her name and her school at the postnatal contact on 7th November 2016. Her address is not recorded in the health visitor records. A comment by Jane that Beth wanted her younger sibling home led health visitor A to make the assumption that she lived in the family home. There is no record of questions being asked about Beth's health or well-being during any of the contacts for Child L and Emily. She would have not been expected to be present during the contacts as they were usually daytime contacts during term time. There is a clearer picture in the records for Child L about Emily, and her appearance and behaviour were commented on during professional contacts for Child L.

6.3.4 The fact that there was so little professional curiosity is respect of Beth is of considerable concern. It was presumed that she lived with the family at the first contact in November 2016, however she is never referred to again. Bearing in mind the other concerns identified, which should have resulted in a referral to social services, consideration should have been given to the living experience of the other child believed to living in the premises and any safeguarding considerations relevant to them. It is surprising that none of the professionals entering the premises identified the fact that there were no belongings attributable to a child of primary school age, particularly in relation to attendance at primary school. Advice was given in respect of safe sleeping, however there is no reference to where Beth was sleeping.

6.3.5 If it had been identified that Child L had an older sibling not residing with the family, further scrutiny should have taken place to ascertain the reasons why. This may have identified safeguarding concerns relevant to Emily and Child L.

6.4 What was known regarding maternal and paternal mental health and their substance misuse?

6.4.1 John's GP records provide information around potential family safeguarding concerns in relation to substance misuse. It is clear from the notes that in 2009 he was receiving medication for depression and anxiety. He had searched the internet regarding his symptoms of dry skin and teeth problems and believed that he was suffering from a genetic disorder involving defects of the hair, nails, teeth and skin (a diagnosis was later confirmed). In February 2009 it was indicated that he had moderately severe depression. At this consultation he admitted to smoking cannabis. It is documented that he had previously used heroin and crack cocaine but that he had stopped; however, he reported that he was estranged from his family because of drug misuse. He also informed the GP that he had anger issues, had been physically violent towards people and had previously been a problematic alcohol user. He stated that he had recently been released from prison following a drink driving charge. In July 2009 he attended the GP practice whilst on a community service order, as he had missed a session due to his skin problems.

In October 2012 he attended the GP practice complaining of low back pain and reported that he smoked cannabis as he found it less sedating than analgesia. There is a letter dated 29th November 2012 from the GP stating that John had been charged with cultivating cannabis and was using it due to chronic back pain. However, there would be no reason for the midwifery team to check the medical records of John unless safeguarding concerns had been identified within the records of Jane. It would be difficult to justify accessing medical records if there were no specific family safeguarding concerns. This can be problematic as a holistic picture of the family is not always possible.

6.4.2 There is no reference within Jane's medical records that there were concerns regarding her mental health or substance abuse. There is reference to her being tearful during the visit on 7th November 2016 following the birth of Emily. There is no evidence in the records of this being signposted to the GP or acknowledged as a risk after the birth of Child L. It is recorded that she was asked about substance misuse appropriately throughout her antenatal checks, but did not disclose any misuse.

6.4.3 Whilst parental substance misuse does not automatically indicate child abuse or neglect, it can have an impact on children in a number of ways, which includes impairment on the development of an unborn child. A parent's practical caring skills may be diminished by substance misuse and withdrawal from substance misuse may give rise to mental states or behaviour that put children at risk of injury, psychological or emotional distress or neglect. Children of parents experiencing withdrawal are known to be at increased risk of significant harm[19]. Substance misusing parents may find it difficult to prioritise the needs of the children over their own and money available to the household to meet basic needs may be reduced. Children may be at risk of physical harm, or death, if drugs and drugs paraphernalia are not stored safely and children have access to them.

6.4.4 In this case the parents admitted to police following the death of Child L that they had used drugs and alcohol the night before and, during the home visit, drug paraphernalia and a cannabis plant was found in the house. This would suggest that the parent's substance misuse was regular and that the children were at risk of significant harm, especially in light of what

[19] Altobelli & Payne, 2014

was known about John's previous misuse. However, at the time of Child L's death, professionals were not aware of the substance misuse because the parents had not disclosed it and there is no information to suggest that professionals could have been aware of it as part of their observations within the home. A reference was made to historic paternal cannabis use within the health visiting record in respect of the visit on 30th April 2018, which was the antenatal visit for Child L. The home conditions were described as 'minimally acceptable' on this visit, and therefore the paternal cannabis use should have been considered further as information relevant in considering a referral to Social Services.

6.5 The financial circumstances of the Family

6.5.1 It was good practice by the NNU staff to identify that there were financial concerns when Emily was on the NNU. However, there is no evidence of an in-depth discussion with Ann, maternal grandmother, when it was reported that she purchased 'all the shopping 'and that Jane had attended hospital with plastic bags over her feet. It was identified that Ann provided a lot of support to the family following the home contacts after the birth of Emily. This could have been explored further. Parents had also agreed to accept a food hamper prior to Christmas 2016.

6.5.2 Requests for financial assistance were made by Jane in January 2018, when she enquired about food vouchers, and this was not adequately explored to obtain a clear picture of how this impacted on the children. They may not have had enough food at that time and this should have been established immediately. Jane was pregnant, Beth was understood to be residing in the house, and Emily was only a year old. There were delays in contacting Jane after the request for financial assistance and it was not understood how the lack of food affected the daily experience of the children. An inappropriate judgement was made by the community nursery nurse that the request for food vouchers could not be discussed with John, and greater oversight from the health visitor was needed to examine why this conclusion was reached. Consequently, it does not appear that the vouchers were issued.

6.5.3 There is no mention of Ann after the birth of Emily. A theme throughout the contacts following her birth was the support, particularly financial, which she provided. It is unlikely that the financial circumstances of the family had improved, particularly in light of the request for food vouchers in January 2018, and the prospect of a second baby. This is something which should have been explored further to ascertain if her support was still available to the family.

6.5.4 The request for food vouchers was made by Jane, and it does not appear that John was present. The community nursery nurse did not feel able to discuss the matter with him when he answered the telephone. It may be that he did not feel comfortable asking for financial support, and this may have extended to him exerting control over Jane in this respect. However, this is supposition, and there is no evidence of further controlling behaviour. If the reasons behind Beth residing with grandmother had been explored, further information may have been available.

6.6 How effective was the information sharing between the three agencies?

6.6.1 The report provided by BCPNHST identifies that there was evidence of good links between the health visiting service and the midwife and the neonatal nurse. A health visitor

in the team liaised regularly with the community midwife and this helped the service to identify the population requiring an antenatal contact. This has now extended to monthly meetings between the two agencies There is no record of any enquiries with the GP Practice to discuss the family and consideration of a Multi-Discipline Team meeting.

6.6.2 There is evidence of good information sharing between the NNU and health visitor A, which resulted in the joint visit to the home prior to the discharge of Emily in November 2016. However, on July 5th 2018, both the CMW and Health Visitor C attended the household on the same day, but separately.

6.6.3 According to the BCPNHST IMR the Protocol for Antenatal Contact (2018) was followed by the health visiting service with a contact with Jane and John prior to the birth of Child L. There was communication between the midwifery and the health visiting service prior to the contact. The midwife notified the health visitor that, in their professional opinion, the family required universal health visiting services. Health visitor B did not access the health visiting records for Emily and was not aware of the previous health assessments.

6.6.4 However at the time of the death, professionals did not appear to be aware of the substance misuse despite a reference to cannabis use within the antenatal health visiting records. There is no evidence within the GP records that this had been discussed with the midwife or health visitors.

6.6.5 The health visitors all stated at interview that the systems for records storage changed periodically and they found it confusing. The records system was based on the division of records alphabetically, and by surname, which could mean that family members' records were stored separately. However, it is reported that the records are stored in close proximity and this is not a barrier to checking all family members.

6.6.6 There is no indication in the health records that the family were discussed with a GP at the point where the community nursery nurse was having difficulty re assessing Emily's gross motor development, during March 2017. The procedures indicate that a failed contact after 2 attempts is escalated to the health visitor and then further attempts are made by engaging other partner agencies. During this period, there were also failures by parents to take Emily to her dietician appointment, and subsequently rearrange it.

6.7 How effective was the safeguarding supervision

6.7.1 At the time of Child L's birth community midwives were not receiving safeguarding supervision. They are now receiving formal supervision every three months, with any immediate concerns being escalated in the interim.

6.7.2 The health visitors had a meeting with their team leader every 6-8 weeks to discuss families of concern. One health visitor was newly qualified and had increased access to meetings with the team leader and some supervised support during visits. The health visitors showed awareness of the signs of neglect but also appeared to view the family circumstances as similar to the majority of their caseload, and without safeguarding supervision were less likely to reflect on this narrative and assess individual circumstances.

Child Protection Supervision Standard Operating Procedure (2016)[20] encourage practitioners to have safeguarding supervision following a child being subject to a Child Protection Plan and to access supervision for other concerns as they required support. Safeguarding Supervision was not mandatory and the health visiting team did not access supervision for Child L and her siblings. The team leader confirmed having regular meetings with the team members every 6-8 weeks and encouraging them to discuss concerns and challenges. A newly qualified health visitor did not have child protection cases initially, and then was supervised by the team leader. The team leader offered a system of one to one's to identify challenges for the practitioners.

Safeguarding Supervision was not mandatory and was not accessed for this family, or for practitioner support.

6.7.3 Management of Was not Brought Appointments Standard Operating Procedure (2018)[21] relates to professional decisions when health visiting appointments are not kept. A delay in making contact with the family to review Emily's gross motor development was noted in the health records, when no response was received to a letter making arrangements. The community nursery nurse attempted to make contact but did not escalate to the health visitor when contact was not successful. There was an opportunity to discuss gross motor development during a clinic visit but it was not addressed by the community nursery nurse because financial concerns were raised by Jane. A referral back to the health visitor was appropriate at the first indication of a delay. There was also a dietician appointment which was missed, and a failure to rearrange this by the parents.

7. Conclusions

7.1 Considering the information used to undertake this review, it would appear that there had been very little multi-agency involvement with the family and that it was predominantly the midwifery and health visiting services which had had any recent contact with them. Despite concerns raised regarding home conditions in the antenatal and postnatal period by the health visiting team, and in the postnatal period of Emily by the midwifery team, there was no requirement to discuss this with the GP or document it in the GP records. There was no requirement to consider a referral to social services based on the information that the GP service were aware of.

7.2 At various interventions with the family, a referral by way of a Multi-Agency Referral Form (MARF) should have been submitted in respect the family as early as the NNU staff identifying financial concerns and the post-natal joint visit in November 2016. It should also have been completed following a number of other contacts prior to the death of Child L. The description of the home conditions as 'minimally acceptable' indicates that they clearly weren't. Completion of the GCP2 tool during 2017 and 2018, when it became widely used across Dudley borough following other SCRs, would have indicated the necessity to refer in respect of the home conditions. The CIRS tool could have been used to provide an additional indication.

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[20]BCPNHST Standard Operating Procedure 7 (SOP 7)
[21] BCPNHST Standard Operating Procedure 9 (SOP 9)

7.3 The report has established that Beth, the older child of Jane, had resided with her maternal grandmother, Ann, since birth. There was no professional curiosity in respect of the circumstances of this arrangement, despite a Residency Order being in place since 2012. She became invisible and no consideration was given to her at any point after Emily left the NNU. If the reason for this arrangement had been explored further, it may have identified concerns in respect of the parenting ability of Jane and John.

7.4 There is no evidence of consideration throughout the scoping period in respect of the experiences of Beth and Emily of living within the household, and how the parenting abilities of Jane and John were impacting upon them. Beth is not referred to again by professionals after the birth of Emily. Appointments were not attended and not rebooked in respect of Emily. This is of particular concern as she was born 9 weeks prematurely. There is no indication that consideration was given to how the birth of a new sibling would affect the living experience of Beth and Emily, despite the home environment already being 'minimally acceptable'. Jane declined offers of smoking cessation, despite the fact that both Emily and Child L were IUGR. The sleeping arrangements and the financial circumstances were not properly explored. As co-sleeping was identified as a factor in the death of Child L by the pathologist, this was of particular relevance. The lack of consideration of the living experiences contributed to the failure to make a referral to social services.

7.5 There is evidence of disguised compliance on behalf of both parents. The home conditions were improved following the initial visit by health visitor A. There are a number of occasions when the home contacts failed at the first attempt, which could have provided John and Jane with an opportunity to improve the conditions. On two of the occasions when Jane has been on her own with professionals, she expressed concern about the home conditions and their finances. This could be interpreted as an indication that John exerted a controlling influence within the relationship, and likewise to professionals. The community nurse did not feel comfortable exploring the request for food vouchers, and a health visitor apologised for confusion over the timing of a visit.

7.6 Throughout the scoping period, John and Jane did not disclose alcohol and substance misuse to any professionals. They consistently denied abuse when asked, and there is no documented physical evidence of it within the reports. They were asked about it in accordance with procedures. However, there was an indication of historical misuse by John which was known by the health visiting team. Jane chose to reside with John in preference to her daughter, albeit this is supposition. Both Jane and John confirmed that they had consumed alcohol and used drugs during the period immediately before Child L's death, and it was considered a contributory factor by the pathologist. The historical substance misuse in respect of John should have been taken into consideration when determining that a referral should have been made to social services.

7.7 There seems to be a theme of each contact being viewed in isolation. Concerns around the home environment were identified prior to the discharge of Emily. The environment was described as 'minimally acceptable' at the antenatal visit for Child L, and Health Visitor C felt the need to make contact following the post-natal visit to address a particular concern. By not looking back at historical information, and recurring patterns of behaviour, there was not the opportunity for a full appreciation of the risks of neglect. The perceived difficulties accessing records prior to a contact with the family may have contributed to the trend of not reviewing the information and therefore not fully understanding the risks.

7.8 There is evidence that the risks presented by the home circumstances and the failure of the parents to prioritise the needs of the children were not appreciated by the professionals engaging with the family. Health visitors refer to the circumstances being prevalent in a number of the households they visit. The CMWs made no reference to the home conditions when they visited postnatally. Training and Supervision should challenge the risks of 'normalising' families living in poverty. Professional curiosity and disguised compliance need to be embedded into practice through the staff accessing and receiving regular safeguarding updates and training, and regular monitoring and auditing by supervisors and managers.

7.9 The review found no issues around culture, religious identity or disability of the children and family identified within the records. The family were of White British extraction with no reported disabilities or particular cultural issues.

8. Recommendations

8.1 Recommendations – Single Agency

Each agency has identified single agency recommendations following completion of single agency incident management reports.

8.2 Recommendations – Multi Agency

- The Dudley Safeguarding People Partnership (DSPP) should ensure the GCP2 tool is utilised in every case where concerns are raised regarding home conditions and potential neglect. It should also ensure that the CIRC is utilised where clutter is identified as a factor. Cases should be audited to ensure compliance.

- The DSPP should review multi-agency training to ensure that training in respect of neglect includes professional curiosity, disguised parental compliance, and the avoidance of normalising poor conditions is embedded.

- DSPP to encourage BCPNHSFT and DGNHSFT to consider the feasibility of conducting the antenatal and postnatal visit jointly, especially in cases where safeguarding concerns are observed.

- The authors of the single agency reports have produced thorough and reflective reports which have incorporated relevant single agency recommendations, some of which have already been put into practise. The DSPP should monitor and ensure that these are completed.