Dudley Safeguarding People Partnership

Serious Case Review

Child: CHILD A

23rd June 2019

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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 case 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. CSPRs have replaced Serious Cases Reviews, Working Together 2015.

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 cases 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 Joint Agency Meeting (JAR), which is a multi-agency meeting which takes place immediately after a child dies or is seriously harmed, 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 determined 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 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 and still working under the 2015 arrangements, a SCR has been undertaken.

1.6 From the scoping information there were emerging concerns about how the agencies had shared information and worked together to ensure that Child A's parents were adequately supported in being equipped to care for Child A. Child A's mother is a care leaver and had disclosed that she was concerned about her cannabis usage. His father was also known to use cannabis. His mother moved from Sandwell Borough to reside independently in Dudley Borough whilst she was pregnant. A referral made by Sandwell Children's Trust (SCT) to Dudley Childrens Social Care (DCSC) was sent to an e mail account which was no longer in use, and therefore the e mail was not viewed. There were concerns that both parents were using cannabis whilst they visited Child A on the neo natal unit (NNU). They were also observed to be co-sleeping with Child A when they spent a night in the neo natal flat prior to his discharge.

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 (Appendix C), the agencies involved and the scoping period.

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

Four agencies have been identified as having contact with Child A's mother and her family during the period of the review –

Dudley Clinical Commissioning Group (CCG) – GP services

Dudley Group NHS Foundation Trust (DGNHSFT) – midwifery and neonatal

Sandwell Childrens Trust and Care Leavers Team (SCT) – supporting young adults leaving care.

Sandwell and West Birmingham NHS Trust (SWBNHST)– providing antenatal care

Individual Management Reports (IMR) were requested from each of the above agencies. Details of agency contacts were also requested and used to populate a chronolatry document. These documents, together with the information shared at the JAR 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 four IMR authors presented their agencies respective reports, which were subject of discussion and clarification.

2.4 The parents 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 agencies involved.

3. Scoping period

3.1 The scoping period commences in October 2016, which is the period when the mother of Child A would have become a care leaver. This period is necessary in order to understand the support which was provided to her and whether it considered what additional support was required when the pregnancy was reported. It covers the antenatal period and the period which Child A spent on the NNU, in order to identify what support and advice his parents received, and whether this was appropriate and sufficient.

3.2 The scoping period concludes on 23rd June 2019, the day Child A died.

4. Background to the Case Review

4.1 The 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 A – aged under 3 months
Mother of child A - Mother, aged between 18 - 25 years
Father of child A - Father, aged between 18 - 25 years

4.2 Child A lived with his mother and father in a one bedroomed flat. He was born prematurely and spent some time on the NNU prior to being discharged home on Friday 21st June 2019. He died in the early hours of 23rd June 2019. There was another male sleeping on the second sofa in the premises at the time of Child A's death. He has been identified as a friend of Child A's parents. The home address of Child A and his family was visited on the day he died by the Police and the lead nurse for child death. Concern was jointly noted in respect of aspects of the home environment.

4.3 At the JAR meeting, a number of concerns were raised[1];

- Father of child A had attended the NNU smelling of cannabis. His health records indicated that he has been using cannabis since the age of 15.
- It was known that Mother of child A was a cannabis user, and there appeared to be evidence that she was also using cannabis whilst pregnant. Dudley midwives were unaware of the fact as the case was not formally transferred from SWBNHST maternity care. Mother of child A had also smelt of cannabis whilst on the NNU unit.
- Whilst staying in the NNU flat, mother and father were observed to share a bed with Child A and were reminded of the dangers of co-sleeping.
- Mother was a care leaver and was open to the Sandwell leaving care team. She had recently moved from supported accommodation in Sandwell Borough to live independently in Dudley Borough. Her leaving care Placement Advisor (PA) made a referral to Dudley Childrens' Social Care (DCSC), by way of an electronic Multi Agency Referral Form (MARF) in March 2019, reporting that Mother of child A's brother was staying in the property. It was reported that he was possibly dealing drugs. A check on DCSC IT system revealed no evidence of the MARF being reviewed.
- Information regarding Father of child A's cannabis use was not shared with the Specialist Midwives at DGNHSFT, however they were aware that mother had missed her first antenatal appointment at the hospital. As there were no other identified concerns, this was not followed up.
- When Community Midwives are aware of current or historic safeguarding concerns (for example, that mother was a care leaver, or there is a history of maternal mental health issues) a cause for concern form is normally completed and forwarded to the receiving midwife when a mother moves across a borough boundary. This does not appear to have been completed when the Mother of child A moved from Sandwell borough to Dudley borough.
- It did not appear that a referral to the Family Nurse Partnership (FNP) had been considered once the mother moved to Dudley, and there was no antenatal home visit carried out by a health visitor (HV) as Child A was born prematurely.
- There was a history of mental health issues for both the Mother of child A and the Father of child A.

[1] CCG agency feedback report

- There did not appear to have been any communication between SCT and the Dudley Community Midwives (CMW) despite the Mother of child A having a leaving care PA, who had visited her at her new address antenatally.
- The Dudley CMW was asked to conduct a home visit by the NNU staff prior to Child A's discharge from hospital to check home conditions. It is recorded that no concerns were identified, despite the documented concerns following the home visit on 23rd June 2019.
- Following the death of Child A, it was evident that the Father of child A had been co-sleeping with Child A. He was discovered by the Mother of child A, between Father of child A and the side of the sofa[2].
- At the point Child A died there had been an unknown male adult staying at the address whom professionals were not aware of.

4.4 From the information gathered, it was identified that the Mother of child A was a care leaver and was being supported by Sandwell Care Leavers Team. She had reported her pregnancy at the end of November 2018 and had received antenatal care from SWBNHST. There are reports of concerns that her relationship with the Father of child A was controlling. Her cannabis usage was known and she had self-reported concerns in respect of it. In February 2019 she had moved to an independent address, and her antenatal care was transferred to DGNHST.

4.5 Prior to his discharge, Child A had been cared for on the NNU at Russells Hall Hospital. Cannabis usage by both parents was reported, and there were concerns in respect of the frequency and regularity of their visits to Child A.

4.6 In light of the above, a referral was made to SCR panel on 1st July 2019. The SCR panel recommended that a SCR be undertaken, which was subsequently supported by the Independent Chair for the Dudley Local Safeguarding Children Board (LSCB) and the National Review Panel.

5. Summary of Facts

5.1 Child A was found unconscious on the sofa at home on the morning of 23rd June 2019 by the Mother of child A. The Father of child A was also asleep on the sofa. They called Father of child A's parents, who informed the West Midlands Ambulance Service, and an ambulance attended at 0820hrs. Child A was taken to Russells Hall Hospital, however at 0900 hrs it was confirmed that Child A had died.

5.2 When the parents of Child A were spoken to by the Police and the Paediatrician, as part of the multi-agency Sudden Unexplained Death of an Infant (SUDI) protocol[3], they said that the Mother of child A had bottle fed him at around 2330hrs on 22nd June 2019. She changed his nappy, and then handed him to the Father of child A in order that she could sleep. Father of child A stated that he rocked Child A in his arms, and then placed him in his moses basket,

[2] SUDI report – Dr CT
[3] SUDI report 3rd July 2019 Dr CT

where he fell asleep. At around 0130hrs on 23rd June 2019, Child A woke up. He was crying and not settling. Father of child A tried to comfort him for about an hour and then put him back in his moses basket, however Child A did not go back to sleep. Father of child A took him downstairs and continued rocking him in his arms. He did not settle, so Father of child A sat down on the sofa. He put Child A on his chest, with Child A's chest against his chest. He then fell asleep. When the Mother of child A came downstairs at approximately 0800hrs she found the Father of child A asleep on the sofa, however Child A had slipped down the side of the sofa, between the Father of child A and the side of the sofa.

5.3 A post mortem has been completed and the cause of death is inconclusive.

5.4 West Midlands Police have investigated the circumstances leading to the death of Child A, and the role of the parents. Neither parent has been charged or cautioned for any offences and the investigation has now concluded.

5.5 The following periods have been identified as being significant in respect of professional involvement with the family, and references made have been drawn from the agencies IMR's and from the author's briefing event.

- October 2016 – October 2018, which is the period that the Mother of child A was a care leaver and commenced the relationship with the Father of child A.
- November 2018 – April 2019, which is the period of the Mother of child A reporting her pregnancy and moving to reside in independent accommodation in Dudley.
- April 2019 – May 2019, which is the period of antenatal care provided by DGNHST and Mother of child A residing independently.
- May 2019 – June 23rd 2019, which is the period Child A was cared for on the NNU, and arrangements being made for him to be discharged home with his parents, up to the day he died.

5.6 October 2016 to November 2018

5.6.1 The IMR provided by SCT reports that the Mother of child A became a Care Leaver on 31st October 2016. She had been a Looked After Child (LAC) from a very young age and had lived with a family member, who was approved as a Kinship Foster Carer. A Kinship Foster Carer is when a friend or family member becomes an official foster carer for a child. The Care Leavers (England) Regulations 2010 [4] provide a detailed definition of a care leaver, and also directs that the relevant local authority where the child was in care have an ongoing responsibility to provide a pathway of support until they attain the age of 25.

5.6.2 There was evidence of emerging difficulties in the placement with the family member, resulting in a placement breakdown in January 2018. Mother of child A moved into supported living accommodation on the 9th February 2018, having spent a month residing with another family member and a friend. In May 2018 Mother of child A's placement staff reported that she had cannabis in her room. A meeting was held between Mother of child A, her PA and the placement to discuss the concerns and expectations moving forward. However, it is

[4] The Care Leavers (England) Regulations 2010

reported in the SCT IMR that the Mother of child A was not receptive to the concerns. The report outlines that in July 2018 she applied to live at an address in Dudley with the Father of child A. Following this application, staff at the placement recorded concerns that the Father of child A was displaying coercive and controlling behaviour towards her, and that it was believed that both were misusing drugs. A further meeting was held, however the Mother of child A maintained that the reports were inaccurate. In October 2018 the IMR states that staff at the placement reported that she was in a controlling relationship with the Father of child A, and heavily reliant on cannabis. A further meeting was held to discuss the concerns, which she continued to deny. The review has confirmed that the Mother of child A was in breach of the tenancy agreement due to the fact that the Father of child A was staying at the premises. This was interpreted as controlling behaviour by the Father of child A. There has been no further information to suggest that the relationship is coercive or controlling.

5.6.3 The IMR provided by the CCG states that the Father of child A's medical notes state that he reported feeling low and stressed due to issues with a partner, loss of his job, death of family members and debt problems during 2017. He was referred for a mental health primary care gateway assessment, where it was identified that the risks to his mental health could be unpredictable and could escalate when he is under the influence of cannabis. He was advised to self-refer to a substance misuse service, but there is no evidence that he took any action in respect of this advice.

5.7 November 2018 to April 2019

5.7.1 On 29th November 2018 Mother of child A disclosed she was pregnant to her PA. According to her medical records and the CCG IMR, she reported this to her GP on 15th December 2018, when she was 9 weeks gestation.

5.7.2 The IMR report provided by Sandwell and West Birmingham Trust (SWBNHST) indicates that on 22nd January 2019 a maternity referral was received with regard to the pregnancy. A booking appointment was made for 28th January 2019. At this point she was 16 weeks and 2 days pregnant. She disclosed at this appointment that she had been a looked after child, but did not disclose the details of this. However, she did give consent for the Sandwell community midwife (CMW) 1 to contact her PA. There were no other concerns noted at this appointment, however she was referred for consultant led care due to a complex history, noted as known to social services, a smoker and a history of self-harm. There is no mention of consideration being given to referring Mother of child A to the Best Start programme[5]. The Sandwell CMW1 contacted the PA requesting information in respect of Mother of child A on the same day.

[5] The Best Start Programme helps women who are pregnant with their physical and emotional health, as well as those in their first year of motherhood. They receive practical tips on their parenting skills, and advice on how to strengthen relationships with close family and friends, including their baby, which in turn ensures that their child will achieve their full potential. Women taking part will be offered six home visits in the antenatal period and 12 home visits from birth to one year. In certain circumstances the Best Start Programme can continue until the child's second birthday.

5.7.3 On 31st January 2019 it is recorded within SCT records that the Mother of child A informed her placement worker that her brother intended to live with her, and that he was involved with drugs. A Multi Agency Referral Form (MARF) was considered, but not submitted. This was not completed until 29th March 2019. On 6th February 2019 a dating scan was carried out and a health in pregnancy discussion took place. The estimated due date was ascertained to be 13th July 2019.

5.7.4 The SWBNHST IMR states that on 11th February 2019 Sandwell CMW1 and the PA had a telephone conversation. The PA confirmed that the Mother of child A was living in supported accommodation due to a breakdown in the relationship with her foster carer. Concerns had been raised by placement staff regarding the Father of child A being controlling and that Mother of child A smoked cannabis. However, the Mother of child A was receiving support from the workers within her supported accommodation to assist her in ceasing her cannabis use. Mother of child A had stated that she wished to move to Dudley to be nearer her family. The PA reported that she did not have any safeguarding concerns at this point, but that she was going to discuss with her manager to see if a single agency assessment was required. It was agreed that the PA would share any future information with CMW1. Mother of child A failed to attend a clinic appointment, and it was rearranged for 25th February 2019 to coincide with a foetal anomaly scan. On the 12th February 2019, Mother of child A was seen by Sandwell CMW2 for an antenatal follow up. Mother of child A was 18 weeks and 3 days pregnant and it is recorded that no concerns were noted[6]. However, she was not asked about domestic abuse or her cannabis use.

5.7.5 On the 21th February 2019 Sandwell CMW1 and the PA had a telephone conversation. The PA reported that she had been to see the Mother of child A and that she had no concerns. Mother of child A had stated that she had cut down on her cannabis use and that her brother might be moving in with her as he was being evicted on 07th March 2019. It is recorded on the SCT IMR that the PA informed her that if this was to happen then she would be putting her unborn child at risk, as she had said that he was involved with drug dealing, and that a referral would need to be made to Children's' Social Care. She was waiting for the keys to a new property, and the PA was visiting her every other week. The Pathway plan which was completed by the PA states that it was felt that she would benefit from a parenting course, and that this would be discussed with her and she would be supported to attend.

5.7.6 The chronology indicates that the Mother of child A had a routine anomaly scan and antenatal clinic at Russells Hall Hospital on 25th February 2019. It is recorded that she had been a looked after child and had a history of self-harm. However, a referral was not made to the Specialist Midwife for Vulnerable women despite the criteria being met. The scan was incomplete and she was booked for a further viewing.

5.7.7 The Mother of child A moved into her flat on a full-time basis with Father of child A from 28th February 2019 and, despite stating that her brother would not be moving in, she advised her PA on 21st March 2019 that he had moved in on a temporary basis.

5.7.8 The Mother of child A reported abdominal pain on 14th March 2019, and was prescribed antibiotics for a urine infection.

[6] SWBH trust electronic records

5.7.9 The PA and the PA Team Manager completed a MARF in respect of the risk posed to the unborn child by the Mother of Child's A brother moving in with her on 29th March 2019. It was forwarded to an e mail address which was not in use, and therefore it was not reviewed.

5.8 April 2019 to May 2019

5.8.1 On 1st April 2019 the Mother of child A was seen by Dudley CMW1 at her new GP practice in Dudley. It is reported in the SWBNHST IMR that she did not attend her scheduled antenatal appointment on 2nd April 2019 with SWBNHST. However, it was shared by the GP practice that she had moved address to Dudley. Therefore, another appointment was made by Sandwell CMW3 to see her in one weeks' time for routine care. On the 04th April 2019 a clinical note was recorded by Sandwell CMW2 that, following her change of address, Mother of child A had transferred her care to a medical centre in Dudley borough. A new midwife had been appointed and Mother of child A reported that she had been seen by her and another follow up appointment was also in place. CMW2 called the new midwife to update her with Mother of child A's history; however, there was no answer. Details of the new midwife were shared by CMW2 with the PA.

5.8.2 On 5th April 2019 the DGNHSFT IMR reports that the Mother of child A started receiving antenatal care upon her move to Dudley borough. She received Consultant Obstetric led antenatal care due to her social vulnerabilities (she had been a looked after child) and medical history, which included smoking and a history of self-harm. On 29th April 2019 she attended antenatal clinic, at 29 weeks gestation, and the growth scan evidenced severe Inter Uterine Growth Restriction (IUGR), necessitating increased monitoring of the pregnancy. A plan of care was formulated to include more frequent scans. It is recorded within the records that smoking and the impact of her pregnancy was discussed, however she declined referral to the smoking cessation team. There is no record of consideration being given to referring her to the Family Nurse Partnership[7], however it is unlikely that she would have been eligible as she was more than 25 weeks pregnant.

5.9. May 2019 to June 23rd 2019

5.9.1 Regular scans commenced, and on 2nd May 2019, the Mother of child A reported that she had stopped smoking. However, a scan on 13th May 2019 showed that growth of Child A had dropped to well below the 10th centile and the Mother of child A was referred to the smoking cessation team. There is no record of her seeking the support of the team. Her pregnancy was closely monitored and the potential for early delivery was discussed.

5.9.2 She was admitted to hospital on 20th May 2019 and Child A was born shortly afterwards at 32 weeks gestation, weighing 1.180kg, by Caesarean section due to severe IUGR (consistent with a mother who had smoked during pregnancy[8]) and maternal Pregnancy Induced

[7] The FNP Programme is a strength based, intensive, preventative home visiting programme and is offered to first time teenage parents.

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

Hypertension. He was admitted to the NNU. He had mild breathing difficulties and was treated for sepsis.

5.9.3 Visiting to the NNU was consistent and daily by parents between 25th May 2019, following Mother of child A's discharge, and 2nd June 2019.

5.9.4 On 2nd June 2019 the DGNHSFT IMR and the medical records report that nurses had noted that both parents and a friend had poor personal hygiene and smelt of cannabis smoke on their arrival on the ward. They left to visit the hospital shop and, on their return, there was an obvious smell of cannabis. A referral was made to the neonatal outreach team and the CMW. On 3rd June 2019 records show that a home visit was arranged by Dudley CMW 2 to check the home conditions. A telephone call was also made to the health visitor, and it was established that they did not have any records in respect of Child A. A call was also made to Dudley Children's services and it was identified that the Mother of child A had been a looked after child. The home visit was cancelled by the parents, as they stated that would be visiting Child A on the NNU. However, they did not attend until after 1600hrs. They were spoken to by NNU staff and advised about smoking and the risk to Child A, particularly as he was premature and small. It is recorded that they smelt strongly of cannabis, although it is recorded that there was no smell the following day.

5.9.5 On 5th June 2019 the medical records record that staff encouraged the parents to visit more frequently and to be more involved in the care of Child A. The home visit was completed by Dudley CMW 2. The home was described as 'smoky' and cats and a dog were present. However, it was described as safe to discharge a baby home to. Smoking advice was given and a referral to the stop smoking team. On 6th June 2019 the Mother of child A was advised that she needed to increase the frequency of expressing milk if she wanted to continue breast feeding. She was given further encouragement the following day, as only one bottle was brought in. On 8th June the parents were advised that they needed to bring supplies of nappies into the unit for Child A, as they had not provided any for two days. They visited daily for the next three days, although a strong smell of cannabis was noted on 11th June 2019. They did not visit or contact the unit on 12th June 2019 and only visited for 30 minutes on 13th June 2019. Between 14th June and 19th June 2019, they visited Child A every other day, and did not contact the unit by telephone on the days which they did not attend.

5.9.6 They were also spoken to regarding safe sleep and the risks of co-sleeping, as they were observed to have Child A in the bed with them when they stayed overnight in the flat in the unit on 20th June 2019.

5.9.7 At 1500hrs on 21st June 2019, at 36 weeks gestational age, Child A was discharged home with his parents. It is documented within the medical notes that that they were advised regarding the risks of smoking, provided with safe sleeping advice, and the Mother of child A was also given a practical demonstration of resuscitation. Arrangements were made for the community midwife to visit over the weekend. He weighed 1.75kg.

5.9.8 On 23rd June 2016 at 0900hrs Child A died.

6. Analysis

6.1 How effective was the support which was provided to Mother of child A as a care leaver?

6.1.1 The Government's Care Leavers Strategy (2013)[9] recognises that around 10,000 young people leave care in England each year aged between 16-18 years old. They leave home at a younger age and have more abrupt transitions to adulthood than their peers. Unlike their peers who normally remain in the family home, care leavers will often be living independently at age 18. Information from the Children Right's Director's surveys on care leavers[10] and Children in Care Council (CICC) meetings show that many care leavers feel that they leave care too early and often feel isolated and lonely. Research and inspection reports show that the quality of support care leavers receive is patchy and that their journey through the first decade of adult life is often disrupted, unstable and troubled. They often struggle to cope and this can lead to social exclusion, long term unemployment or involvement in crime. The government produce annual statistics in relation to looked after children, which reflect that achievements can be lower than those of children who were not looked after.[11]

6.1.2 The Mother of child A is a care leaver who had experienced around 18 months of instability prior to the birth of Child A. Several concerns had been raised, including anti-social behaviour, domestic abuse and cannabis misuse. The recording on her case file, according to the SCT IMR, is consistent and detailed but the context around some of the concern is missing. The PA was able to explain that anti-social behaviour by the Mother of child A and her visitors refers to her allowing Father of child A to stay overnight at the supported accommodation, which was in breach of her tenancy agreement. It was this issue of concern that led to the PA and Placement supporting her in finding her own accommodation, and reflected her wish to live with the Father of child A.

6.1.3 Mother of child A's lack of compliance with the tenancy agreement raises concern around her future compliance as she moved to independence and becoming a parent. Her cannabis use was known and self-declared. There had also been concern expressed in respect of the controlling and coercive nature of her relationship with Father of child A. She was pregnant. The PA considered Mother of child A to be ready to live independently, but on reflection when interviewed for the IMR, they could appreciate that living independently with a new baby and a partner who had not been assessed and of whom little was known may have been too great a risk.

6.2 What care, support and advice was provided to the parents once the pregnancy was reported, and was this sufficient?

[9] Care Leaver Strategy: A cross-departmental strategy for young people leaving care. October 2013
[10] https://www.childrenscommissioner.gov.uk/wp-content/uploads/2017/06/Care-monitor-v12_1.pdf
[11] https://www.celcis.org/news/news-pages/latest-statistics-looked-after-children-england/

6.2.1 Children looked after and Care Leavers are estimated to be six times more likely to have children in their teenage years, with figures showing around a third of young people and a half of young women had become parents within 18-24 months of leaving care (Rodgers & Carson, 2013). Early pregnancy has also been shown to be associated with greater levels of poverty and unemployment, which likely compound the disadvantages experienced by many Care Leavers already (Knight et al., 2006)[12]. Both teenage motherhood and a presence of childhood abuse in the mother's personal history have been identified as risk factors for the future abuse of one's own children; both of which feature significantly within the Children Looked After population as a whole (Weston 2013)[13].

6.2.2 The Mother of child A disclosed to her PA that she was pregnant in November 2018. The placement staff had already reported concerns in respect of her relationship with the Father of child A, and with her breaching the tenancy arrangement in allowing him to stay. It was known that she used cannabis. However, no referral was made in relation to the unborn child in his own right until the end of March 2019. The Leaving Care Service continued to work with her throughout her pregnancy, and there is evidence of support being provided by her PA. All concerns raised have been responded to. However, the SCT IMR identifies that the support offered was very practically based. There is limited evidence of reflection as to whether the intervention was effective and it did not consider an assessment of risk in respect of the unborn child. Consequently, no formal assessment was completed in respect of Child A's needs and his parents' ability to meet his needs, what support they required or what risk they posed. There is reference to the fact that she would have benefited from a parenting course, but no evidence of this being followed up.

6.2.3 There is limited reference to the Father of child A as the father of Mother of child A's unborn child, and somebody whom she was in a relationship with and subsequently lived with. She had consistently stated that she planned to care for her baby together with him, according to the SCT IMR. Throughout, the focus is on support provided to her, with limited focus on safeguarding Child A, and the role that the baby's father would have.

6.2.4 SCT became aware of the pregnancy in November 2018. According to the SCT IMR, the PA and current Team Manager understood the process and procedure relating to contact, referral and assessment in relation to safeguarding concerns pre-birth. However, they did not follow the procedure because they did not believe the threshold was met. Whilst the threshold for compulsory involvement of social care may have not been met at this point, consideration should have been given to the offer of Early Help.
The couple were well supported by the Father of child A's parents and, subsequently, the Mother of child A's aunt, which was another reason why it was felt that a referral to social

[12] Knight, A., Chase, E. & Aggleton, P. (2006). 'Someone of your own to love': experiences of being looked after as influences on teenage pregnancy. Children & Society, 20, 391-403.
[13] Weston, J. L (2013) Care leavers' experiences of being and becoming parents. Submitted in partial fulfilment of the requirements of the University of Hertfordshire for the degree of Doctor in Clinical Psychology

care was not needed. The PA provided the Mother of child A with details of local Children's Centres providing antenatal support, and it is documented within the SCT IMR that the PA was confident at the time that Mother of child A was ready to move to her own independent accommodation. The PA was clear that the move was not prompted by the pregnancy.

6.2.5 The SCT IMR states that the PA was able to give examples of what would have raised her concerns, and that they considered the strengths and potential areas of concern, and approached their Team Manager for advice. However, the chronology of concern in respect of the Mother of child A's lifestyle and the impact that this could have upon caring for Child A was not sufficiently considered. When the IMR author provided the PA with a summary of the concerns, she was able to reflect and consider that the threshold may have been met for a referral to the Multi Agency Safeguarding Hub (MASH) in relation to the unborn child, or the consideration of Early Help being offered. It is important to point out that the Team Manager at the time would, to a degree, be dependent upon information provided by the PA and other professionals when making decisions. However, the SCT IMR identifies that the view taken presents as over optimistic and there is insufficient evidence of challenge by the Team Manager. Most importantly, there was very limited information in respect of the Father of child A, who was living with Mother of child A, and who would also be caring for Child A.

6.2.6 When interviewed for the purpose of the SCT IMR, the PA stated that they did not complete any formal assessment, but had talked to the Mother of child A about relationships, finances and reducing her drug use. She stated that the Mother of child A was well prepared for the baby and was supported by the Father of child A's parents. However, the IMR author has identified that the Father of child A had not been included in the assessment. The PA confirmed that she did not know him very well and had only met him on one occasion. Prior to the death of Child A, the PA had last visited the property on 17th April 2019, when she went to meet the Mother of child A's brother. She had visited on one previous occasion, which was 1st March 2019. The PA confirmed that, although the Mother of child A had communicated well with her prior to and following the birth of Child A, she was not aware that Child A had been discharged from hospital until she was informed of his death.

6.2.7 The referral to SWBNHST maternity services on 22nd January 2019 was late as the Mother of child A was already 15 weeks and 1 day into the pregnancy at this point. However, it appears there was a delay in the referral being sent by the GP as she appropriately reported her pregnancy to the GP on 15th December 2018.

6.2.8 As a consequence, the antenatal booking was carried out on 28th January 2019, as an urgent appointment, with Sandwell CMW1. This was good practice and within the 2-week timescale for urgent bookers, as per SWBNHST policy. Apart from the social history given by the Mother of child A, the SWBNHST IMR states that there were no other concerns noted. However, all midwives are expected to make a routine enquiry regarding domestic abuse at this appointment. This did not happen, despite her being seen alone. Consent was sought from the Mother of child A by CMW1 to contact the PA with regard to obtaining additional information appertaining to her social history. This demonstrates good practice. A health assessment was completed and the Mother of child A disclosed that she smoked and had self

– harmed previously (2014)[14]. She also disclosed information regarding her foster carer and that she was awaiting housing. The SWBNHST IMR identifies that there was no demonstration of professional curiosity by Sandwell CMW1 to explore why she was in foster care and what had led to the breakdown with the relationship between her and her foster carer. Furthermore, there is no information in relation to the baby's father, and his views and feelings about the pregnancy. The IMR states that the Mother of child A's views, feelings and expectations around the forthcoming birth appear not to have been considered. No consideration was given to completing a referral to the specialist midwives for vulnerable women or to the Best Start programme, which would have provided the Mother of child A with advice and support on becoming a parent.

6.2.9 Sandwell CMW1 contacted Mother of child A's PA the same day and they had a conversation on 11th February 2019. This was prior to a routine antenatal check which was due on 12th February 2019. This was good practice. However, the theme of the conversation is in respect of the Mother of child A and her circumstances in relation to housing, her relationship with the Father of child A, her brother moving in with her and reduction in her cannabis use. It was identified that a referral would need to be submitted in respect of her brother moving in with her, however it does not appear that the safeguarding of her unborn child was identified as a separate risk. The antenatal check on 12th February states that no concerns were noted, despite Sandwell CMW1 being aware of the concerns documented above. There is no reference to an enquiry being made in respect of domestic abuse.

6.2.10 A further conversation took place between the PA and CMW1 on 21st February 2019. Again, this was good practice. The conversation concerned the fact that the Mother of child A's brother intended to move in with her, and that a referral would be submitted to Social Services in Dudley if this was to happen. It is noted that she had said that she was reducing her cannabis use.

6.2.11 The medical records state that a referral was made to the Specialist Midwife for vulnerable women following a routine anomaly scan on 25th February 2019. This was in relation to the fact that Mother of child A had been a looked after child and had self-harmed previously. There is no reference to this again and it does not appear that the referral was actually made.

6.2.12 In April 2019 the antenatal care transferred from SWBNHST to DGNHSFT. She was at 25 weeks gestation. It was good practise for Sandwell CMW2 to try and make contact with the new midwife in Dudley, however it was not attempted again when there was no reply to the phone call. The DGNHSFT IMR confirms that the parents received routine care during the pregnancy. They were not eligible for a referral to the Family Nurse Partnership (FNP) for additional support at this point as the pregnancy was too advanced.[15] The FNP Programme is a strength based, intensive, preventative home visiting programme and is offered to first time teenage parents.

6.2.13 Mother of child A was a smoker and she was offered smoking support on a number of occasions. It is documented within her health records that, although she was made aware of the impact on the pregnancy, smoking cessation support was declined. Once the IUGR was recognised the appropriate care pathway was established and there were frequent scans to

[14] Medical notes reported in the CCG IMR

[15] Family Nurse Partnership Dudley - Voluntary, First Time Parent, resident in Dudley, 19 years or 24 years if CLA, 24 weeks gestation, or up to delivery if concealed

assess the growth. It is important to note that shortly after the care had been transferred, there was considerable concerns in respect of the health of both mother and the unborn child, and this took priority. The fact that child A was born prematurely also reduced the opportunity to provide parenting guidance to the parents antenatally.

6.2.14 Mother of child A was prepared appropriately for early delivery by both obstetric, midwifery and neonatal team. The DGNHSFT IMR states that Child A's weight at birth was in the low birth weight range as expected, however the Apgar scores were good and he was breast fed initially. Child A was transferred to the NNU. The Mother of child A was supported to have early contact with him, and staff recorded the care given as appropriate. There was good initial contact and visiting to the unit by the parents.

6.2.15 Child A is recorded as being jittery in the first 24 hours. Being jittery is a possible sign of Neonatal Abstinence Syndrome[16] however this does not appear to have been followed up. The rationale is that staff checked with the Midwifery team and checked the NHS Spine, neither of which highlighted any concerns.

6.2.16 Parents visiting decreased in frequency when Child A was two weeks old. There is no evidence that a risk assessment or consideration for Early Help was explored.
The concerns about lack of visiting, the Mother of child A having been a child who had been looked after, and the reluctance to accept smoking cessation advice should have triggered a discussion about what support was available to the parents, and whether Early Help was necessary. There is evidence of cannabis misuse in respect of both parents, but a lack of challenge from staff to parents about this. The DGNHSFT IMR author spoke with NNU staff for the purpose of the report and highlighted a perceived lack of understanding of the effect that cannabis use can have on a parent's ability to care for their children. The trust Safeguarding Children policy and safeguarding training highlights the risks to children when parents use illegal substances, giving clear guidance about the use of threshold documents and how to make a referral[17].

6.2.17 The day Child A was discharged from hospital was a Friday. Babies are not usually discharged on a Friday as the NNU do not have the resources to make a home visit over the weekend. Arrangements were made for a CMW to attend on this occasion, and this would have taken place on the day he died. Arrangements have subsequently been made for the NNU to be able to carry out a home visit at the weekend if required.

6.2.18 Crucially, the family did not have any antenatal contact with the health visiting team prior to Child A being born or being discharged. The antenatal contact with the health visiting team provides an opportunity for an assessment to be made of the family and the unborn child's potential needs and for advice and guidance in respect of parenting to be provided.[18] The premature birth prevented a visit occurring antenatally. However, consideration could

[16] Neonatal Abstinence Syndrome (NAS) is a constellation of symptoms occurring in a baby as a result of withdrawal from physically addictive substances taken by the mother.
[17] https://safeguarding.dudley.gov.uk/media/13797/dudley-threshold-guidance-and-framework-september-2019.pdf

[18] BCP Standard Operating Procedures for Healthy Child Programme Universal Service Offer

have been given to arranging for the health visiting team to visit the home prior to the discharge of child A.

6.3 How effective was the information sharing between agencies, and the subsequent transference of support between the different agencies.

6.3.1 There is evidence of good communication between the PA and Sandwell CMW1 when the pregnancy was first reported, up to the point that the parents moved to Dudley.

6.3.2 There is an appropriate reference to making a referral to the Specialist Midwife for Vulnerable Women in Dudley on 25th February 2019, however it does not appear that the referral was made, or that it was communicated to Dudley midwives that it was considered necessary

6.3.3 The PA alerted her Team Manager when the Mother of child A informed her that her brother may be moving in with her, and this information is shared with DCSC by way of a MARF. There was a delay in submitting the MARF which, according to the SCT IMR, was because the Mother of child A was an adult and should be given the opportunity to make an informed choice. However, the concern should have been for her unborn child as well, and therefore the delay should not have occurred.

6.3.4 DCSC did not review the MARF. The SCT author has established that it had been sent to an email address that was no longer in use. The PA, when interviewed confirmed that the MARF was sent by administration staff within the Leaving Care Team to the email address on Dudley Safeguarding Children's Board's (DSCB) MARF, which had been downloaded. The PA was not able to confirm which web site the MARF had been downloaded from. It may have been from DSCB's live website or it may have been an old form saved in a Sandwell directory. The PA was able to confirm that she did not receive an automatic response stating the Dudley email was no longer in use. There is confirmation in case note records that the MARF was sent on 29.03.19. It was procedurally correct to notify DCSC as the Mother of child A was living in Dudley borough, however it may have been better practice for SCT to have completed the pre-birth assessment. The move was very recent and she had been known to SCT for most of her life. SCT had a significant amount of information and knowledge in respect of her. If any action was required, a MARF could have been submitted to DCSC at that point. It is also good practice for the referrer to check the information has been received and understood. The PA confirmed that she did not contact DCSC to confirm they had received it or to discuss how DCSC and SCT would work together to support the Mother of child A and her baby. The PA confirmed that it was not her usual practice to follow up sending information by email with a telephone discussion or other form of contact. The PA advised she had not given further thought to this and received no further guidance from her Team Manager. The SCT IMR has identified that the information contained within the MARF was limited and that, even if it had been received, it potentially would not have met the threshold for intervention. There was no reference to the social care history and vulnerabilities, no reference to her brother's social care history or the risk he posed, and no reference to the limited information held by SCT in respect of the Father of child A. The MARF did not specifically request a Pre-Birth Assessment. It is important to state that from this point the PA did continue to support Mother of child A,

and her brother moved out prior to the birth of Child A, which reduced one element of the risk.

6.3.6 There is also evidence of good practice between professionals in that information sharing and liaison occurred between Sandwell CMW3 and the GP, when Mother of child A missed her antenatal appointment on 2nd April 2019 because she had moved. This was to verify when she had last been seen and to confirm her address. However, it would have been good practice for CMW3 to have tried to call the Mother of child A and speak to her in person, to establish the reason for her not attending her appointment and to ascertain if she was able to attend another appointment.

6.3.7 Whilst Sandwell CMW2 made attempts to contact Mother of child A's new midwife in Dudley, it would have been good practice to have to attempted to speak with them on another occasion after the initial failed call, and verbally handover her care. This would have provided an understanding of the concerns, and an opportunity to clarify whether she had registered or attended for her antenatal appointments. However, details of the new midwife were shared by Sandwell CMW2 with the PA.

6.3.8 Although the PA was aware that the antenatal care had been transferred to Dudley midwives, there is no record of any communication with the Dudley midwifery service. Therefore, Dudley midwifery were not aware of the concerns which had been previously discussed.

6.3.9 Whilst Child A was on the NNU, there is evidence of attempts to check and share information by the NNU on 3rd June 2019, after concerns had been raised about cannabis use by his parents. Checks were made with the health visiting team and social services. However, it was DCSC and not SCT. Mother and child were not known to DCSC. The MARF which had been sent on 29th March 2019 had not been reviewed as the e mail account was not monitored.

6.3.10 The Sandwell Leaving Care Service were not aware Child A had been discharged from hospital until after he died, and consequently there was no discharge plan in place.

6.4 How effectively were the risks of co sleeping articulated to the parents

6.4.1 Co-sleeping has been identified as a feature in a number of child deaths in Dudley 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 CMWs and the health visitors in the antenatal and postnatal periods. The Dudley Safer Sleep Policy outlines the responsibility of each agency in delivering safe sleeping advice.

6.4.2 The PA confirmed that she did not have any discussion with parents about the risks of co-sleeping. The SCT IMR author confirmed that this would not routinely be expected as it is understood that health professionals will do this. However, given Mother of child A's drug misuse the PA could have been more proactive and reinforced the additional risk this poses

to co-sleeping. The PA did confirm that if either parent had indicated they were or intended to co-sleep she would have advised them against this.

6.4.3 The advice is not normally provided as part of the antenatal care provided to a mother in the initial stages of pregnancy, as this focuses on her health and well-being, and that of the unborn child. It is provided in the latter stages of pregnancy, however as Child A was born at 32 weeks gestation, it was not provided prior to his birth by the CMWs

6.4.4 The antenatal home visit conducted by the health visiting team did not take place because Child A was born prematurely. This visit provides an opportunity for safe sleeping advice to be discussed and reinforced, as well as facilitating an examination of the home environment, identifying where the baby will be sleeping, and that the appropriate facility is provided. As Child A was on the NNU for a number of weeks prior to his discharge, there would have been an opportunity to notify the health visiting team prior to discharge to arrange for the visit to take place. This would have been good practice, especially in this case as other concerns had been identified.

6.4.5 In preparation for Child A's discharge, the parents were offered an overnight stay in the NNU flat, to enable them to experience caring for Child A, on their own, overnight. The provision of the flat is routinely provided to parents and is an example of good practice. They were observed by staff to have Child A in the bed between them, which the parents confirmed, albeit they said that they hadn't been asleep, and they were given safe sleeping advice. Safe sleeping advice is given as a talk and parents are advised about a leaflet which clearly states the risks from smoking and co-sleeping. However, there are no means by which staff can check that parents have accessed the leaflet or how well this information has been assimilated. There was no suggestion that they did not understand it. It is important to note that the parents of child A did not take the baby in to bed with them. The Father of Child A took the baby downstairs and sat on the sofa. He did not intend to fall asleep. There is recognition that co-sleeping advice is not always given prior to the parents staying in the flat and this process has been amended.

6.5 How effective were the arrangements to ensure that the home environment was suitable for the discharge of a premature baby?

6.5.1 Prior to the death of Child A, the PA had last seen the Mother of child A's property on 17th April 2019 when she went to pick up the brother. Other than this, the PA had seen the accommodation only once, on 1st March 2019. The SCT IMR states that the PA confirmed that they were well prepared for the baby in relation to basic equipment, but the specifics are not recorded in the records. The PA stated that, although the Mother of child A had communicated well with them prior to and following the birth of Child A, they were not aware Child A had been discharged from hospital until they were informed that he had died. If they had been notified, there would have been opportunity to consider a post birth discharge plan, which would include identifying additional needs for the Mother of child A in caring for Child A as a premature baby and reinforcing the risks of co-sleeping.

Antenatal visits are usually also conducted by the health visiting team; however, this did not take place because Child A was born prematurely.

6.5.2 The home environment was assessed as suitable for a premature baby by the Dudley CMW2 who visited on 3rd June 2019. The property was deemed to be smoky and there was a dog and cats in the home. There is no mention of anyone else living in the property. The detail in respect of the home is limited, and the Graded Care Profile 2 (GCP2) was not utilised. 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. Training on the GCP2 is available for all midwives and health visitors and would give guidance through assessment of evidence of neglect at home. The midwife's visit had been rescheduled once by the parents, who stated they were visiting the NNU. This was not correct as they visited late in the afternoon that day. An antenatal visit is conducted by the Neo Natal Team in the following circumstances;

- all babies going home on oxygen.
- all families where there are concerns identified on NNU.
- Joint visits with midwives, health visitors and social workers if required[19].

The visit seeks to confirm that the house is clean and that there is no risk of infection, it is not cluttered, the temperature is appropriate, residents are identified, and that it is smoke free. Consideration is also given to financial circumstances, and practical and emotional support available to the mother. It would have been appropriate for the NNU to conduct a home visit in this case, as concerns had been identified on the NNU. It could have been conducted jointly with the CMW or the health visiting team, or independently.

6.5.3 Arrangements had been made for a visit by the CMW on the day Child A died, which was two days after his discharge from hospital, and the health visitor was due to visit the following day.

6.5.4 The home was not visited antenatally by the health visiting team because Child A was born prematurely. This would have been an opportunity for the unborn child's environment to be assessed and potential risks identified, which could have been arranged whilst Child A was still on the NNU

6.6 What was known about the parenting skills of the parents of child A, and how did this impact upon their ability to care for Child A?

6.6.1 The DGNHSFT IMR reports that staff on the NNU were of the opinion that Child A's parents appeared to be able to care appropriately for him. This is in spite of the fact that the NNU notes record that they needed to be encouraged to take a more active role in caring for

[19] Information provided by DGNHSFT e mail 13/12.2019 BP

him and to visit more frequently. It was observed that they smelt of cannabis on three occasions, and they needed to be reminded to provide nappies. Concerns in respect of their own personal hygiene had been noted, and the home environment was known to be smoky and pets were present. Both were smokers and had not shown any commitment to embrace the offer of smoking cessation support. They were also observed to be in bed with him the night before he was discharged. They were relatively young parents, he was their first child, and he was a premature baby. It was positive that he was breast fed and that efforts were made to express milk for him.

6.6.2 There is no evidence of the parents being provided with any guidance on how to care for a baby prior to the birth of Child A. The PA makes reference to a parenting course being beneficial. They should have been considered for the Best Start Programme.

6.6.3 If the MARF submitted on 29th March 2019 had been reviewed by Dudley MASH it is likely that the family would have been offered Early Help[20]. An unborn assessment would have been made, which would have identified that the parents were likely to need more support than universal services.

6.6.4 There was concern in respect of the health of Mother of child A and her unborn child from around week 28 of her pregnancy. It is at this point that the health visiting team usually start engaging with the family and providing support and advice in preparation for the birth. The family were not able to benefit from this because of the health concerns and the fact that Child A was born prematurely at 32 weeks. This was not something which was taken into consideration by the NNU staff or CMW2 in assessing the parenting skills prior to discharge of child A from hospital.

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

6.7.1 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 include 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[21]. 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.

[20] Threshold Guidance and Framework for Support 2018

[21] (Altobelli & Payne, 2014) https://www.bacp.co.uk/bacp-journals/bacp-children-young-people-and-families-journal/march-2014/noticing-the-hidden-harm/

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.

6.7.2 The Leaving care team were aware that both used cannabis, as it had been reported by staff at the supported accommodation and by Mother of child A herself. The PA shared the information about the Mother of child A smoking cannabis appropriately with Sandwell CMW1, however no mention is made of the Father of child A. The associated risk of Mother of child A wanting her brother, whom she stated was involved with and wanted to be a drug dealer, to move into the property with her and the baby was also shared. It was not explored how long she had been abusing cannabis, and whether she was known to substance misuse agencies.

6.7.3 Despite the PA and Sandwell CMW1 being aware that both parents regularly used cannabis, there is no evidence of this being shared when the antenatal care was transferred to the Dudley midwives, as the phone call which was made by Sandwell CMW2 when the couple moved into the Dudley area was not answered, and there was no communication at all between the Dudley CMW team and the PA . This resulted in a subsequent failure to refer to the Specialist Midwives for Substance Misuse in order to offer more targeted support.

6.7.4 In July 2017, Father of child A had been referred for a mental health primary care gateway assessment after he reported feeling low and stressed. During the assessment he disclosed that he used cannabis weekly and was advised to self-refer to CRI (a substance misuse service) and to request medication from his GP. There is no evidence within the GP records that he ever contacted substance misuse services for support. Father's records are not routinely checked during their partner's pregnancy. However, it was known by the Sandwell midwifery team that there were safeguarding concerns in respect of the Mother of child A, which included her cannabis use. They would have been justified in checking the Father of child A's records in response to these concerns. This would have identified that both parents had a history of cannabis use, and may have prompted further exploration about substance misuse, which would have supported a requirement to submit a referral to Social Services in respect of Child A as an unborn child.

6.7.5 There were three episodes of staff recording a suspicion of cannabis use due to the odour around parents. Parents were also observed to have poor hygiene on occasions. There is no evidence of staff having a discussion with the parents and a visitor about their suspicions of cannabis use. During interview for the purpose of the DGNHSFT IMR two members of the NNU staff highlighted a perceived lack of understanding and tolerance to the use of cannabis by parents in general.

6.7.6 There were concerns raised regarding Mother of child A's brother and the possibility that he was involved in drug dealing. Mother of child A was known to use cannabis. Both parents and a friend smelt of it whilst visiting Child A on the NNU on three occasions. These pieces of information do not appear to have been viewed holistically in order to complete a comprehensive analysis of the risks posed to Child A by his parents using cannabis

6.7.7 During the home visit following Child A' death, small plastic bags, commonly used for drugs, were noted strewn around the lounge. The possibility that any illicit substances were removed from the house prior to the home visit should be considered, although this would

be supposition. Following the death of Child A, Father of child A reported that he had used cannabis two days prior to his death[22] and prior to his discharge home.

6.7.8 Mother of child A had been referred to CAMHS in April 2014 due to issues of self-harm. Both parents had therefore experienced a mental health concern. These seemed to have been managed in isolation and did not appear to have been acknowledged during the antenatal period in order to analyse risk and offer any appropriate support.

6.8 How effective was the safeguarding supervision

6.8.1 Following a previous SCR[23], it was identified that DGNHSFT 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. It does not appear that any concerns were escalated in the three-month period between Mother of child A commencing her antenatal care and the death of Child A. However, it should be noted that the focus was correctly on Mother of child A's health and that of her unborn child initially.

6.8.2 The SCT IMR has identified that there is no recording of management direction or oversight by the previous Leaving Care Team Manager from the point the pregnancy became known (November 2018) until Child A died. The PA advised that she relied on her Team Manager to provide guidance at the time, but there is no reference to process or procedure within the Team Manager's recordings of how this was provided.

6.8.3 SCT became aware of Mother of child A's pregnancy on 30th November 2018. Between this date and Child A's death on 23rd June 2019, there was a consistent PA allocated to Mother of child A but the Team Manager was absent from work from February 2019 until just prior to the death of Child A. The SCT IMR has identified that there were several complex and high-profile cases in the Leaving Care Service during the scoping period which created additional pressure. Despite this, the current Team Manager has supported the allocated PA and had regular oversight of the case notes in the absence of the previous Team Manager. The PA stated that she had raised concerns with her previous Team Manager. Although the PA and current Team Manager could not identify how circumstances within the service had impacted specifically on this case, they both highlighted the difficult circumstances in which they were working. Both were open to reflection on how they could have done things differently and learning for the service moving forward.

6.8.4 SWBNHST community midwives are receiving formal supervision every three months, with any immediate concerns being escalated in the interim. It does not appear that any concerns were escalated in the two-month period between the Mother of child A commencing her antenatal care and her care being transferred to Dudley. Consideration should have been given to seeking supervision in light of the looked after status and the concerns in respect of cannabis misuse.

[22] Information obtained from the Police

[23] Child L

6.9 Training

6.9.1 The IMRs provided have not identified that any members of staff had not received the training considered as relevant to their roles.

6.9.2 All Sandwell and Dudley midwives are required to attend level 3 safeguarding training every 3 years. They are also encouraged to book and attend training with both Sandwell and Birmingham Children's trusts. Midwives can also access the named midwives within the safeguarding children team for advice and support regarding any identified safeguarding concerns. The SWBNHST has a Safeguarding Children and Domestic abuse policy which are accessible to all staff via the trust intranet and access to the policy is reinforced at every level 3 training session.

6.9.3 The DGNHSFT IMR has identified that there is a lack of awareness of the impact cannabis abuse can have on the parenting ability of parents.

7. Conclusions

7.1 Support provided to Mother of child A as a Care Leaver.

Mother of child A did receive consistent support from the Care Leavers Team. There appears to be a positive relationship with her PA. There is also evidence of challenge in respect of her behaviour and cannabis use. However, she was inappropriately supported in moving to independent accommodation in February 2019. There should have been more emphasis on the negative issues which were evident. There was insufficient consideration given to how she would manage living independently, with the additional responsibility of living with Father of child A and her unborn child. The focus of the support is on the adult, with a lack of consideration for the unborn child.

7.2 Support provided to enable Mother of child A and Father of child A to be parents to Child A

Due to the combination of risk factors identified, a pre-birth assessment should have been completed in respect of Child A, and a referral made by SCT, SWBNHST and DGNHSFT. The West Midlands Regional and Sandwell Children's Safeguarding Partnership Child Protection Procedures require a pre-birth assessment to be completed in respect of all Unborn Children who meet the threshold criteria for intervention by Children's Social Care[24]. This would have

[24] Where agencies or individuals anticipate that prospective parents may need support services to care for their baby or that the unborn child may have suffered, or be likely to suffer, significant harm, a referral to local authority children's social care must be made **as soon as concerns are identified.**

A referral should be made at the earliest opportunity in order to:

- provide sufficient time to make adequate plans for the baby's protection
- provide sufficient time for a full and informed assessment

identified what support was required by the parents in relation to independence and parenting. Mother of child A also should have been referred to the Best Start Programme for Vulnerable Women. Whilst there were positives identified in the parents' ability to care for Child A whilst he was on the NNU, there were also concerns. There was sufficient concern in respect of the parenting abilities to justify a referral to DCSC by the NNU.

7.3 Consideration of the role of Father of child A

There is no evidence within the SCT IMR that consideration was given to whether Father of child A was an appropriate person for Mother of child A to live and raise a child with. This demonstrates a lack of professional curiosity around household members and the dynamic within the family. An NSPCC review of Serious Case Reviews (2015)[25] found that men play an important role in children's lives and have a great influence on the children they are involved with or care for. Despite this, they can be ignored by professionals who sometimes focus almost exclusively on the quality of care children receive from their mothers and female carers.

7.4 Information sharing

There is evidence of good communication when the pregnancy was first recorded. However, when the Mother of child A moved from Sandwell Borough to live in Dudley Borough, and her antenatal care transferred from SWBNHSH to DGNHSFT, the communication between the two trusts did not take place and there is no process in place to ensure that it does.

A referral was made by SCT to DCSC, however the referral was not received as it was sent to an unmonitored e mail account and not followed up as per the West Midlands Safeguarding Procedures[26].

- avoid initial approaches to parents in the last stages of pregnancy, at what is already an emotionally charged time
- enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome for the baby
- enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth.

[25] https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/hidden-men/

[26] Within the West Midlands, there are nine local areas that collaborate with regards to child safeguarding procedures. With the introduction of *Working Together to Safeguard Children 2018*, each local area's multi-agency safeguarding arrangements are led by the statutory safeguarding partners/organisations: local authorities, clinical commissioning groups and the police.

These child protection and safeguarding procedures are for nine participating areas and are effective from 31st March 2017.

7.5 Co – sleeping advice

The risks of co-sleeping were explained to both parents, however the facts that Child A was born prematurely and the parents were not referred to the parenting programmes available, meant that opportunities to emphasise the risks were missed. However, the parents of child A did not take him to bed with them and his father took him downstairs when he would not settle. When delivering safe sleep advice parents are advised to place the baby in their cot or Moses basket. The alternatives for when a child is distressed and a parent very tired are not identified, but the dangers of being extremely tired and then falling asleep whilst holding a baby and sitting in a chair or on a settee are highlighted in the co-sleeping information.

7.6 Substance abuse

It was known that both parents were cannabis users. The parents should have been challenged in respect of the evidence that they were using cannabis and they should have been offered Early Help, with consideration being given to a referral to MASH if they declined. The information known about the parent's substance misuse should have also prompted referrals for specialist antenatal care.

7.7 Home conditions

There were opportunities for professionals to have visited the family home prior to the discharge of Child A, which may have identified that they were likely to need more support. The home was not assessed utilising the Graded Care Profile 2 (GCP2). 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 practice 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.

Sub-optimal home conditions have been a theme in other cases reviewed in Dudley[27]. One of the recommendations from a previous review was that the use of the GCP2 was promoted when concerns are raised regarding home conditions/potential neglect. This has now been incorporated into the unborn safeguarding pathway, and DGNHSFT will be trialling the use of a GCP2 A, which is specifically designed for use by midwifery professionals, and focuses on the suitability of the home conditions for new born babies.

[27] SCR child L

7.8 Holistic picture

There seems to be a theme of each concern being viewed in isolation. Throughout agencies involvement with the family a number of concerns were considered. However, there is no evidence of a holistic approach being taken to consider the circumstances of the family and how the parents would be able to care for and safeguard child A.

7.9 Diversity and Inclusion

The review found no issues around race, gender, culture, religious identity or disability of the children and family within the records.

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

1. **Formal transfer process for midwifery care between trusts**
   DSPP and SSPPB should ensure that there is a formal process to transfer care between midwifery services across the Black Country when pregnant women cross boundaries during pregnancy.

2. **Formal transfer process between CSC and Health**
   DSPP and SSPPB should ensure that there is a formal process to share information between Children's Social Care across the Black Country when families cross boundaries.

3. **Training – review impact of cannabis use on parenting ability**
   DSPP should ensure that training of professionals includes the impact which cannabis use can have on parents and their ability to care for their children

4. **Co sleeping**
   DSPP should examine the information and any recommendations following the review currently being undertaken by the national panel for child safeguarding.

5. **Home conditions**
   DSPP and SSPPB should promote the feasibility of BCPNHSFT, DGNHSFT and SWBNHST conducting the antenatal and postnatal visits jointly, especially in cases where

safeguarding concerns are observed. This should include arrangements to ensure the antenatal visit by the health visiting team is conducted as soon as possible after a premature birth, and that the GCP2 tool is utilised in every case where concerns are raised regarding home conditions and potential neglect.

6. <u>Single Agency Reports</u>

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 and SSPPB should ensure that these are completed.