LOCAL CHILD SAFEGUARDING PRACTICE REVIEW – EMMA EXECUTIVE SUMMARY

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1. This Child Safeguarding Practice Review (CSPR) concerns a 3 month old baby; Emma, who, in May 2020, was discovered not breathing by her mother and pronounced dead by paramedics. The review considered how agencies worked together and with the family leading up to her death.

2. Emma died as a result of (suspected) asphyxiation. It is believed that the asphyxiation was caused by Emma being propped up on a pillow in her pram and her head having fallen forwards, restricting her airways.

3. The Mother in this case had four other children; Sibling 1 (17months), Sibling 2 (6 years), Sibling 3 (9 years) and Sibling 4 (Adopted 2010).

4. The new Working Together to Safeguard Children 2018 guidance sets out the process for new national and local reviews. Local safeguarding partners must make arrangements to identify and review serious child safeguarding cases within a defined criteria, and, in their view, raises issues of importance in relation to their area.

5. The Hartlepool and Stockton on Tees Safeguarding Children Partnership (HSSCP) led on safeguarding arrangements and the local review and conducted a Rapid Review, and it was decided that a local CSPR was appropriate.

6. The Rapid Review identified what appeared to be rapid decline in living conditions which are indicative of neglect, even though neglect had not previously been a significant issue for the family.

7. There were a number of other cumulative factors that impacted upon the life and care of Emma and how partners supported and protected Emma and other family members.

Background

1. The family had previously been supported by professionals via Child Protection Plans under the category of sexual abuse and previously under Neglect. At the time of death, the case was Child in Need and ready to step down into Early Help.

2. Between 2013 and 2017 there were four referrals for neglect.

3. The Mother of Emma had been a looked after child herself and had experienced trauma and abuse. She became pregnant at 16. This first child was adopted due to neglect in 2010.

4. At the time of Emma's death, Mother had three other children in her care; Sibling 3 and Sibling 2 from a previous relationship and Sibling 1.

5. Father and Mother ended their relationship and a number of domestic abuse incidents were recorded involving both parties between February and May.

6. Mother was taking citalopram for depression and GP's were concerned over an addiction to the use of Tramadol, Mother had taken this drug since 2007.

7. Emma was born in January 2020 at 33 weeks by C-Section and spent 11 days in the special care baby unit (SCBU).

8. In March 2020 Mother attended hospital at 12 noon with Emma who had stopped breathing at 4am. Maternal grandmother (MGM) had performed 'rescue breaths' and the baby had resumed breathing. The hospital shared this information with CSC as they were concerned that Mother had delayed seeking medical attention.

9. The last 2 physical visits to the house by professionals were 23rd and 25th April 2020. The health visitor conducted a planned visit on the 23rd and reported that the house was clean and the police did not identify any concerns on the 25th.

10. On the evening of the 1st May 2020, Mother stated that she had been up all night with Sibling 1, as he had difficulty sleeping. She recalled Emma crying to be fed, but was unsure of the time due to there being no set feed times and Mother feeding Emma on demand. Emma took a bottle of milk and was laid back in her pram to sleep. Mother stated she then went to bed. Upon waking sometime later, she asked Sibling 2 to check on Emma, who was discovered unconscious in her pram. An ambulance was called and Mother commenced CPR. Paramedics and police attended and Emma was pronounced dead upon arrival.

11. Paramedics at the scene and police in attendance raised issues in relation to neglect. The blankets and cushion in the pram were covered in mould and not suitable for a child to be sleeping in. The home address was described as being in a chaotic state, with faeces and dirty nappies strewn around, clothing in piles and lose tablets on the floor. The sleeping arrangements were not considered suitable. Despite Emma having a cot, this had not been used and she had been sleeping in a pram with inappropriate bedding and being propped up on a pillow.

12. Medical examination of Emma following her death ruled out any non-accidental injuries and indicated that suspected cause of death was asphyxiation. The doctor also noted some signs of neglect upon examination such as animal hairs under her arms and in her fingers, dirt in the crevices of her body and severe nappy rash.

Summary Analysis of Key Findings

13. The key lines of enquiry for the CSPR were explored through the process of considering the details submitted by agencies as part of the Rapid Review and also a learning event which was attended by practitioners who had worked with the family.

14. The major themes which have emerged during this review are:
    - Over optimism and over reliance on Mother's ability to parent and manage a partner who posed a risk for a sex offence and contact with 4 children.
    - Lack of professional curiosity in assessing Mothers' behaviours and understanding the impact of childhood and historical adverse experiences and in particular Mother's ongoing relationship with her own mother (MGM).
    - Recognising the impact and role of the Father and MGM in assessments.
    - Assessments and multi- agency interventions should recognise and support all areas of risk, not a "headline" risk of sexual abuse.
    - Missed opportunities in identifying indicators of neglect
    - Professional curiosity and multi-agency oversight to assess or identify significant changes in circumstances and conditions, particularly the timing of step down and closure of the case
    - Sleeping arrangements for babies and how these are communicated with parents.
    - Information sharing and recording.

What was life like for the children in this family? Consideration of agencies understanding of the known needs and vulnerabilities of the family at this time and how these were considered, supported and met.

Key Learning and Recommendations

15. At key points in this case, partners were unaware of relevant information of needs and vulnerabilities with the family. This would have informed assessments and single agency involvement. There were missed opportunities in considering these in totality and engaging with the family at times of increased need.

16. Communication between partners should be more effective to enable vital information to be shared in a timely manner. HSSCP may want to seek assurance that reflects this learning point.

17. Partners were over optimistic in Mothers' parenting abilities, and placed a significant responsibility upon her around managing the Father's sexual abuse risk. Partners should ensure that assessments and expectations recognise parenting capabilities.

18. The Mother regularly portrayed an image to professionals that she was able to cope and was a capable parent, yet there were multiple ongoing and emerging issues that affected this. Partners should exercise sufficient professional curiosity with parents in assessing their abilities to cope and care for their children.

19. There was a lack of professional curiosity in recognising Mother's behaviours her background and mistrust of professionals, possible fragility in coping or intentional efforts not to disclose information. Assessments of parents should take into account historical information and the impact of this on coping mechanisms.

20. Mother's own childhood experiences of trauma and abuse, her on-going vulnerability and troubled and abusive relationships were not assessed against her capacity to parent. HSSCP may wish to consider an assessment tool and the provision of therapeutic services for mothers in similar circumstances.

What did the multi-agency support and oversight look like?

Key Learning and Recommendations

21. At key points in this case, information was not shared or recorded effectively. Individual agencies should ensure record keeping and information management systems within their organisation are robust and routinely implemented and that any deficit in the information is addressed by practitioners with appropriate management oversight.

22. Partners recognised missed opportunities in convening multi-agency meetings at key points in this case, particularly between January and May when there was an escalation of need and risk.

23. There was a key missed opportunity for a multi-agency response to the incident following Emma stopping breathing. The HSSCP may wish to seek assurance that such incidents will trigger multi-agency responses in the future.

24. There would have been increased opportunities to monitor the impact of the domestic abuse upon the children if the information had been shared wider through Operation Encompass processes, with health visitors and other health partners. Partners have recognised this gap and changes to processes are intended to widen the notifications to enable this.

25. Local safeguarding partners should ensure practitioners are trained in recognising and responding to parental engagement. Practitioners should exercise professional curiosity in recognising barriers or that disguised compliance could be occurring, and the reasons why this may be occurring.

26. Partners should recognise the importance of both collating and reflecting on the information held by different professionals and agencies, to enable assessments to consider all and cumulative impacting factors.

Where there any indicators of neglect?

Key Learning and Recommendations

27. The Core groups ended at a critical point and partners reflected that information sharing was less effective after this time. This was a missed opportunity in identifying indicators of neglect.

28. The multi-agency partnership response to neglect should ensure practitioners are competent and confident in working with all aspects and types of neglect including assessment of parenting capacity, motivation to change and sustainability of any improvements once services withdraw. Practitioners need to be equipped to recognise possible feigned compliance and to address this in assessment and plans.

29. The focus on the single issue of the sex offence meant that partners were not as alert to indicators of neglect.

What did the multi-agency decision making look like at case closure?

Key Learning and Recommendations

30. The decision and timing to close and step down the case resulted in a lack of multi-agency oversight at a key point in the life of Emma.

31. The decision to step down the case was overly optimistic and could have been revisited given the changing and escalating circumstances within the family and the possibility that Mother and Father would reconcile.

32. Partners acknowledged an inconsistency of the Early Help offer locally and understanding of what Early Help involves. The HSSCP may wish to seek assurance around communication and consistency of approach.

Compare the conditions reported by professionals on attending the incident with agencies last observations. (When was the last meaningful visit / involvement and what was the nature of this? What was observed?)

Key Learning and Recommendation

33. Partners were unable to assess or identify significant changes in conditions at a key point in Emma's life, as there were minimal agency visits and limited checks or assessments. The impact of national lockdown in March 2020 also had an impact on how and when professionals engaged with Mother and the children.

34. The review has identified that multi-agency oversight was not in place at a critical point in the life of Emma, and when it was the focus was not on neglect.

35. This review has been unable to establish the reasons for the rapid decline in conditions in the home of Emma, which were not identified by agencies. Partners should exercise professional curiosity and recognise increased pressures and vulnerability.

Sleeping Arrangements for Babies

Key Learning and Recommendations

36. Safe sleeping arrangements for babies who have spent time as in-patients in SCBU or neo natal care should be carefully explained by discharge staff with parents / carers taking into account any cognitive (or other communication) difficulties that they may have. This should be reinforced by health visitors, midwives and social care staff once babies are returned home.

37. Safer sleeping advice should be given, repeated and reinforced by professionals in all agencies both during pregnancy and infancy and carers' understanding of the expectations checked at each meeting. Where there are concerns about co-sleeping or unsafe circumstances, Child Protection Plans should include a specific requirement regarding safer sleeping arrangements.

Voices of the Children

Key Learning and Recommendations

38. Partners should be cognisant of potential coping strategies and disguised compliance when considering the voice and lived experience of the child.

39. Partners should focus upon the voice and lived experience of the child when assessing and responding to known risks within the family.

40. Partners should consider all potential impacts and particularly cumulative factors when interpreting the voice and lived experience of the child.

Conclusions

41. This review has been unable to establish why the living conditions in Emma's home appeared to change so dramatically in the final days of her life. Whilst the conditions were not the direct cause of her death, they were indicative of a mother who was struggling to cope and who was not therefore meeting Emma's needs and ensuring that she was in a safe sleeping position.

42. Mother's own childhood experiences of trauma and abuse, coupled with substance misuse and her relationships with MGM and Father had a significant impact upon her ability to care for Emma and three other children. It appears that the trauma had not been addressed, key information was not shared between partners and assessments did not focus on cumulative risks, and in particular, neglect.

43. There were a number of incidents over the preceding few months that cumulatively increased need and risk, and could have been predicted. At such a critical point partners had reduced multi-agency oversight and closed the case. The timing of this decision, meant that partners were unable to recognise this rapid decline.

44. Emma, who was a premature baby with a recent serious respiratory infection, died of asphyxiation caused by unsafe sleeping arrangements, Mother believed this was a correct way to allow a baby to sleep, yet professionals, including those who had shared safe sleeping information with Mother were unaware of this sleeping arrangement.

45. There are important lessons from this review, many of which mirror the lessons from other reviews:

- Over optimism and over reliance on Mother's ability to cope under extreme stress.
- Assessments and multi- agency interventions recognising all areas of risk
- Missed opportunities in identifying indicators of neglect
- Professional curiosity to assess or identify significant changes in circumstances and conditions.
- Sleeping arrangements for babies and how these are communicated with parents.
- Information sharing and recording.
- Lack of Multi-agency oversight at times of increased vulnerability

46. Partners who attended the learning event had recognised some of these learning points and have taken steps to address single and inter-agency working.