SERIOUS CASE REVIEW OVERVIEW REPORT

Serious Case Review in respect of	Matt
Date of Incident	June 2019
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1. Introduction

1.1 The subject of this review is Matt, who at the time of his death in June 2019 was 2 and a half months old. At the time of his death, Matt was in the care of his parents. The ambulance service attended the home address at the request of the parents and sadly Matt was found deceased. Both parents were arrested to allow the circumstances of Matt's death to be fully investigated, the Crown Prosecution Service have reviewed the evidential file and decided to NFA the case. There was evidence at the time that the parents had used cannabis and/or alcohol on the night of Matt's death.

1.2 The cause of Matt's death has not been formally determined and this review has been undertaken on the basis that abuse or neglect is suspected.

1.3 In July 2019, the case was discussed by the Coventry Safeguarding Partnership Rapid Review Group and it was agreed that the case met the criteria for a serious case review.

1.4 The names of those involved in this review have been changed.

2. Terms of reference

2.1 The subject of this review is Matt. Matt had one older sibling Luke.

2.2 The dates that the review focused on were from the time that Luke was born in February 2018 and to the date of Matt's death in June 2019.
In addition to the dates within scope, agencies were asked to consider any information that impacted on or had potential to impact on matters that related to safeguarding Matt or Luke.

2.3 As well as generic safeguarding issues, agencies were asked to consider the below areas.

(i) What were the indicators of neglect in the lives of the children? - consider the following:

- non-attendance at appointments/ occasions when children were not brought to appointments. This should include the antenatal period and the period in the special care unit.

  Factors to be considered should include the following:

  - Cleanliness of the children
  - Nappy rash

- Home conditions
- Nutrition
- Disguised compliance
- And any other indicators

(ii) Were there indicators of substance misuse?
(iii) Were there indicators of domestic abuse?
(iv) How did agencies respond to these indicators of neglect? – Please include inter agency communication and working.
(v) How did agencies respond to indicators of substance abuse?
(vi) Is there evidence that the childhood experiences of the parents' influenced their ability to care for their own children?

- how was this addressed?
- Have you identified any areas that you consider to be good practice?

3. Methodology

3.1 Working Together 2015, the guidance under which this review was completed, allows Local Safeguarding Children Boards to determine their own processes for the review. The Case Review Sub-Group of the Coventry Safeguarding Board, which managed the review process, identified which organisations were involved in the case. Each organisation was asked to prepare and submit an Individual Management Review (IMR) and a chronology detailing the relevant interaction they had with the family. The organisations supplying IMRs and Chronologies were: -

South Warwickshire Foundation NHS Trust
Coventry Children Services
National Probation Service
University Hospital Coventry and Warwickshire NHS Trust
NHS City of Coventry Healthcare Centre
GP surgeries
West Midlands Police
Coventry and Warwickshire NHS Partnership Trust

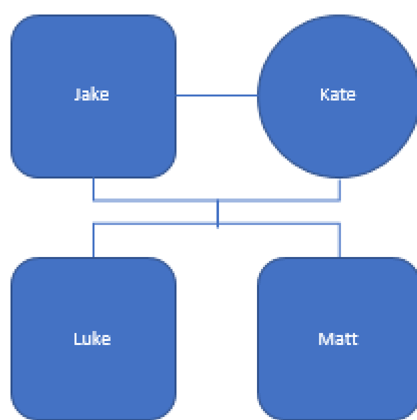
The below organisations were involved to a lesser degree and were asked to provide covering reports of their involvement.

Keystage 2 Housing

3.2 The review was paused between March and September 2020 due to the challenges presented by the Covid19 pandemic. In September 2020, a virtual learning event took place, with professionals from all the agencies involved gathering to discuss the case. The outcome of this discussion is reflected in the report.

4. The family and parallel proceedings

4.1 Matt's birth parents are Kate and Jake. It is not known exactly how long they have been together as a couple, but for at least for the time period focussed on by this review. Matt's older brother, Luke, was born in February 2018. Kate was a former looked after child and as a result, during the first part of this review, lived in supported accommodation before moving to a flat and taking up her own tenancy. It is apparent that Jake lived at both addresses for large parts of the time.



4.2 Kate was known to Children Social Care (CSC) from the age of 4. She had experienced domestic abuse and neglect in her childhood and as a result became the subject of a care plan on two occasions. Kate was the subject of care proceedings on three occasions with a care order being made in March 2012, when Kate was 12 years of age. Kate was then accommodated in several placements and was considered vulnerable to Child Sexual Exploitation (CSE). There were a number of incidents recorded where Kate was suspected of using cannabis. This was denied by Kate.

4.3 Kate was 17 years and 10 months when Luke was born and was 19 years old when Matt was born. When Kate attained the age of 18 years, she received services from Coventry Local Authority as a former relevant child[1]. She had the support of a personal advisor and was provided accommodation from a housing support organisation before she secured her own tenancy.

4.4 Little was known regarding Jake's early life. There are records which suggest that he had a strong family network and this is reflected in the chronology, where Matt's paternal grandfather told CSC that he had concerns regarding the ability of Jake and Kate to

[1] ***Relevant children*** are those aged 16 and 17 who meet the criteria for eligible children but who leave care. ***Former relevant children*** are those who before reaching the age of 18 were either eligible or relevant children. – Children Leaving Care Act 2000 - http://www.legislation.gov.uk/ukpga/2000/35/notes/division/2

manage financially and that he had assisted them (March 2018). The worker completing the CSC pre-birth assessment of Luke mentioned separately that there was evidence that Jake had used cannabis, but this is not fully reflected in the actual assessment At the time of the birth of Matt, Jake was 22 years of age and was 3 years Kate's senior.

5. Summary of Facts

5.1 In mid-February 2018, Matt's sibling, Luke was born. At the time of his birth, his mother Kate, was 17 years and 10 months of age and was a Looked after Child. Prior to his birth there had been concerns expressed by the community midwife that Kate had not been engaging with the Family Nurse Partnership (FNP)[2]. This resulted in a referral being made to Children Social Care (CSC).

5.2 In early February 2018, there was also a referral from police after they had attended a domestic incident involving Kate and Jake at their home address. The incident had been reported by a third party. The incident was relatively low level, being a verbal altercation and no offences were disclosed.

5.3 At the time CSC undertook a pre-birth children and family assessment and deemed that Kate should be supported by the Common Assessment Framework (CAF)[3]. The CAF was not in fact utilised as it was considered that the agencies already involved with Kate could provide the required support.

5.4 Kate's key worker, from the supported accommodation, visited the address 5 days after Luke's birth, at the time Kate was not in, but the key worker noted that the property was in a poor state. There were dirty nappies on the coffee table in the lounge, there was rubbish and uneaten food evident in various areas and a concern that Luke was not sleeping in his moses basket. The key worker contacted Kate's LAC social worker and made a safeguarding referral to the Multi Agency Safeguarding Hub (MASH).

5.5 Kate's meaningful engagement with services continued to be a concern after Luke's birth. The community midwife attempted to visit twice but was not able to see Kate or the baby on these visits and was not able see Luke until one week after his birth. At this time the community midwife noted no concerns. The key worker re-attended the address and found that the property was spotless. Kate apologised for the previous condition of the property and attributed the mess to Jake.

5.6 Kate was discharged by the midwifery service two weeks after the birth of Luke to the support of the GP and health visiting services. At the beginning of March 2018, the family nurse contacted Kate's social worker and disclosed that Kate had been visited. The

[2] Family Nurse Partnership - voluntary programme for young first-time mothers (and their partners), aged 19 years or under. Specially trained nurses provide regular home visits, from early pregnancy until the child is aged two. FNP uses methods on attachment, relationships and self-efficacy.
[3] Common Assessment Framework (CAF) - The Common Assessment Framework (CAF) is the process to identify children who have additional needs, assess needs and strengths and to provide them with a co-ordinated, multi-agency support plan to meet those needs.

nurse noted that the state of the property had declined, as had Kate's personal hygiene. Kate also stated that she was giving Luke larger feeds to prevent him requiring feeding so frequently. The social worker completed a request for Early Help outlining the poor engagement with professionals, missed health appointments and poor home conditions. There is no evidence that the early help requested was provided.

5.7 The key worker visited in early March and highlighted concerns that Jake had been feeding Luke next to an open window, exposing him to a draft and was seen to be washing plates with bathroom bleach. Around this time there were also a number of visits made by family nurse and LAC social worker where access could not be gained. In mid-March 2018, Kate's social worker visited the address and access was directly denied and a suitcase was placed across the letterbox to obscure vision through it. The social worker made a referral to the MASH.

5.8 The following day the social worker and key worker visited the address. They again found it very difficult to gain access to the address and Kate was verbally abusive. Kate and Jake were arguing with each other, shouting with Luke present. Initially Kate refused to allow the professionals to see Luke, but finally relented. Luke had a full nappy; his bottom was described as being 'red raw' and he had dried vomit on his clothing. When Luke's bottom was wiped, he was described as being in pain. It was also noted that Kate handled Luke roughly and was not supporting his head. The social Worker advised the parents to take Luke to seek treatment at the 'walk in centre' to have his bottom treated. There is no evidence that any measures were put in place to ensure this happened. The professionals made a referral to the MASH, drawing attention to the poor condition of the property, the ability of the parents to provide basic care to Luke, lack of food at the property and unhygienic conditions.

5.9 Three days after this referral was made Luke was admitted to hospital with an abscess/swelling at the top of his buttocks. Luke was treated with intravenous antibiotics and transferred to the children's hospital for ongoing care. Luke also had conjunctivitis and it was noted that he was not registered with a GP. A strategy meeting took place the day, following Luke's admission. The previous information regarding the concerns on poor engagement, concerns on parenting ability and neglect were shared. It was agreed that CSC would undertake a single agency investigation with a view to progressing to an Initial Child Protection Conference (ICPC). If the parents continued to fail to engage, CSC would present the case to the legal panel to consider proceedings. The case was closed by police at this stage, after being recorded as not being a recordable crime.

5.10 During the course of Luke's stay in hospital, staff raised concerns over the inappropriate behaviour by the parents. There were also concerns raised regarding the personal hygiene of the parents. Two days after Luke's admission, he was discharged from hospital. On discharge, the social worker put a written agreement in place with the parents to agree to both announced and unannounced visits, recognising that any failure to cooperate would result in legal advice being taken. Before Luke was discharged, the social worker and key worker visited and checked the living conditions of the home address.

5.11 Unannounced visits were undertaken through the remainder of March 2018, with conditions noted as generally good with no safeguarding concerns noted. On one occasion, there was no one in, but a faint smell of cannabis could be detected through the letterbox. The parents were challenged with this on the next visit and refuted that they were responsible, attributing the smell to a neighbour.

5.12 In early April 2018, the family nurse visited and recorded no concerns. The home was clean and uncluttered. Safe sleeping was discussed at some length, and the nurse was shown a photo of Luke asleep on Jake. It was noted that there was good family support, and this had been witnessed on a previous visit with grandparents being present. Luke had still not been registered with a GP and this was, according to the parents, to be undertaken the following day. A similar picture was noted by the social worker who visited two days later.

5.13 There followed evidence that engagement became patchy with visits cancelled for the key worker who was supposed to visit the family every other day and the family nurse. Luke was not taken to a previously arranged paediatric appointment to explore a heart murmur that had been identified at birth. On 20th April 2018, the CSC children and family assessment was completed. It concluded that there were no current safeguarding concerns and the original concerns were no longer apparent, and it was left for the agencies supporting the family to remain involved. Luke's case was closed to CSC.

5.14 Towards the end of April and into May 2018, there continued a pattern of missed and cancelled appointments by the parents. The housing key worker raised concerns as they were not able to see the family as required. On the same day in late May 2018, the records indicate that the family was visited by the social worker and housing key worker. Entry was not permitted initially, and the housing key worker facilitated entry using their own keys. They noted the property being untidy and cluttered. The same day the family nurse visited and noted the surroundings as being appropriate and Luke being well cared for.

5.15 In June 2018, the key worker expressed concerns to the social worker on a number of occasions. The concerns being that Luke was not being stimulated by the parents and the family nurse had not been able to gain access to the home on occasions. The social worker stated there should have been early help support in place as this had been requested in March. The social worker stated they would chase the referral.

5.16 The key worker was a regular visitor and continued to be concerned about the time the parents took to answer the door and felt that they were concealing something. They felt that Luke was not sleeping in the moses basket as there was no apparent bedding and he was sleeping with the parents. There was a dog at the premises that had been aggressive towards a worker. The service noted that the property could be poor one day and within a short space of time would be spotless. They felt that home conditions altered depending on when a visit was anticipated.

5.17 At the end of June 2018, the support/housing agency made three referrals with concerns over the home conditions. They stated that Luke's mattress was heavily stained

with urine. Luke was often seen in dirty nappies and his feeding bottles were dirty. Luke was also being left in his cot for extended periods of time. There had also been a domestic abuse incident where Jake had sustained bruises and bite marks. The support service also forwarded 11 photographs to support their concerns.

5.18 On the same day the Family Nurse attempted to visit and spoke to Jake, who stated that he and Kate had been in dispute for some days and had now separated. Luke and Kate were with her parents at the time.

5.19 No strategy meeting was convened but CSC undertook a children and family assessment. The support service arranged for the address to be cleaned and cleared. They found that the state of the house was extremely poor with rotting food found in cupboards, filthy nappies and used condoms all evident.

5.20 As part of the assessment the allocated social worker (same social worker as previously) visited Luke at his home address. Luke was observed to be' thriving and secure attachments' were observed. Jake was present during the visit but said not to be living at the address, but visiting daily. The parents were challenged on the previous poor condition of the address and domestic abuse and were said to appear contrite.

5.21 The result of the assessment was that a child in need plan would be put in place. The assessment had only included one visit and discussion with the parents, and this was undertaken with them both together. The plan included an action for the police to be called if access could not be gained to the address in the future for checks to be made. The family nurse remained concerned over the parents' engagement. As a result of the inability to visit they had no record of Luke's development or weight.

5.22 In early July 2018, the social sorker attended the address on an unannounced visit and saw Jake outside the address. Kate and Luke were not in.

5.23 During July 2018, the family were visited on a number of occasions, it was said that Jake was still living separately but visiting daily. Kate had financial pressures and was being supported by both maternal and paternal grandparents. CSC also provided support in the form of food vouchers on two occasions.

5.24 Towards the end of July 2018, the social worker and key worker attended the address and saw that Luke was suffering from a bad nappy rash. There also appeared to be a burn on his leg, which the parents claimed was part of the nappy rash. A Child Protection medical was arranged and it was confirmed that Luke was suffering from a severe nappy rash and this accounted for the rash on his leg. The medical was arranged outside of the child protection procedures and as such the family nurse had no knowledge of the medical taking place or the result of it.

5.25 At the start of August 2018, the family moved to a new address. On the same day they were visited by the family nurse and social worker. There was a good record made by the family nurse on the home conditions and how the parents were interacting with Luke.

5.26 There were a number of Child In Need (CIN) meetings in July, August and September 2018. The meetings did not always have all the relevant agencies present and the minutes do not reflect the level of concerns that had previously been expressed. At the August 2018 meeting it was noted that the family had taken acquired two dogs, one being a large Pitbull type of dog.

5.27 At a visit in late August 2018, the family nurse advised regarding the safety issues associated with the dog and leaving Luke unsupervised with them. In this visit and one undertaken by the social worker, no safeguarding concerns were noted. Although the Family Nurse did note that Luke had a mis-shaped head and a red warm skin patch was observed on Luke's back. At this time no nappy rash was observed.

5.28 In September 2018, the social worker attempted visits on two occasions but there was no reply. Kate failed to attend a Child In Need (CIN) meeting and it was re-scheduled. Kate and Luke had not been seen by professionals for two weeks and the social worker and family nurse liaised over their concerns.

5.29 At the reconvened CIN meeting in September 2018, it was recorded that '*social care have no safeguarding concerns presently and the case to step down to CAF level 2. PA (personal advisor) to remain involved and family nurse until Luke is two'.* It was recorded that CSC would undertake a couple more unannounced visits and then step the case down. The meeting was attended by Kate's personal advisor, LAC social worker and the family nurse, and there is no record of professional disagreeing with the decision.

5.30 During October 2018, the social worker attempted to contact Kate on two occasions to arrange visits, but no response was forthcoming on each occasion. No unannounced visits were undertaken, and the case was closed to CSC in late October 2018. In the management oversight review, it was stated that the situation had significantly improved. It recognised that there had been no response to the request for Early Help but supported the decision for the case to be closed.

5.31 The day after the case was closed, Kate attended her first early scan appointment for her second pregnancy, the pregnancy of Matt. By the end of October 2018, the family nurse had further concerns over the parent's lack of engagement and started to discuss referring the case back to CSC.

5.32 Through November 2018, the non-engagement continued with Kate cancelling and not responding to family nurse contact. The new housing provider also stated that the tenancy stipulated that in the first 10 days Kate had to be seen regularly. This had not been achieved and there was evidence that Kate was avoiding contact with professionals. Kate's personal advisor was also not being contacted by Kate.

5.33 As a result of the lack of contact, the personal advisor made a referral to the MASH to request the police to undertake a safe and well check. This was done and whilst the home conditions, particularly Kate's room was very untidy, there were no safeguarding concerns noted. The parents were very compliant with the police and claimed their lack of contact had been due to neither having a working mobile phone. The police confirmed that they would be visited by CSC the following day.

5.34 A Child and Family Assessment was not undertaken as the previous case had been closed within 8 weeks. The social care team manager agreed that the family should be visited by the social worker within one week.

5.35 At the beginning of December 2018, the social worker attempted to visit the family but there was no reply. The social worker left a note at the address. In mid-December 2018 the personal advisor and staff from the housing association saw Kate at her home address, Luke was also seen, and no safeguarding concerns were noted. Kate stated that she was to be evicted due to rent arrears and that she was over 12 weeks pregnant and had not seen her GP. The social worker discussed the visit with the personal advisor and on the basis that Kate and Luke had been seen by them and the police, the case was closed to CSC. There was no management oversight on closure. The family nurse contacted the Central Team of CSC and the MASH requesting the name of the allocated Social Worker, to challenge the decision but this information was denied. There is no record that this decision was challenged.

5.36 During January 2019, there were a series of failed visits to Kate by the family nurse with messages being left. At this stage Kate was 20 weeks into her second pregnancy and had not booked an appointment with a midwife. The personal advisor had also been trying to have contact with Kate but had not been successful.

5.37 During February 2019, Kate saw her GP for an infection and stated that she had paid for a private pregnancy scan at 16 weeks and all had been normal. A midwife appointment was made for the end of February but despite numerous attempts to contact Kate, she did not attend this appointment.

5.38 At the end of February and beginning of March 2019, Kate, Luke and Jake were seen by the family nurse. Luke was seen to be well but still not registered with a GP and was aged 13 months. Safe sleeping was discussed with Kate and child safety in the garden, which was cluttered. Kate to be cleared.

5.39 At the beginning of March 2019, GP records show that Luke was not bought to a nurse appointment, which was re-arranged. In mid-March 2019, the personal advisor saw Kate. Kate stated that she had been unable to get a midwifery appointment. The personal advisor was concerned at the lack of antenatal care but did not make referral to CSC.

5.40 In mid- March 2019, Kate was seen by the community midwife at home for a booking in appointment, she stated she was 25 weeks pregnant. At the end of March 2019, the family nurse saw Kate, Luke and Jake at home. There were no concerns, the home was clean and uncluttered and the engagement between the family was viewed as warm and appropriate.

5.41 At the beginning of April 2019, the community midwife tried to visit on three occasions but there was no response. Kate also cancelled a family nurse appointment and did not attend an antenatal clinic appointment. On 9th April 2019, Matt was born prematurely, at 29+6 weeks gestation. Matt underwent 2 days intensive care, 9 days high dependency care and 32 days special care. The parents visited the hospital on most

days. The hospital staff raised concerns regarding the parent's personal hygiene, but this was only raised with the parents on two occasions. While Matt was in hospital, the personal advisor and family nurse submitted a referral to Children Social Care detailing their concerns regarding the parent's engagement. The family nurse had completed 10 of 39 attempted contacts with Kate. There were concerns over the parent's care of Luke and his diet, which was making him overweight for his age. Matt was discharged home on 21st May 2019. The hospital had heard from CSC on 16th May 2019 that a Child and Family Assessment would be undertaken as the family nurse still had concerns regarding the parent's engagement.

5.42 Whist Matt was still in the Special Care Baby Unit (SCBU) his father Jake presented at A&E (the same hospital). He was registered at a different GP to the mother. He presented after being assaulted and having a slight injury to his neck. The A&E staff were not aware that he had a child in SCBU. There was no connection made between the mother and children and the father from a GP perspective, which could impact on the identification of any associated safeguarding concerns.

5.43 While Matt was still in hospital, the newly allocated social worker tried on a number of occasions to visit the family at the home address and no reply was received. On occasions the social worker felt that someone was in but not answering, as on checking it was established that the family were not at the hospital.

5.44 On 21st May 2019, a discharge planning meeting took place at the hospital. The day prior to this the social worker had attended the home address and spoke with both parents. The house and baby care items were checked for appropriateness and advice was given. The parents had purchased a new mattress and cover. The social worker discussed the use of controlled drugs, which they denied, and alcohol use which Jake stated he used irregularly. The social worker also discussed domestic abuse, which the parents stated was not currently present in their relationship. Prior to the discharge from the hospital the parents were given advice on safe sleeping for the baby.

5.45 The day after the hospital discharge the social worker visited the family at home, by arrangement, the maternal grandmother was present. Both Matt and Luke were seen, and no concerns were noted. The house and surroundings were clean and there was fresh food in the fridge. Advice was given on safe sleeping when it was noted that Luke was asleep with toys in his cot.

5.46 The social worker visited the following two days by arrangement, on one of the occasions the family nurse was present. The only matters of note were that the house smelt musty (which had previously been noted) and there was no stairgate. On the second occasion the notes of the visit were not completed by the social worker. The family nurse completed the new birth visit. Safe sleeping was again addressed, and the sleeping arrangements were seen and recorded as appropriate. The parents also stated they had been given information on Cardiopulmonary Resuscitation (CPR) at the hospital. Both parents stated they smoked outside, and the family nurse discussed the risks associated with smoking. At the end of May (29th) 2019, the social worker visited the

family to complete family history for the assessment. The maternal grandmother was present.

5.47 The next visit by the social worker was a pre-arranged visit on 6th June 2019. In the interim Matt had not been taken to a routine ophthalmology appointment (this was re-arranged and Matt was taken as arranged on 10th June 2019) and the Family Nurse had visited the home and received no reply on a pre-arranged visit. On the June visit the social worker visited with a housing officer. It was noted that the home conditions were poor. Luke's mattress was dirty and smelt unpleasant. There was bagged rubbish in the garden. The same day the family nurse visited and recorded that Matt was gaining weight well.

5.48 Social care records indicate that police were called to a domestic abuse incident at the family address on 10th June 2019. This incident actually involved Kate's sister and her boyfriend. It would appear that Kate's sister was staying on the sofa at the address at this time. During the argument the boyfriend is said to have armed himself with a knife.

5.49 The following day the social worker visited the family and noted that Kate's sister was present. The home conditions were said to have improved slightly.

5.50 On 12th June 2019, the social worker visited the family home for a pre-planned visit. The home conditions were said to have improved on the previous days findings. The parents stated they were going to buy Luke a new mattress that day. There was a concern noted that Luke was overweight.

5.51 Early morning on 13th June 2019, an ambulance was called to the family home on the report of a child in cardiac arrest. Matt was conveyed by ambulance to hospital, where despite best medical efforts he was pronounced as deceased. In view of the circumstances and comments made by Kate, both parents were arrested on suspicion of neglect.

6. Analysis of involvement

6.1 Assessment of risk and intervention

Pre-birth of Luke

6.1.1 Luke was born in February 2018, prior to his birth there had been a pre-birth assessment. Just prior to his birth there were two referrals received, these were concerns raised regarding Kate's engagement with professionals during her pregnancy and police attendance at a domestic abuse incident. In addition, as a Looked after Child CSC would have had a history of Kate's engagement with professionals and an awareness of any adverse childhood experiences that might have informed the decision making related to her ability to meet the needs of an infant. The outcome of the two referrals was that support should be provided by a CAF. The CSC IMR author recognises that the pre-birth assessment in 2018 and the response to these referrals focused on the issues relating to Kate as opposed to

recognising the early stages of neglect and the potential risk factors to the unborn baby. It was also overly optimistic to expect the parents to engage meaningfully in a CAF when their previous engagement had been so poor. In fact, the CAF was not put in place as it was considered that agencies were already supporting the family. Whilst this may have been the case, it left the ongoing support without any real coordination.

Post -birth of Luke

6.1.2 Once Luke was born a referral was received from the housing key worker who was scheduled to visit the family every two days. The referral detailed some serious concerns regarding the poor state of the address and neglectful care This is evidenced as Luke was being part bottle fed and Kate did not have a bottle steriliser. There was also a concern that Luke was not sleeping in his moses basket.

6.1.3 This referral was assessed in the MASH with contact made to other professionals, the key worker and midwife. Kate was spoken to, but Jake was not. Kate stated that the address had fallen into a poor state since Luke had been discharged from hospital. This contradicted what Jake had told the key worker, stating that he was responsible for the mess as he had been living in the address whilst Kate was in hospital.

6.1.4 The CSC IMR author makes the point that the referral enquiries and management oversight focused on Kate as opposed to the emerging picture of neglect and what interventions may be appropriate. There is no record to indicate that the sleeping arrangements for Luke were explored, which is surprising considering it was one of the principle concerns raised by the key worker. The key worker re-visited the address two days later and found that the home address had been tidied. This formed a pattern over the duration of the case with conditions varying according to the level of agency attention.

6.1.5 The outcome of the referral was that early help support should be coordinated by a CAF at Level 2. As identified by the CSC IMR author, due to Luke being a newborn baby and highly vulnerable to the adverse effects of neglect, the previous poor engagement by the parents and history of risk factors a more appropriate outcome would have been a Children and Family Assessment at this stage.

6.1.6 This was the third occasion that a request for early help had been made but at no stage was any service provided. The early help records indicate that the case was to be discussed at the next family hub integrated case management meeting. There is no record of this meeting taking place. The MASH Procedures[4] state '*Where the case does not meet the agreed threshold for Social Care Intervention and a diversion to Early Help is deemed necessary, the Triage Worker will discuss the case with the*

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[4] Coventry Multi Agency Safeguarding Hub Operating Procedures (January 2018) - https://coventrychildcare.proceduresonline.com/files/mash_procedure.pdf (accessed 26/10/20)

CAF Co-ordinator co-located in the Family Hubs. All families that require Family help intervention, will be diverted to the most appropriate agency by the Team Manager.' There is no record of this discussion ever taking place.

6.1.7 The next referral was in March 2018 and followed a visit by the social worker where access was denied to the address with the parents placing a suitcase across the letter box to prevent any visual access. This followed a period where other professionals (the family nurse and personal advisor) had also experienced difficulties in seeing the family. At this point the Social Worker should have considered obtaining assistance from the police to gain access. This course of action would have ensured the safety and welfare of Luke was checked and demonstrated to the parents that there were boundaries which would be adhered by a robust and coordinated multi agency response.

6.1.8 The social worker made a referral to the MASH and visited the next day with the housing key worker. Again, initially the parents denied access and were abusive. When access was gained initial access to Luke was denied. When they did see him, they noted that Luke had a substantial abscess on his bottom which was causing obvious discomfort when wiped. Kate was also seen to handle Luke roughly. No action was taken at this time, but a further referral was made to the MASH. The social worker suggested that Luke should be taken to the walk-in health centre the next day, which did not occur. Considering the previous demonstrated lack of engagement and attempts to prevent professional access to the home, a more robust approach should have been considered to ensure that Luke obtained more immediate medical attention and to ensure that a strategy discussion was initiated. It is not clear how this, whether Luke did receive medical attention or not, was to be followed up. There was a significant concern and risk to Luke at this time which warranted immediate action.

6.1.9 A strategy meeting was convened three days later when Kate presented Luke at hospital with the abscess, which required intravenous antibiotic treatment. The strategy meeting was not attended by the social worker who made the referral. The hospital safeguarding nurse informed the meeting that the abscess was not believed to be caused by poor hygiene but it was unusual for a baby to have such a condition and there were concerns.

6.1.10 It is the view of both the Police and CSC IMR authors that more robust intervention should have been considered at this stage. The police author suggests that an offence of child cruelty[5] should have been recorded by police and this would have necessitated an investigation. The case and rationale for this is well made out in the IMR basing it on the factors of the injury presented, the history of the parents' avoidance of professionals, non-engagement and abusive behaviour to professionals and the neglectful state of the home address witnessed. Whilst it is accepted that a

[5] Cruelty to persons under the age of 16 - Children and Young Persons Act 1933 (accessed 26/10/20)

criminal prosecution may not have ensued or indeed would have been the desired outcome, the recording of the offence would have initiated and supported a clear response to the presenting concerns.

6.1.11 Both the police and CSC authors feel that the nature and cause of the injury to Luke should have been more fully investigated, whether this was by a child protection medical or a written report by a hospital consultant.

6.1.12 Another factor that was not effectively explored was the parents' use of cannabis and what the impact of this would have been on the care afforded to Luke. There was evidence of historical use of cannabis by Kate and Jake and recent concerns from professionals, but this is not recorded as being considered.

6.1.13 There is little evidence that the professionals directly involved with raising the previous concerns and involved with the family were effectively consulted and liaised with during the section 47 enquiry and their views reflected.

6.1.14 Had there been a joint police/CSC investigation, there may not have been a criminal outcome and indeed this may have not been a desired outcome but it would have allowed a better understanding of the extent and complexities of parental neglect and injuries to Luke. It would also have allowed health records to be tri-angulated.

6.1.15 The outcome of the section 47 enquiry was that child protection concerns were not substantiated. It is clear from the information gathered by the IMRs and made available to the review author and the detailed analysis undertaken that there was evidence that Luke was at risk of significant harm and that an Initial Child Protection Conference (ICPC) should have been convened at this stage

6.1.16 There continued to be concerns regarding the parent's meaningful engagement with agencies. Whilst Luke was in hospital, concerns were noted by the hospital staff regarding the appropriateness of the parents' behaviour and their personal hygiene. On 20th April 2018, the Children and Family (CAF) assessment was completed, the conclusion of the assessment was that CSC had no present safeguarding concerns and the recommendation was for the case to close. Whilst there was management oversight on this decision, there is evidence that the conclusion was over optimistic and did not take into account other hypothesis, such as disguised compliance (discussed in more detail at section 7.2).

6.1.17 Within the assessment a number of safety factors were identified, which it would be difficult to rely upon. One of these was the involvement of the Family Nurse Partnership. Whilst this initiative provides real value to young parents, it is voluntary and relies on good parental engagement which could not be relied on in this case. In 39 attempted contacts, the FNP, despite best efforts only saw the family on 10 occasions. The assessment focused too much on the current period of time without considering the significant history and previous adverse childhood experiences of, in particular, the mother. In addition, as a Looked after Child the mother had a named LAC Nurse. The LAC Health team would have been involved

with this mother for many years, and the management of her transition to adulthood and the organisational memory of her engagement would have provided additional evidence of her lack of engagement to meet her own health needs

6.1.18 The CSC IMR author also recognises that apart from considering the risks presented by the extended family the assessment also had the opportunity to explore any strengths presented by the family network, such as building on the information and support provided by the paternal grandfather.

6.1.19 The case was closed to CSC on 17th May 2018, this was despite continued concerns regarding access to and engagement with the family. There was also evidence of a large and aggressive dog now being present at the premises. The parents continued to fail to register Luke with a GP. Through this period, it is apparent that the social worker believed that there was early help support in place, which was not the case.

6.1.20 In late June 2018, significant concerns were raised by the key worker on the condition of the premises. During the previous assessment there was a written agreement put in place with the family, one condition of which was daily access by the key worker. The key worker made three referrals to the MASH regarding the 'extremely poor condition' of the premises. These referrals included 11 photographs to evidence the concerns. It is not clear that the photographs were used as part of the decision-making process. The referrals detailed concerning neglect and the presence of domestic abuse. The family address was thoroughly cleaned by the key worker organisation and this gave cause to further concerns over neglectful conditions. The outcome of the referrals was that a Children and Family assessment would be commenced.

6.1.21 The CSC author rightly recognises this point as a missed opportunity to convene a strategy meeting to consider a joint section 47 enquiry. The decision made did not appear to give due consideration to the long-term impact and continued neglect that was presenting. At this time Luke was five months of age and overall the conditions experienced by him were declining as opposed to improving.

Child in need plan - Luke

6.1.22 The outcome of the assessment, which was completed in early July 2018, was that a Child In Need(CIN) plan would be put in place. Luke and his parents were only seen once during the assessment and the parents not seen separately. Domestic abuse was discussed but no DASH[6] risk assessment was undertaken, which would have informed and assisted the assessment. The assessment did not include the views of all agencies, notably the personal advisor and the housing key worker. The CSC IMR identifies that the assessment lacked professional curiosity and insight into what life was like for Luke when professionals were not involved, and the plan failed to focus on the relevant issues. There is little evidence of consideration of what

[6] DASH - The Domestic Abuse, stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management tool used by all professionals.

factors could potentially impact on the parent's ability to effectively parent Luke and what their parental ability and understanding of Luke's needs were.

6.1.23 The CIN plan contained a condition that if access to the family home was denied or frustrated, police would be called and this would initiate child protection processes. Which did not occur.

6.1.24 In July 2018, the social worker and key worker visited the family and noted that Luke had a bad nappy rash and what they thought may have been a burn on his leg. A child protection medical was arranged but this was outside of the child protection process, there was no strategy meeting or any section 47 enquiry. This meant that there was no escalation considered and not all parties involved with the family were aware of the medical or the concerns. The red mark was thought to be part of the ongoing nappy rash.

6.1.25 In August 2018, the family also moved from the supported accommodation taking up a tenancy for new premises. One of the effects of this was that the key worker was no longer involved in daily checks and this decreased the professional attention on Luke. During September 2018, the social worker attempted visits but there was no reply and Kate failed to attend a CIN meeting. Whilst there were concerns, the police were not asked to undertake a check as was the contingency in the plan or any escalation in child protection processes

6.1.26 During the course of the child in need plan there was continued evidence of neglect and whether the parents were meaningfully engaging with professionals. The concerns included: the relationship of the parents being under pressure; Kate not working with her personal advisor; aggressive dogs being introduced to the house; concerns over Luke's excessive weight and development; Luke's cot being stained and without a properly fitted mattress; Luke not being registered with a GP. Despite these concerns the September 2018 CIN meeting agreed that the case could be stepped down to early help. CSC are recorded as there being no concerns at the time. There is no recorded disagreement or challenge from other agencies. This decision did not reflect the current situation and there was not enough evidence of any sustained and meaningful improvement. Any early help had not been delivered to date and it was not delivered at this time as a result of this step down. The Family Hub did not accept the referral, on the basis that agencies were involved in the family. This decision should have resulted in re-consideration of the appropriateness of the step down.

6.1.27 The case was closed to CSC at the end October 2018, there was management oversight which supported the decision and closure. This supported the fact that there had been significant improvement, which due to the factors outlined is not evident. The CSC IMR author makes the point that '*the lack of evidence-based analysis of neglect meant that such judgements were subjective and did not consider the overall cumulative impact of neglect'*. In conclusion, it would have to be said that the child in need plan did not achieve the required improvement and on this basis, it was closed prematurely.

Pre -birth – Matt

6.1.28 By November 2018, the plan had only been closed one month and there were continued concerns regard in engagement. Kate was pregnant and was not contacting or responding to contact from her personal advisor, the family nurse or the teen age pregnancy midwife. The personal advisor made a referral to the MASH and requested a police safe and well check. The referral was not taken forward as Kate was considered to be less than 12 weeks pregnant. The previous social worker was asked to visit Kate, which they did but were not successful in making contact.

6.1.29 The police undertook a safe and well check in late November 2018, the police officers recorded the visit on body worn video, which was reviewed for the purposes of this review. The address was seen as cluttered but appropriate. The police officers walked through the address and assessed suitability of conditions. The officers assessed that there was no risk of significant harm at this time and made contact with CSC whilst at the address and arranged for the parents to be available for a visit the following day, which was good practice. The parents were compliant but the police IMR author assesses that their behaviour, taking into account the history, indicated disguised compliance.

6.1.30 The social worker did attempt to make contact with the family a week later but was not successful. On the basis that the family had been seen by police and the personal advisor, the case was closed to CSC. This was another missed opportunity to convene a strategy meeting and consider a pre-birth assessment for Kate's unborn child and for Luke. The Coventry Safeguarding Pre- birth procedures state: -

'*Risk factors which could indicate that an unborn child may be likely to suffer significant harm and therefore be subject to a pre-birth assessment may include:*

Are known because of historical concerns such as previous neglect, other children subject to a child protection plan, subject to legal proceedings or have been removed from parental care.'

The history of the case and concerns raised, the fact that Kate was pregnant again and failing to contact professionals was another opportunity to convene a strategy meeting and undertake a pre-birth assessment.

6.1.31 There then followed a number of missed appointments with the parents not engaging with professionals and missing appointments. Kate was not engaging with maternity services at all and claimed that she had paid for a private scan at 16 weeks, although this was never evidenced. During this period although there were concerns no further referrals were made.

Matt is born

6.1.32 Matt was born prematurely in April 2019. Matt was in hospital for around 43 days in varying levels of special care. During this time the parents are said to have visited on most days. The hospital recorded that there were concerns over the parent's personal hygiene. The hospital did not make referrals regarding this but did liaise with the family nurse. The family nurse made a referral and CSC agreed that a Children and Family assessment would be undertaken. This was another opportunity for a strategy meeting to be convened.

6.1.33 A new social worker was allocated the case and started to try to have contact with the parents from 14th May 2019.There is some evidence of the parents still avoiding contact but the Social Worker explained that Matt would not be discharged until they were confident that all necessary measures were in place. There is some evidence of good practice by the social worker being intrusive around practical elements of care for Matt but some concerning elements still existed, for example the poor condition of the mattress that was to be used for Matt.

6.1.34 Matt was discharged home on 21st May 2019. Most of the visits that occurred after his discharge were announced and no concerns were noted except that during a visit in June 2019, the home conditions were noted as being poor and Luke's mattress, smelt unpleasant. This was a re-occurring theme, which on each occasion Kate accounted for and her explanation was accepted. There was also a recorded domestic abuse incident between Kate's sister and her partner, who appeared to be living at the address.

6.1.35 There were a number of opportunities for strategy discussions to be convened and a joint section 47 enquiry undertaken to better understand and deal with the fundamental concerns. Neither the child in need plan or the children and family assessments witnessed an improvement in the conditions for Luke and more latterly Matt. As Kate had been a looked after child much was known about her history, the challenges she had faced and her own adverse experiences. There is not much evidence that this was considered sufficiently when undertaking assessments and making key decisions. There is a strong theme of the parents responding when there was strong agency focus and when this diminished so did their attention to the care of Luke. There is little doubt that this case should have progressed to an initial child protection conference as discussed as early as March 2018.

6.2 Working with families who are difficult to engage and disguised compliance

6.2.1 The first concerns raised in this case were the meaningful engagement of the parents with professionals. This continued throughout the case, fluctuating at times. The engagement moved between avoidance of professionals to, on occasions, being outwardly aggressive and abusive and denying them access.

6.2.2 There was also a pattern of there being real concerns over issues such as the cleanliness of the home address and the conditions that the children were living in. When the parents felt that these aspects were under focus the parents improved the area of concern very quickly, but these positive changes were not maintained over any period of time.

6.2.3 Kate had a long history with CSC and to this degree may have had a 'hardened' approach to some agencies. The history and level of cooperation with agencies as a looked after child does not seem to have formed part of the assessments that were undertaken. There were many agencies involved with the family and a more coordinated approach may have assisted in building a better relationship with the family.

6.2.4 Disguised compliance involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement

(Reder et al 1993). Disguised compliance was identified as being presented by the parents but there was little evidence of this being effectively addressed. The NSPCC Learning from Case Reviews briefings - Disguised Compliance[7] notes reflect well many aspects of this case. Parents missing and cancelling appointments, professionals being over optimistic and disguised compliance being recognised but no effective action being taken. The briefing recognises that there should be more of a focus on the child's lived experience instead of the parent's actions.

6.2.5 The Coventry Safeguarding Children Partnership has disguised compliance practice guidance within their procedures[8]. This guidance highlights the necessity for professionals to discuss concerns over challenging families and disguised compliance at supervision. Work should be undertaken to enhance the practice guidance to a procedure which includes steps to escalate and address the behaviour.

6.2.6 Where measures are put in place or boundaries set it is important that they are adhered to. As part of the child in need plan a contingency was that if the family were not seen or avoided contact the police would be called, this did not happen as a matter of course. When the police were asked to see the family in November 2018, they did so and spoke to CSC from the family address, which was good practice. It was left that the social worker would visit the next day. This did not happen with the CSC manager setting a week for the visit to occur. In fact, when contact could not be made with the parents the case was closed, with the rationale of relying on the previous police and personal advisor contact.

6.3 Recognition, assessing and intervention for neglect.

6.3.1 There is no doubt that neglect was an ongoing concern in this case, the imminent risks and long-term harm and the cumulative effect of neglect are well evidenced and referenced in the Coventry Safeguarding Board Neglect Strategy 2018[9], which also links to other strategic initiatives. The strategy seeks to address neglect in Coventry under the themes of Identify, Prevent, Protect and Evaluate.

6.3.2 Whilst the concern of neglect was identified, there is little evidence that any contributory causes were investigated and assessed. There was the ongoing concern of the parents' use of cannabis but what impact this may be having on the care afforded to and wellbeing of Luke, and more latterly Matt was not effectively considered. There is also little evidence on consideration of the parent's basic ability to effectively provide good care to the children.

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[7] NSPCC learning from case review briefings 2019 – Disguised compliance (accessed 26/10/20) NSPCC disguised-compliance

[8] Working with families who refuse to consent or engage, or demonstrate disguised compliance practice guidance (accessed 26/10/20) - West Mids Child Protection Procedures

[9] Coventry LSCB Neglect Strategy – (accessed 26/10/20) Coventry neglect_strategy

6.3.3 Where there was a focus on neglect, it tended to be on the parents' and not on what the lived experience of the children was. In assessing the level of neglect, the use of a tool would have assisted in assessing the level of neglect and the risk presented. The Graded Care Profile 2 (GCPC2) is a tool that is used by the NSPCC in Coventry. An NSPCC evaluation found that use of GCPC2 resulted in practitioners feeling referrals were clearer and more likely to lead to actions that would support the child and some families were reported to make health and lifestyle changes as a result of use of the tool[10].

6.3.4 The Coventry Strategy under the Prevent heading also seeks to use serious case reviews to learn the lessons in relation to neglect. The previous Coventry serious case review of Baby E[11] undertaken in March 2018 involved the accidental co-sleeping death of a 5-month-old child. The review identified that '*Training on a multi-agency basis to recognise the possible indicators of neglect arising from a series of low-level concerns, and particularly to understand the cumulative way in which these can impact in children, is needed.'* The need for this continued training, awareness and focus still exists.

6.3.5 The continued failure of the parents to register Luke with a GP was a concern which should have been more robustly followed up to ensure that he was able to access all health support. Another complicating factor was that the father was registered with a different GP, and it was not recorded that he had a partner and two children. Therefore, any safeguarding issues that might have been a concern would have not been seen in the light of his role as a father. For example, his attendance at A&E with a hand injury due to punching something was not connected to his family and any risk his behaviour might pose.

6.4 Co – sleeping

6.4.1 Whilst the cause of Matt's death has not been formally determined there is sufficient information available to draw learning on how safe the sleeping arrangements were for Matt.

6.4.2 The majority of neglect related deaths of very young children involve accidental deaths and sudden unexpected deaths in infancy where there are pre-existing concerns about poor quality parenting and poor supervision and dangerous, sometimes unsanitary, living circumstances which compromise the children's safety. These issues include the risks of accidents such as fires and the dangers of co-sleeping with a baby, where parents have substance and/or alcohol misuse problems (Brandon et al, 2013). There is evidence throughout this case that there were concerns regarding the sleeping arrangements and condition of the cot and mattress. There is also evidence that safe sleeping advice was given, both routinely and when concerns were noted. There was also a suspicion of cannabis use. The impact of the

[10] NSPCC - Implementation Evaluation of Graded Care Profile (accessed 26/10/20) – NSPCC GCP2 Evaluation

[11]

use of cannabis and the risks of co-sleeping cannot be underestimated, and the lived experiences of the children in this environment is of grave concern.

6.4.3 That said, there continues to be cases where, harm is caused by unsafe sleeping arrangements. The Baby E case review, already referenced made the following recommendation '*Review the evidence of awareness by parents of the risks of co-sleeping, and where there are seen to be gaps, develop effective communication strategies about the risks and dangers, addressing both professional audiences and parents/families.'* This recommendation should be re-visited to understand if the message to both professionals and parents/carers should be refreshed and enhanced and whether this message to parents should be differentiated according to risk.

6.4.4 In July 2020, the National Child Safeguarding Review Practice Panel published their second thematic review, Out of Routine: A review of sudden infant death in infancy (SUDI) in children where children were considered at risk of significant harm.[12] The report identifies that between June 2018 and August 2019, of the 568 incidents reported to the panel, 40 were cases of SUDI and sadly most of the deaths were preventable. The review examined 14 of these cases and identified that there was a range of pre-disposing risk factors. Many of the cases involved co-sleeping. Many of the identified risk factors are present in this case, co-sleeping, parental substance misuse, evidence of neglect, domestic violence and young parents who had suffered a number of adverse childhood experiences. These are all features of this SCR.

6.4.5 The report identifies the '*need for local working that recognises a continuum of risk of SUDI, with support and interventions that are differentiated to all families, families with additional needs and families at significant risk.*'

6.4.6 The report identifies a number of areas of good practice including a SUDI risk assessment tool utilised by the Nottingham Safeguarding Board[13], which seeks to help identify the families most at risk and focus discussions with them.

6.4.7 In the Coventry partnership, the Family Nurse Partnership already uses resources from the Lullaby Trust[14]. There is an opportunity to review the findings of the national report and to seek to locally to adopt the findings, in particular the identification of the most at-risk families and utilisation of a differentiated response according to the risk.

6.5 Multi agency working

6.5.1 There is evidence of agencies working together and undertaking some joint visits to the family. What this case lacked was overall coordination of the multi-agency approach, whether this came from Early Help or statutory intervention. Although early help was requested, it did not transpire and the approach to

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[12] Out of Routine: A review of sudden infant death in infancy (SUDI) in children where children were considered at risk of significant harm (accessed 26/10.20) - A review of sudden infant death in infancy (SUDI

[13] Nottinghamshire Safeguarding Children Board safe sleeping risk assessment tool (accessed 26/10/20)– Nottinghamshire safe sleeping risk tool

[14] The Lullaby Trust (accessed 26/10/20) - https://www.lullabytrust.org.uk/

assessment resulting in child in need and child protection procedure has already been discussed. Without this coordination, it was identified in agency reports that there should have been multi agency meetings to ensure that information was appropriately shared.

6.5.2 On occasions, not all agencies were involved in important aspects of the case, such as the family nurse in the child protection medical (July 2018) and the CIN meeting. The Family Nurse Partnership also requested information from CSC and the MASH on the name of the allocated social worker but was denied the information. This response should have been challenged and escalated. There is no evidence of this happening.

6.5.3 Where referrals were made to the MASH, they were graded as amber, before being re-graded as red once a strategy discussion had taken place. There was an agency view that the referral could have been more robustly assessed in the first instance to allow a timelier response.[15]

6.6 Management oversight and professionals experience

6.6.1 When the case was open to CSC, there were occasions when the case was closed without the required level of management oversight. The CSC IMR author recognises that there is now a clear expectation within Children Services that all children's cases have a closure summary, which requires management oversight and authorisation. In this case the management oversight, at the point of closure, was overoptimistic and lacked the required level of scrutiny. The CSC author makes the point that at the point of closure the views and opinions of other professionals involved with the family should be sought and recorded on closure records. This would ensure that a range of professional opinion was reflected when considering if a case should be closed.

6.6.2 Any closure decision would have benefited from a clearer demonstration of reflective supervision, developing hypotheses and critical thinking. Consideration of the history of the case through the chronology may have led to a more cautious approach when considering the closure of the case.

6.6.3 This management is even more relevant where staff involved are less experienced, as was seen during periods of this case. The panel discussed and challenged whether less experienced staff had been fully supported and whether there could have been increased supervision to assist them in what was a difficult case. This was particularly seen where the social worker was within their assessed and supported phase of their career. The social worker did demonstrate good levels of curiosity and challenge, but it is not clear that the appropriate level of support was in place.

7. What are the learning points from this case?

7.1.1 All agencies need to be sure that practitioners: understand and are able to identify neglect and be aware of the lived experience of the child/children in the

[15] Coventry MASH Procedure - coventrychildcare.proceduresonline (Accessed 26/10/20)

family home. That they understand the harmful effect of the cumulative effect of continued neglect; that neglect is appropriately assessed. This would benefit from the use of the Graded Care Profile 2 tool. An important area for professionals to consider is the lived experience of the child. Management oversight is important in neglect cases from all agencies and it is important that this is not overly optimistic and carefully considers the history of the case to ensure that any improvements are sustained.

7.1.2 There should be a renewed assessment of whether safe sleeping is adequately covered by all agencies as appropriate to their function. Whilst there is evidence in this case that safe sleeping was discussed, it continued to be an area of concern. Where there is this concern, despite advice, there needs to be an escalation and consideration of a differentiated response according to risk. The use of cannabis by parents and safe sleeping message needs some additional focused attention by the Coventry Safeguarding Children Partnership.

7.1.3 There was clear disguised compliance identified by various professionals, and the parents at time were abusive and avoidant. If there had been greater liaison with the LAC Health Professionals from health at the LA, during Kate's transition to adulthood, some of her patterns on non-engagement might have been predicted. Professionals need clear guidance, how having experienced these concerns, they proceed. This may require the current protocol being developed into a clear procedure. Where boundaries are set for parents they need to be adhered to.

7.1.4 Suspected drug use (cannabis) by the parents was challenged more latterly in this case, however it was not effectively considered in the CIN or CAF assessment, and neither in the section 47 enquiry. Consideration would have allowed for the hypothesis that the parents were using cannabis to be ruled in or ruled out.

7.1.5 Early Help was considered and requested on a number of occasions but was never delivered, one of these occasions being the step-down from child in need plan. There needs to be a clearer pathway between CSC and early help to ensure that a case is accepted and suitable for early help before it is closed to CSC.

7.1.6 An area for further exploration is how well children leaving care, particularly those who become pregnant at an early age, are prepared for parenthood and how the adverse childhood experiences of these parents may factor on their parenting understanding and ability, and how information is shared at the transition into adulthood.

7.1.7 Where there are concerns around neglect or other vulnerabilities, e.g. parents that are care leavers, a pre-birth assessment should be considered. This review may offer an opportunity to enhance professional knowledge of the pre-birth procedures and share information to inform future decision making.

7.1.8 Where there are disagreements or unresolved challenge, professionals should use the Resolution and Escalation of Professionals Disagreement Procedures. This review should present an opportunity to promote the procedure.

7.1.9 Where a referral is made to the MASH and a strategy meeting takes place, the professional making the referral should attend the meeting unless it would prevent the meeting taking place within timescales. Any CSC assessment should seek the views of other involved professionals and this should be reflected in the recorded assessment and similarly the views of other involved professionals should be sought and recorded when closure is being considered.

7.1.10 All children should be registered at a GP surgery to ensure their health needs are being met. There is evidence that Luke was not registered until his second year of life which complicated his health needs being met and understood from Primary Care

7.1.11 Jake, the children's father, was registered at a different GP surgery to Kate and the children. This makes understanding family dynamics and information sharing more complicated from a Primary Care perspective. There was no connection between the father and his children, therefore this has the potential for concerns to be understood regarding his role as a father. This is an area that requires review and strengthening the information that is held in Primary care.

8. Recommendations

1. The Coventry Safeguarding Children Partnership should review the neglect strategy to ensure that the identification of neglect is identified and appropriately responded to. This should include: -

    - The continued implementation and embedding of the Graded Care Profile 2 to all relevant staff.
    - Recognition of the harm caused to children by the cumulative effect of all types of neglect.
    - Using this and previous reviews which have focused on neglect as learning for professionals.

2. The Coventry Safeguarding Children Partnership should use this review and the findings of the National Children Safeguarding Practice Panel to review the approach to safe sleeping by: -

    - Review commissioning to promote safe sleeping within a local strategy for improving child health outcomes.
    - Promoting the identification of pre-disposing risks of SUDI and delivering differentiated interventions according to risk, with particular focus to parents that are suspected or know to use substances and/or alcohol.

3. The Coventry Safeguarding Children Partnership should consider what support, training and advice is in place for professionals dealing with families demonstrating disguised compliance or who are avoidant and/or resistant and determine whether further support is required which could include: -

- A tiered and robust multi agency approach, utilising the skills and powers available from each agency providing consistency and clear boundaries.
- Undertaking coordinated but unannounced visits.
- Triangulating historic and family information with other agencies, extended family and community.

4. The Coventry Safeguarding Children Partnership should be assured that :-

- Referrals to the MASH are appropriately triaged and where appropriate a strategy meeting takes place; this meeting should include where possible the agency making the referral.
- That assessments include all relevant agency information.
- That pre-birth assessments are undertaken in relevant cases and the procedure is embedded.
- That prior to closure of Child in Need plans, there is clear evidence that the desired outcomes have been addressed.

5. Coventry Children Social Care should ensure that the pathway to allow families to access Early Help provision is clear and robust, in particular where cases are stepped down. This should include a notification to the social worker that the case has been accepted by Early Help , where consent is given, before the case is closed.

6. The Coventry Safeguarding Children Partnership should ensure that the Coventry and Warwickshire Resolution and Escalation of Professionals Disagreement Procedure is understood by professionals and there are no barriers to it being used.

7. Coventry Safeguarding Partnership should review what provisions are available to support and understand the needs young people leaving care in anticipation of impending parenthood.

Appendix A

Details of author

The author in this review has no prior involvement with the case and is not connected to any of the agencies involved.

He is a retired senior police officer, who had responsibility for strategic and operational safeguarding and was a senior investigating officer. He has undertaken serious case reviews, safeguarding adult reviews, MAPPA case reviews and domestic homicide reviews, with various boards across the country. He has also worked with Clinical Commissioning Groups, The Church of England and the third sector on safeguarding matters.