**Royal Borough of Windsor and Maidenhead**

**Multi-agency adults and children’s safeguarding arrangements**

**A Local Child Safeguarding Practice Review**

**Child T**

**April 2021**

**Independent Author – Ian Vinall**

**Contents**

Introduction

Methodology and Process

Key Practice Episodes

Emerging Practice Themes

Examples of Good Practice

Conclusions

Summary of learning

Recommendations

1. **Introduction to Child T**
   1. Child T was born in May 2019 and was the second child of the birth parents. She has a dual heritage background and at the time of her death, aged 11 months, she was living solely with birth mother and her older sister. Her birth parents have both Christian and Muslim faiths and the children have been brought up in both faiths at different stages of their lives. Child T was described by her birth mother as a happy and healthy child who had a strong relationship with her older sister. She loved dancing, music and loved her food. Child T was described by her mother as being a ‘big child’ for her age. Child T had moved to new accommodation with her birth mother and sister a month before her death. Child T and her sister have had several disruptions to their care arrangements in a very short period.
   2. Child T and her sister had been known to safeguarding agencies in 4 previous local authorities.
   3. Child T died in late April 2020 from asphyxiation. She was found by her birth mother lying face down with her head wedged between the bed guard and the mattress.
2. **Introduction to the Review**
   1. Following the death of Child T, a Rapid Review was undertaken, and the local review panel concluded that the criteria for a local child safeguarding practice review was met and that the case offered the opportunity to provide learning which could prevent similar deaths occurring in the future. There is learning for several agencies across the 4 local authorities involved with the family. This review is being carried out to identify learning and is not about blame or culpability.

1. **Methodology and Process**
   1. Child T’s birth parents were separately interviewed in the presence of their social worker for this review. These discussions were understandably difficult for both parents and their contribution to this review was welcomed.
   2. A review panel was established and chaired by a senior representative from the police. The review panel requested the timing of the review should be from November 2019 up to the death of Child T in April 2020. There has been significant involvement of agencies in 2 previous local authorities which is relevant to the children’s lived experience and are included in the timeline of the review. The information provided by the parents and agencies involved with the family, formed the basis of the review and some agencies provided chronologies and analysis of their involvement and what improvements they have made as a result of this situation. Interviews took place with representatives from the safeguarding and voluntary sector partners.
   3. There was some anxiety in the voluntary and community sector being involved in the process of a child safeguarding practice review owing to their lack of experience of the process yet there has been a good level of engagement and subsequent learning.
   4. For the purposes of the review, the local authorities involved with the family are in chronological order and recorded as ‘local authorities 1, 2, 3, 4 and 5’. The agencies that provided chronologies and an analysis of practice included:

* Children’s social care in three local authorities
* Services from the voluntary and community sector
* Health Visiting Services in two NHS Trust areas
* Police
* An NHS Hospital Trust
* Community Safety Partnership

1. **Key Practice Episodes**

**May 2017 – April 2020**

* 1. Child T’s sister had been the subject of child protection and child in need planning in local authority’s 1 and 2. This was primarily owing to birth mother’s lack of engagement with services and professionals, the conditions of the home environment, birth mother’s ongoing use of drugs and her association with adults that placed the child at risk of harm. Ongoing concerns remained about domestic abuse perpetrated by birth father. Evidence from the police indicated that birth mother was a high-risk victim of domestic abuse and homicide with allegations of domestic and sexual violence over a 4-year period. Birth father has never been convicted of any domestically abusive behaviour and strongly denied acting in a domestically abusive way.
  2. The level of risk prompted local authority 1 to seek legal advice with a recommendation to support birth father with a private law application so he could resume full care of the eldest child.
  3. A pre-birth assessment was undertaken on Child T in local authority 2 with the recommendation of an initial child in need plan leading to an initial child protection conference at 30 weeks gestation. Birth mother did not engage with the child in need plan and the threshold was considered not met for an initial child protection case conference despite the recommendation from the assessment.
  4. Child T was born in May 2019 and was cared for by birth mother and children’s social care in local authority 2 closed Child T’s case in July 2019.
  5. A further domestic abuse incident occurred in October 2019 which prompted birth mother to apply for a Non-molestation Order[[1]](#footnote-1) and Prohibited Steps Order[[2]](#footnote-2) and she resumed the full sole care of both children and moved to a refuge in local authority 3. This was reported by birth father as the last time that he saw Child T alive.
  6. Children’s social care in local authority 3 were of the understanding that the family still had an allocated social worker in local authority 2 and an assessment was being undertaken so they did not progress any work with the family. Information provided by local authority 2 confirmed the case was in fact closed to them the day before the family moved to the refuge.
  7. The refuge made several referrals for support for birth mother including to the MASH (Multi-agency Safeguarding Hub)[[3]](#footnote-3) and a homeless application to local authority 4. Birth mother described struggling with her own mental health and parenting Child T’s older sister. She was displaying worrying behaviour including pulling her mother’s hair, constantly eating, and seeking out food, had stopped potty training, and was having nightmares. Child T had not been weighed since her 3-week check and not had her 16-week inoculations and at 8 months, was not sitting up unsupported and not crawling.
  8. There were several issues raised in the practice of the health visiting service in local authority 3 and these have been addressed through a separate Significant Incident Review[[4]](#footnote-4).
  9. Birth mother and the children moved to local authority 5 in March 2020. This was accommodation found by the domestic abuse housing officer in local authority 4 and birth mother was assisted in making the application for Housing Benefit and Council Tax. The case was then closed to the Housing Team in local authority 4. The flat was part furnished, with 2 bedrooms, including bunk beds and mattresses for the children. The Housing Team in local authority 5 were not made aware that a vulnerable family had moved into their area.
  10. Local authority 5 was emailed by the refuge yet this email went to an obsolete email box in the MASH but was picked up by staff by chance. The address given was incorrect and no consent was given for the referral. This referral was consequently ’sent back’ to the refuge. The refuge have no record of this. At this point no statutory safeguarding agency in local authority 5 knew that the family were moving to accommodation in their area.
  11. The refuge did make a referral to a voluntary agency in local authority 5. This voluntary agency provided short term support to families and provided practical and emotional support via volunteers. They offered support to the family in settling into the area and with practical help. The refuge agreed to continue to offer the family support via the telephone after they moved out.
  12. The UK went into ‘lockdown’ owing to the Covid-19 pandemic on the 23rd of March with the UK government ordering people to ‘stay at home’. This resulted in agencies restricting home visiting to a minimum.
  13. The voluntary agency was tasked with sourcing and delivering household and child related items. Birth mother requested a bed guard for the bottom bunk. She reported to the volunteer that it was her intention to place Child T in the bottom bunk bed with the bed guard. Child T’s sister aged 3 would occupy the top bunk.
  14. The voluntary agency referred the family to a local specialist domestic abuse charity and the case was allocated to an outreach worker. The outreach worker was told by birth mother that she had registered with a local GP and was awaiting contact with the health visitor. This was in fact, not the case. There was no liaison between the health visiting team and the voluntary sector agencies as birth mother had not registered and the health visiting service in local authority 3 had not communicated that the family had moved.
  15. The outreach worker had several calls with birth mother, and she repeated her concerns about the behaviour and presentation of her eldest daughter.
  16. The volunteer reported that birth mother was not adhering to social distancing[[5]](#footnote-5) and birth mother reported that a friend was staying at the flat during this period of lockdown.
  17. There were a further 5 calls between the outreach worker and birth mother, 2 of which went unanswered and two short phone calls from the volunteer.
  18. The night before Child T died, mother reported seeing her at approximately 10pm in bed in the bottom bunk with the bed guard attached. Birth mother confirmed that evening that she and a number of friends drank alcohol and smoked cannabis together in the flat until the early hours.

1. **Emerging Practice Themes**
   * The children’s experience.
   * Birth mother and birth father relationship and domestic abuse.
   * The number of moves for the children and the transfer of children’s cases between local authorities and safeguarding partner agencies.
   * Safer sleeping advice and guidance.
   * Voluntary sector engagement with safeguarding partnerships.
   * COVID-19 and its influence on practice.
2. **The children’s experience.**
   1. The children had been the subject of child in need, child protection and early help plans, 4 child and family assessments, referrals, risk assessments and private law court processes by the ages of 3 and 11 months, respectively. Child T’s sister was probably more ‘visible’ to agencies given there was significantly more information available about her.
   2. There is limited evidence available on how these processes impacted on the children. The children did seem lost in the issues of their parents and decisions regarding their care were based on who was deemed the most appropriate parent to care for them at the time. There were references to the children being ‘safe’ in the care of either birth parent. The perception that the children were considered safe at the refuge and in the care of birth mother took no account of the children’s history.
   3. There is little evidence, from the point of Child T’s birth, that consideration was given to the impact on the children of experiencing domestic abuse and neglect[[6]](#footnote-6). When the family moved to the refuge, Child T was assessed as developmentally delayed and Child T’s elder sister was clearly ‘communicating’ to her mother and professionals how she was feeling. Birth mother reported this behaviour was in response to her witnessing domestic abuse. These two very small children’s lives had been one of parental discord, disruptive family moves, domestic abuse, adult mental health, drug and alcohol misuse and parental neglect. An integrated chronology was not undertaken to inform assessments and interventions and therefore no purposeful and child centred assessments of the risks and needs were undertaken after Child T’s birth and at each transition stage.
   4. There was a significant lack of communication and information sharing between local authority’s children’s services, health, and two of the voluntary sector agencies. There can be no clear reason for this, other than individuals not considering the importance of information sharing about the children and a focus on the needs and issues of the parents. The refuge staff did contact partner agencies and sought support for the mother and the children whilst at the refuge, yet this still did not prompt agencies to discuss the children with each other.
   5. Birth mother asked for help and the community nursery nurse did provide practical guidance for Child T’s development. Given birth mother already had significant needs of her own, it is questionable whether providing her with behaviour management techniques for her child was likely to be effective.
   6. Safeguarding agencies focused attention on the behaviour of the adults to address safety from risk and harm. Safety for the children was birth mother taking appropriate action to flee a domestically abusive relationship yet safeguarding agencies did not investigate and were not professionally curious as to the children’s presentation. The history of poor parenting and neglect, as well as the children’s experience of domestic abuse had not been fully considered.
   7. The refuge highlighted the lack of support and services for children under 5 who have experienced domestic abuse and have raised this as a gap in service provision.
   8. The impact and children’s experiences of domestic abuse on children should prompt children’s social care to assess need under Section 17 of the Children Act 1989 regardless of who is considered the ‘so called’ protective parent.
3. **Birth mother and birth father relationship and domestic abuse**
   1. There is a consistent pattern of reconciliation and separation of the birth parents and the eldest child has lived between both parents in her short life. There have been protracted custody disputes, contact arrangements and a history of one or either parent removing the children at contact sessions or not returning them to the other parents’ care. The referrals that brought the family to the attention of children’s social care were reports of a domestic abuse incident perpetrated by birth father. Birth father himself accepts that he needed support at that time and had agreed to work alongside a family support domestic abuse worker, but this work never materialised.
   2. The birth parents originate from different religious and cultural backgrounds. Birth father is black African and birth mother is of Pakistani origin and their relationship was a source of tension in birth mother’s family, particularly birth mother’s stepfather. This caused additional stress to the birth mother and made it more challenging for her to seek family support in her situation. The children had a different religious upbringing until they were in the sole care of birth mother when she reverted to her Muslim faith. The issues of race, culture and religion and their impact on risk and harm were not fully considered in the assessments completed.
   3. Birth father continued to raise concerns about birth mother’s care of the eldest child and children’s social care chronology back up his assertion that birth mother was involved in drug and alcohol misuse, that the family home was in a very poor condition and birth mother’s associations placed the eldest child at risk. Birth mother reported threats had been made by birth father about the future care of the children. Those issues were not the subject of much analysis in assessments and whether the concerns were considered a true reflection of birth mother’s care or part of birth father’s ongoing domestically abusive behaviour through coercive control[[7]](#footnote-7) of birth mother.
   4. Birth mother has a significant history of childhood trauma and abusive, controlling, exploitative adult relationships. She struggled to engage with services and actively disengaged with support. Her experiences have impacted upon her ability to make decisions based on the needs of her children.
   5. Birth father was assessed as providing child focused care. Despite allegations of domestic abuse and rape made against him by his ex-partner, the courts and children’s social care assessed birth father to be the most appropriate parent to care for the eldest child. There is little or no challenge in those assessments on how birth father’s alleged domestically abusive behaviour impacted upon the children.
   6. Birth father denies the allegations made against him of domestic abuse. The large number of police reports and the judgements of the risk assessment checklists of birth mother are contrary to this view.
   7. The period leading up to birth mother’s move to the refuge, the couple had again reconciled and were living together against the advice and hidden from children’s social care. It was after this period that birth mother reported a further domestic abuse incident to which the eldest child was present and witnessed. Birth mother reports that her child attempted to intervene. It is not clear why children’s social care did not assess the risks under Section 47 of the Children Act 1989[[8]](#footnote-8). This prompted birth mother to apply herself for refuge accommodation and father being arrested. The Child Arrangements Order (CAO) and Prohibited Steps Order (PSO) made in favour of birth mother was the catalyst for the family to move to the refuge. This was the last time that birth father saw Child T alive. There was no engagement or contact from any agency with birth father post the children’s move to the refuge until he was informed of Child T’s death. Significantly, no agency or service appear to have picked up that this would have been the first time that birth mother was caring for both of her children on her own.
   8. CAFCASS were involved in the private law proceedings that saw birth father resume care of the eldest child, yet the report author has been unable to obtain information from CAFCASS as to their assessment and judgement. Information available indicates that local authority 2 were not asked to comment or give advice to the court when birth mother made her application for the CAO and PSO other than provide a copy of the pre-birth assessment. There were ongoing private law hearings about contact and residency to which no local authority was asked to contribute as far as we know.
   9. Birth mother and the children who were fleeing a domestically abusive relationship and moving to refuge accommodation were considered to be at significant risk of personal harm. However, it is difficult to reconcile that birth father was completely excluded from further assessment or involvement with the children when they moved to the refuge. He was not afforded the opportunity to contribute and be considered as an important part of the children’s lives. The lack of contact and consideration of birth father’s role appears to be a judgement made by agencies about the risk he posed to his ex-partner. This decision is based on the history of domestic abuse and the risks he has posed to birth mother and the children by his behaviour. However, this conflicts with the previous judgements made about his care of the eldest child in court reports and assessments. The family court has been heavily involved in making care related decisions for the children and the history of domestic abuse has been considered by the courts in making those decisions. The balanced decisions needed in this case is based on the principle of the child’s welfare being paramount. It raises the challenge as to whether adults who are domestically abusive in their relationships can safely parent their children and what support and services need to be provided to make that arrangement safe.
4. **The number of moves for the children and the transfer of the children’s cases between local authorities and safeguarding partner agencies.** 
   1. Child T and her sister were known to 5 local authorities and associated safeguarding partners. They were known to at least 4 voluntary sector agencies. The children experienced inconsistent and disruptive care and the eldest child had moved homes on at least 6 different occasions. They did not experience stability and security and keeping track of the children’s movements between local authorities had been problematic. This has led to a lack of information being shared across agency boundaries and a lack of curiosity by safeguarding agencies as to the children’s history.
   2. This review has led to one voluntary sector agency changing their procedures to reflect the learning from this situation, now asking for information from other agencies with consent. One agency is implementing a ‘health gateway’ which will automatically notify health and others that they are working with a family.

**Children’s social care**

* 1. There were prompt and effective arrangements in place for case transfer between local authority children’s social care when the children were subject to statutory child protection planning. However, when the children were not subject to statutory processes and the case closed, there was no effective transfer of the case information. The birth mother self-reported that she was involved with children’s social care, which prompted the refuge to seek further information.
  2. There is limited evidence that birth mother participated in offers of support for herself and the children. There was outstanding work in the child protection and child in need plans. The closure of the children’s cases was based on alternative care arrangements of the children rather than addressing the underlying parenting issues. The decision to close the children’s case in local authority 2 was just two months after Child T was born. Local authority 2 accept their practice was ‘below expected standards.’
  3. The outline plan highlighted the need for birth mother to address her cannabis use, direct work with the social worker to explore her experience of being parented and birth mother attending health appointments. The closure record indicated birth mother engaged with health services only. It is questionable that a lack of cooperation should be a benchmark or threshold for case closure without a clear understanding of the impact of that lack of cooperation on the child and whether this decision is based on current assessment or the chronology of non-engagement. Whether there was a changed perception of the risk to the children is unclear and whilst positive co-operation is observed in assessments, this should be seen in the context of the history of non-engagement. Resources and caseloads may be a significant factor in decision making and this is a wider practice theme that needs further consideration.
  4. The children’s case appears to have been opened again on the back of the referral from police in October 2019. The judgement made by local authority 2 to visit birth mother following the referral and then to fund transport for the move to the refuge without assessing the children and informing local authority 3 is poor practice. The reasoning for this is unclear but the information available points to the swift exit of the family to another local authority without taking case responsibility or accountability for effective transfer of information.
  5. It highlights a dilemma as to who has case responsibility in children’s social care when families move to refuge accommodation on a temporary basis and whether they are habitually resident in the originating authority. This is not resolved in the records with confusion about who was assessing the family. Transient families in the safeguarding system need one local authority to ‘own’ the children and not revert to quickly closing cases when they move authority. However, it is accepted that this is decision based on capacity and threshold.
  6. With the belief that children’s social care in local authority 2 were undertaking an assessment, local authority 3 did not undertake any statutory assessment of the children. Despite requests from local authority 3, no information was provided by local authority 2. Escalation routes for professional disagreement only appear to refer to those agencies within a local authority boundary and not between local authorities. It may be sensible for local authorities to expand this protocol to other local authorities to ensure disagreements or issues can be resolved more formally. In this case, the failure of local authority 2 to provide detailed information about the children’s known history led to risks for the children remaining unassessed.
  7. Consent based practice, where adults agree for information to be shared as part of a referral, does have the best outcomes for children. However, it does place a barrier to effective information sharing, particularly when an agency must then seek that consent. It is not unreasonable for children’s social care to hold open those children to ensure that they receive an effective response. There have been practice changes in local authority 5 because of this case which means children are ‘held’ open for 48 hours whilst that consent is sought. It would be sensible to consider this more widely to ensure children do not fall out of sight of children’s social care.

**Health**

* 1. The health visiting service in local authority 3 have undertaken a Serious Incident Review[[9]](#footnote-9) on the children. There are significant gaps in the practice of the agency health visitor which have been addressed through the Significant Incident Review and subsequent referral to the Nursing and Midwifery Council.
  2. The health visitor in local authority 3 was an agency health visitor employed in the service from August 2019. The agency health visitor was dismissed from the role in May 2020.
  3. The importance of ensuring that children are transferred safely and effectively between local authority areas needs to be reinforced with health visiting staff, both employed and contracted. Health visitors hold children’s cases under the nationwide Healthy Child Programme, that being ‘universal, universal plus and universal partnership plus[[10]](#footnote-10)’. As the children had previously been subject to a child protection plan, they should have been referred through the existing process under Universal Partnership Plus. It is a reminder to health visiting services across all the boroughs to reinforce this issue through effective supervision and management oversight.
  4. Referral pathways in health visiting services should be well understood by practitioners in health and beyond to ensure children are receiving the correct level of support and intervention from the health visiting service.
  5. There needs to be awareness raising of partner agencies, including health and the voluntary sector, as to the complexity and impact of domestic abuse on children. The children’s presentation and experiences did not prompt further enquiry and investigation.

**Housing**

* 1. Birth mother had made a homeless application to local authority 4 and the domestic abuse housing officer in local authority 4 undertook a CAADA Risk Identification assessment (now known as ‘Safelives’ Dash risk checklist/ assessments), which deemed mother to be at high risk. The domestic abuse housing officer did not believe that birth mother could afford a property in the borough and this may have been the reasoning for not referring the family to other services in the borough. The assumption, which has been reinforced in other commentary, is that birth mother was ‘safe’ in the refuge and that she was receiving appropriate support. The needs and risks of the children do not appear to have been considered separately.
  2. Birth mother reported that she wished to move from refuge accommodation as she was finding the environment difficult to live in with the children. The domestic abuse housing officer did support birth mother with an application for housing benefit and council tax.
  3. Local authority 5 housing department had no contact with local authority 4. Local authority 4’s placement policy for temporary accommodation and private rented accommodation states that ‘We will aim to ensure that information concerning details of placements in temporary accommodation and private rented accommodation outside of the borough is shared as far as possible in a fair and timely manner with the relevant councils in areas where families are moving to’ and ‘Vulnerable families – so far as is practicable if placing vulnerable families outside of the borough we will ensure that such families will continue to receive appropriate support’. Neither of these actions were followed in the case of Child T and her family as the case was closed at the point of the family moving. This is despite the CAADA risk assessment indicating birth mother was at high risk of domestic abuse and the high likelihood that if the family had rehoused in local authority 4, they would have been referred to children’s social care and the MARAC.
  4. The housing department in local authority 4 have reflected that all families moving from refuge accommodation and making homelessness applications to the borough should be referred to the MASH or similar children’s social care front door arrangements.

1. **Safer sleeping advice and guidance**
   1. Birth mother recalls receiving safer sleeping advice from her previous health visitor when her first daughter was born. She stated she understood the risks regarding safe sleeping, but she recalled this was particular to co-sleeping advice.
   2. In the refuge accommodation, birth mother was provided with a cot, a bunk bed and a single bed in her room. This is standard furniture for rooms in the refuge. The refuge have confirmed that their health and safety policy states that no children under 7 should use the top bunk bed and staff advise new residents that children who cannot sleep on their own in a bed must be in a cot. Birth mother reports that Child T slept in the cot in the refuge.
   3. Birth father recalls that he purchased a cot for Child T. This was not present in the 2-bedroom flat that mother and the children moved to in local authority 5.
   4. The property found in local authority 5 was a furnished flat and in the children’s bedroom there was a bunk bed with mattresses. Birth mother had requested a bed guard from the voluntary sector agency for Child T to sleep on the bottom bunk and told the report author that ‘everyone was aware that I needed the bed guard for Child T to sleep on the bunk bed’. This was a safety measure birth mother put in place to prevent Child T falling out of bed thus considering her wider safety. Birth mother also described Child T as being a ‘big child’ for her age and had been eating solid food from the age of 6 months. This was birth mother’s reasoning for allowing Child T to sleep in the bunk bed with a bed guard. Without appropriate guidance and advice from safeguarding professionals, birth mother made a judgement based on what would keep Child T safe in a bunk bed and what was available to her in terms of bedroom furniture.
   5. Given there were indications of Child T having some developmental delay, which remained unassessed until February 2020, this sleeping arrangement may have been less safe for Child T.
   6. No professional or agency entered the accommodation in local authority 5 owing to COVID-19 restrictions and therefore no advice was given to birth mother as the suitability of the sleeping arrangements for 2 very young children. Birth mother was managing on what was provided.
   7. The housing officer and the estate agent resolved issues regarding the condition of the flat and some physical repairs were made. Whilst landlords have responsibilities to ensure that furniture provided meets the legal standards of flame resistance, it is not the role of housing officers, landlords or estate agents to consider the suitability of the accommodation or furniture provided for families with young children. This is a wider safeguarding issue that housing authorities may need to consider as part of their assessment of suitability. Tenants do have to take personal responsibility, but it is not unreasonable for a risk assessment to be undertaken given these circumstances.
   8. Whilst there is information provided to professionals on local authority child safeguarding partnership websites regarding safer sleeping, this does not appear to ‘land’ with the wider network and appears to remain the responsibility of health practitioners.
   9. Whilst local authority 5 have published a ‘Safe Baby Toolkit’ it makes no reference to the safe use of bed guards. There is a need to ensure there is a public health message that touches a wider audience. This view is reflected in the recently published review of sudden unexpected death in infancy report published by the Child Safeguarding Practice Review Panel[[11]](#footnote-11). “We believe that practitioners in all agencies who are working with families with children at risk need to develop a clearer evidence-informed understanding of parental decision-making in relation to the sleep environment and how this might be changed”.
   10. The report goes on to state that “It’s important that we give all families information about safe sleeping, but for some families who are struggling with multiple issues the existing information is simply not enough. This is not about blaming parents who have suffered such tragedies. This is a societal issue, and we need to listen to and talk with families realistically and honestly so we can make sure that their babies sleep safely all the time.”
   11. The report also suggests that children’s changing circumstances became a risk factor, in that routine infant sleeping arrangements were disrupted. It is argued that the extent to which sudden infant death syndrome in out-of-routine circumstances, is not predictable, it can nevertheless be made more preventable.
   12. Rightly, co-sleeping has been the focus of safer sleeping messages, but this should now be extended to the safe use of bed guards.
   13. There is no indication that the second-hand bedroom furniture was a causal factor in Child T’s death. There are studies that suggest that second-hand mattresses are indicative of an increased likelihood of sudden infant death[[12]](#footnote-12) yet more significantly, is the use of the bed guard. Whilst modern cots conform to British Safety Standards negating the need for cot bumpers, this is not the case for children’s bed guards. There are no British Safety Standards specifically for bed guards for children but there is reference in the Health and Safety Executive (HSE) about the safe use of bed rails[[13]](#footnote-13). Poorly fitting mattresses and bed guards have led to mobile babies and young children trapping themselves between the mattress and the bed guard. In normal circumstances, the manufacturer’s instructions contain information on the dimensions and other characteristics, to reduce the risk of possible entrapment. They also contain information on the compatibility with other equipment and whether they are suitable for babies and children.
   14. The evidence points to agencies avoiding the use of second-hand bed guards without the necessary instructions for use. Whilst this is parental choice, agencies providing such equipment through a volunteer or statutory sector agency, should consider the risks and the child’s sleeping arrangements prior to providing such equipment, particularly if second hand.
   15. Whilst birth mother disputes the impact and significance of her own drug and alcohol use on the evening prior to Child T’s death and whether this impaired her ability to care for the children, this is sadly reported in almost all sudden infant deaths reviewed in the report. The post-mortem report and hair strand testing on Child T indicated she had been exposed to cannabis and cocaine but there was no causal link between this and her death. Birth mother denies this was a factor in Child T’s death but, the fact that drugs were found in toxicology reports on Child T suggests she was regularly exposed to birth mother’s drug use at some level. Birth mother reported that she was able to care for the children safely despite her drug and alcohol use the night before Child T’s death.
2. **Voluntary sector engagement with safeguarding partnerships** 
   1. What became evident through this review, was the lack of engagement and relationship with the voluntary sector agencies involved with Child T and her family and the statutory safeguarding partners. It was concerning that there was no contact between these agencies despite the history of the children. Increasingly, the voluntary sector is taking responsibility for families and providing support where previously this would have been the role of statutory services. In this case, the children had suffered significant harm in the care of their birth mother previously and birth mother was fleeing domestic abuse. The children’s presentation did raise worry and concern to the agencies working with the family. However, these children were managed via a universal health offer and several referrals to voluntary sector agencies. Whilst it is vital to have a mixed economy of available support to families, this must be in the context of risk, harm and need. Referrals for support are not an intervention in themselves and leaves open missed opportunities to assess the direct needs of the children.
   2. With the changes in safeguarding partnership arrangements with the introduction of Working Together 2018, there remains a crucial need to ensure engagement with voluntary sector partners on safeguarding matters. Whilst not diminishing their role and expertise in this case, these agencies were working in isolation with a highly complex set of circumstances with volunteers who do not have the requisite safeguarding skills, experience and knowledge despite training and development opportunities being in place. This is a wider safeguarding issue and if there remains an expectation that voluntary sector agencies fill those gaps in services, they must be supported strategically and operationally by those agencies with safeguarding knowledge, skills, and accountabilities.
3. **COVID-19 and its influence on practice** 
   1. The family moved to the new accommodation in early March and the first ‘lockdown’ as a result of the COVID-19 pandemic occurred on the 23rd of March. This banned all non-essential travel and contact with people outside of their home. This shut almost all schools, venues, facilities, and amenities. Nationally, children’s social care services put in place several measures to ensure services were provided to vulnerable children and families. During the initial lockdown they were visiting children that were already categorised as child protection (subject to child protection plans) or were deemed at risk under Section 47 of the Children Act 1989 following a strategy discussion. Some children had an individual risk assessment to consider the most appropriate and proportionate response. Children who were subject to child in need plans or assessments were predominantly visited virtually using Facetime or WhatsApp. Some local authorities instigated a RAG system (red, amber, green dependent on their risk and need) to determine the level of support that would be offered during lockdown.
   2. Sadly, as Child T and her sister were not known to statutory agencies in local authority 5, they were not afforded any of that support. In the case of Child T and her family, the timing of their move could not have been at a more challenging time. The subsequent lockdown had resulted in the only agency contact being via telephone. Birth mother had not registered with a GP, was in new accommodation, in a new area, with no family support and was faced with remaining in the flat for significant periods with 2 very young children, one of whom had challenging behaviour. Birth mother had not had full time permanent sole care of her older daughter for some months prior to the move to the refuge.
   3. Birth mother’s own experiences have influenced and impacted on her ability to effectively care for her children. She had very limited family support and relied on friends and relationships to support and meet her needs. She has a history of abusive and controlling relationships where she has struggled to place the needs of the children first. She has a history of not engaging with the support that has been offered. The move to the refuge was intended to be a fresh start. Her move to new accommodation in a new area was to ‘start again’. Without doubt, the restrictions associated with COVID-19 limited significantly, the contact with supportive agencies. It is within this context that birth mother sought support and to avoid loneliness through friends who stayed with her during lockdown. This sadly triggered a regular use of drugs and alcohol again.
   4. COVID-19 had no influence on the poor practice of not transferring, referring, communicating, assessing or appropriately planning for the children.
   5. Between April and October 2020, almost 40% of serious incident notifications to Ofsted were for babies[[14]](#footnote-14). There was also an increase of unexpected baby deaths in this period, deemed to be preventable tragedies with babies for example not being put down to sleep safely. It was argued that all professionals who work with families must be curious and whilst ‘continuing restrictions may be hampering face-to-face visits…these children are out of sight; they should never be out of mind’.
4. **Examples of good practice**

* The refuge worker remaining involved with the family despite the move to new accommodation in local authority 5.
* The positive engagement and impact of the work of the community nursery nurse in local authority 3
* The referrals to support services by the early help practitioner in local authority 3 were appropriate and considered the needs of the children.
* As a result of this case, health visitors are now assigned to refuge accommodation in local authority 3.
* 2 voluntary sector agencies have changed their referral processes in response to this case and now ask for more detailed information regarding the history of the family and previous and current agency involvement.

1. **Conclusions**
   1. The sad death of Child T could not have been predicted by safeguarding agencies, yet there is learning for agencies and services arising from the review of the children’s circumstances.
   2. Vulnerable families who move regularly between local authorities challenge local agencies to remain focused on the needs and risks of children. Accountability and responsibility for children transferring between local authorities requires proactive action from safeguarding professionals and their responsibilities need to be reinforced.
   3. A lack of knowledge of children’s histories and the role of birth fathers leads to no agency fully understanding the context of children’s risks and needs.
   4. The behaviour of young, particularly pre-school children, needs to prompt further enquiry as to the reasons behind those behaviours rather than addressing this through behaviour management. To do so supports a better understanding of a child’s trauma.
   5. The ability of parents to make use of interventions must be considered in the context of their own childhood experience and current trauma.
   6. Children’s experience of domestic abuse needs to be better understood by all practitioners who meet them.
   7. Professionals need to be aware of their own bias and judgements of risk when working with adults in domestically abusive relationships. Perpetrators of abuse can invoke strong feelings in professionals and this needs to be regularly considered in robust case work supervision and how it influences thinking and judgment. Supervision should be the safe vehicle to explore such issues and provide challenge and support to thinking and planning. Equally, parenting capacity and the impact of domestic abuse on survivors parenting needs to be considered alongside the support those survivors need.
   8. Children’s need to be separately assessed from the needs of their birth parent when they move to refuge accommodation. Children’s social care need to be proactive in informing their colleagues of family’s moves and reassure themselves that accountability for the children’s case is clear.
   9. Safeguarding agencies need to reinforce information sharing and communication both within agencies and between agencies. The voluntary and community sector and statutory safeguarding agencies need to take a proactive role in ensuring they join up.
   10. Children’s social care need to review their arrangements for closure of children’s cases owing to non-engagement with the plan. These judgements, whilst appearing appropriate management of workload, should consider the risks associated with such a decision based on the history of the children’s circumstances.
   11. Integrated chronologies hold considerable value in fully understanding a child’s risks and needs. Local Child Safeguarding Practice Reviews should not be the only opportunity to pull together integrated chronologies. Equally, this information should be shared when children move home.
   12. Survivors of domestic abuse who leave their family homes and flee to refuge accommodation do so with very little or nothing. When it comes to them being rehoused from the refuge, survivors are faced with having to move to a new property at very short notice. Grants and donations of second-hand furniture are the norm to furnish their new properties. It is therefore not unreasonable to consider whether a housing risk assessment should be undertaken for survivors moving from refuge accommodation, to ensure that the property and furnishings meet expected standards and are considered safe for children.
   13. The safe use of bed guards needs to be added to the safe sleeping messages from safeguarding partnerships. Suitable sleeping arrangements for children should be part of all professional’s assessment when working with vulnerable families. Safeguarding partnerships need to ensure the learning from the National Child Safeguarding Practice Review Panel’s recent report into sudden unexpected death in infancy are shared widely.
   14. COVID-19 prevented agencies from visiting family homes. The use of video and social media applications that enable video calling should be encouraged when it may be challenging to visit family homes and as a way of seeing children’s living environments.
2. **Summary of learning**

* There should be effective and appropriate transfer of children’s cases between safeguarding agencies and implementation of escalation routes between local authorities if this is not achieved.
* Children’s cultural and ethnic backgrounds should always be considered in assessments and care planning.
* The voluntary sector, including specialist domestic abuse services, have a key role to play in supporting vulnerable families and should be part of safeguarding partnership arrangements.
* All professionals need to recognise the impact of trauma experienced by parents can have on their ability and availability to then focus on the needs of their own children.
* Professionals need to fully understand the role and importance of absent or non-resident birth fathers in children’s lives.
* Assessments of children should be undertaken alongside the provision of services and interventions to ensure those services are also appropriately targeted to children’s needs.
* Information sharing and communication within and between agencies needs to be reinforced.
* Children moving to refuge accommodation should be assessed under Section 17 of the Children Act 1989. The temporary safety of refuge accommodation for the mother and the children should not influence the decision making in relation to the significant harm experienced by the children.
* Risk assessments of adults also need to address the impact of risk to children.
* Professionals working with vulnerable families need to have support to reflect upon their own professional bias particularly when working with birth fathers who are perpetrators of domestic abuse, such as reflective supervision.
* Closing of children’s case files needs to be based on judgements of risk rather than family moves or non-engagement with a plan.
* All professionals working with families should have a level of understanding about safer sleeping and be able to question the suitability of those arrangements.

1. **Recommendations**

* Safeguarding partners need to seek assurance that individual organisations have effective escalation procedures and policies that go beyond local boundaries.
* The safeguarding partnership needs to consider the appropriateness of implementing integrated chronologies for families that are transient and move between local authorities.
* All families moving to refuge accommodation and making homelessness applications to local authority housing should be referred to the MASH or similar children’s social care front door arrangements in the authority to which they are moving.
* Survivors of domestic abuse moving from refuge accommodation to new properties should be afforded a risk assessment as to the suitability of the accommodation and its furnishings.
* MASH or Single Point of Access arrangements in children’s social care should consider ‘holding’ children open for a short period of time (48 hours) when families are referred as moving into the local authority without consent.
* Local authorities need to consider the use of ‘Transfer In’ meetings to ensure effective transfer of children and families between local authorities regardless of the case ‘status’.
* The Child Death Overview Panel, Public Health and Trading Standards should consider additional warnings regarding the safety of bed guards and their appropriate use in safer sleeping messages.
* The safeguarding partnership should encourage the engagement of the voluntary and community sector agencies in safeguarding partnership arrangements, particularly providers of domestic abuse services.
* Safeguarding partnerships need to ensure there is a strategic link between safeguarding partnerships and Community Safety Partnership and MARAC arrangements.

1. Family Law Act 1996 [↑](#footnote-ref-1)
2. A Prohibited Steps Order is an order which prohibits a party (usually a parent) from a certain activity relating to a child(ren), and which also prohibits a party from exercising their parental responsibility. [↑](#footnote-ref-2)
3. Often the first point of contact, MASH acts as a triage service within the social care front door. The team delivers an information gathering and co-ordination service to identify the most appropriate outcome for children and families. [↑](#footnote-ref-3)
4. A **Significant** Child Protection **Incident Review** aims to help health staff prevent or minimise recurrence and future harm of children they suspect of being at risk.  [↑](#footnote-ref-4)
5. To stop the spread of coronavirus (COVID-19), the public were advised to avoid close contact with anyone they do not live with. This was called social distancing. [↑](#footnote-ref-5)
6. Hazardous home conditions for the child including broken glass on the floor, soiled nappies and health and developmental appointments missed. Use of cannabis and heroin and refusal to engage with any services appointed to support the family. [↑](#footnote-ref-6)
7. **Coercive control**is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. [↑](#footnote-ref-7)
8. Where a local authority have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm. the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child’s welfare. [↑](#footnote-ref-8)
9. The Serious Incident framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. [↑](#footnote-ref-9)
10. Health visitors lead and deliver the Healthy Child Programme. The HCP is the evidence based public health programme for children and young people, which provides a range of health interventions and support beginning in pregnancy and continuing through early childhood. [↑](#footnote-ref-10)
11. Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm. Final report July 2020 [↑](#footnote-ref-11)
12. # Used infant mattresses and sudden infant death syndrome in Scotland: Case-control study, December 2002. BMJ Online

    [↑](#footnote-ref-12)
13. [Health Services - Safe use of bed rails](https://www.hse.gov.uk/healthservices/bed-rails.htm) [↑](#footnote-ref-13)
14. Amanda Spielman, Ofsted Chief Inspector 2020 [↑](#footnote-ref-14)