COVENTRY SAFEGUARDING CHILDREN BOARD

Serious Case Review

Child E

FINAL REPORT

3 March 2016

Independent Reviewer

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Introduction

1. This Report was commissioned by Coventry Safeguarding Children Board as a Serious Case Review (SCR) following the death of baby E in May 2014. He was a five-month old baby who died after he was found unconscious in a bed co-sleeping with adults following a party as his family home. At the time of his death there were indications of drug use, cannabis cultivation in the property, poor home conditions, possible neglect and domestic violence in connection with the family. The family were not open to specialist services at the time of Child E's death and there had not been significant concerns identified prior to his death. There was therefore concern as to whether previous contacts had correctly identified, assessed and acted on any risks, or offered support to the family, to mitigate the issues that became apparent at death.

2. At the time the SCR was commissioned the full post-mortem results were not available, and there was a concern that Child E might have been exposed to drugs and that this might have contributed directly to his death. This was not the case. His cause of death was initially recorded as unascertained, but the inquest in April 2015 recorded a verdict of accidental death with asphyxia as the cause of death. The pathologist stated that the death should not be considered as the result of 'sudden infant death syndrome' (SIDS) as factors such as the unsafe sleeping environment, toxicological status or a combination may have played a role in Child E's death.

3. The family had been in contact with a range of services, and it was not clear what information was known or shared between agencies. Care Proceedings were initiated in relation to Child E's siblings and police enquiries continued, pending the result of full post-mortem investigations.

4. Subsequent toxicology analysis revealed low levels of cocaine and cocaethylene in Child E's blood, bowel and urine. These levels did not suggest deliberate administration and the toxicologist suggested environmental contamination or indirect exposure as possible causes for the presence of these substances.

5. After a review of the available evidence, the Crown Prosecution Service made the decision that no further action would be taken against Child E's mother or father with regard to neglect issues.

6. The following issues were identified for consideration in this Serious Case Review:
   6.1. What was the context for family support and child care in the wider family circle? How were the children supervised and their safety ensured?

6.2. What were the home conditions in which the children were living and did these raise any concerns about their welfare or safety?
6.3. What opportunities were there to observe and assess the levels of care and support, and possible risks of neglect, through contact with the family and particularly home visits
6.4. Why did this family not access greater early help and support from children's centres and pre-school settings?
6.5. What was known about any episodes of domestic violence, substance misuse or criminal activity that might have indicated safeguarding risks for the children?
6.6. Were there aspects of the medical and home care required by Child E's sister for her medical condition that might have affected the care provided to the other children?
6.7. What aspects of previous contact with members of the family might have indicated any needs for the children?
6.8. Were there any opportunities for the concerns that have led to the subsequent creation of child protection plans to be identified or shared between agencies at an earlier stage?

7. The timeframe for this Review is from May 2013 when the family moved into their current home in Coventry to May 2014 following Child E's death.

8. *Working Together 2013 (revised in 2015)* identifies that Serious Case Review reports should:
   - provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
   - be written in plain English and in a way that can be easily understood by professionals and the public alike; and
   - be suitable for publication without needing to be amended or redacted.

9. Brian Boxall was appointed to chair the Serious Case Review process and David Ashcroft was commissioned as the Independent Reviewer to complete the SCR report.

10. Six agencies that had contact with the family were identified and asked to prepare Agency Reports of their engagement and to provide contributions towards a combined chronology. These agencies are represented on the SCR Panel (except for Birmingham Children's Hospital):
    10.1. Coventry City Council – Children's Services (CS) covering social care, schools and Children and Families First Service (CFFS)
    10.2. Arden, Herefordshire and Worcestershire Area Team covering General Practice (GP)

10.3. Coventry and Warwickshire NHS Partnership Trust (CWPT) covering health visiting
10.4. West Midlands Police (WMP)
10.5. University Hospitals Coventry and Warwickshire NHS Trust (UHCW) covering hospital and midwifery services

11. Agency representatives were invited to a briefing on the review process. First drafts of Agency Reports were considered at an SCR Panel meeting in December 2014, and were revised following that meeting. Additional information was provided by agencies during January and February 2015. Due to personal circumstances, David Ashcroft was not able to undertake further work on this report for some time. As Mr Ashcroft had commenced work on the SCR, the Board made a decision to remain with the author to complete the work. Mr Ashcroft was then able to continue the work, and the SCR Panel considered a first draft of the report in August 2015. At this time details of the inquest were obtained from the Coroner, which indicated that he had found the cause of death to be asphyxia. Arrangements were also made to meet with the parents. A meeting between the Independent Reviewer and Mother was held in February 2016, which has informed this report.

12. This Overview Report has been compiled based on the information and analysis collected through the Agency Reports. It is intended for publication as the account of the learning from this case. The Independent Reviewer has presented the key themes and lines of enquiry to the Serious Case Review Panel for discussion and challenge. This report addresses these themes and seeks to provide a final report that takes into account this process of analysis and peer challenge in identifying the learning and improvements that are needed to consolidate good practice. This approach is in line with the revised guidance on interagency working and conducting Serious Case Reviews published in *Working Together 2015*.

Independence

13. David Ashcroft was appointed as the Independent Reviewer for this Serious Case Review in September 2014. He has worked at a senior level in children's services for the past 24 years, including operational responsibility for all aspects of safeguarding and children's social care in a number of local authorities. Mr Ashcroft currently chairs two Local Safeguarding Children's Boards.

14. Mr Ashcroft has conducted a number of Serious Case Reviews, IMRs, inspection and investigation assignments in children's services, covering social care, education and health responsibilities. He has no managerial connection with the agencies involved in this case.

15. Brian Boxall was appointed as the independent chair of the SCR Panel to oversee this Review. Mr Boxall is the chair of a Safeguarding Children Board and has extensive experience in child protection and safeguarding, and in the conduct of investigations and enquiries into significant incidents.

16. All the Agency Report authors have appropriately identified that they were independent of the case. Agency reports have consulted appropriate records and information systems and have been supported by interviews with the key practitioners involved with the family.

Outline of family circumstances

17. Child E lived in Coventry at the time of the incident in a privately rented three-bedroom house with his mother and father, two older brothers (born in 2012 and 2011) and his older half-sister T(born in 2009). They had moved to this property in May 2013. Child E was born in December 2013. He with his youngest brother shared their parents' bedroom.

18. Child E's half-sister T, the daughter of his mother and a previous partner, has a health condition for which she received continuing inpatient and outpatient care from Birmingham Children's Hospital. During the period of this Review, she underwent three episodes of inpatient treatment including surgery. Her mother and stepfather participated fully in her care. She was brought to all her outpatients' appointment on time and the hospital had no concerns about her care.

19. T attended reception class at a local school from September 2013, having attended nursery run by the school during the preceding year. Her school attendance was low for 2013-14 at 47.54%, but all absences were authorised for health reasons. The younger children did not attend any nursery or children's centre provision.

20. Child E's father has three children from a previous relationship who do not live with him. They are twin half-brothers to Child E (born in 2005) and a half-sister (born in 2007).

21. There was no record of contact with social care or Children and Families First Teams for Child E or his siblings.

22. Child E's father has had a significant number of convictions, principally for theft and burglary. Evidence from WMP also cited offences of threats to kill, wounding, criminal damage and harassment. He had previously been addicted to heroin and

there was a history of a number of threats of violence and criminal damage in respect of his current and previous partners.

23. From primary care records Child E's father had a history of depression and anxiety. He was registered with a different GP practice from his wife and the children.

24. Child E's mother has no previous convictions or history known to the police. She had attended several antenatal care appointments when pregnant with Child E, and her non-attendance had been appropriately followed up. Her contact with her GP with her children was routine, although there were fewer than expected attendances at the surgery given the age of the children (about 36% of the average). There was no record of links between the GP practice and the health visiting service, and the six-week development check for Child E and a postnatal check for his mother do not appear to have taken place.

25. Mother commented when interviewed that she had felt experienced as a parent with several children when Child E was born, and had felt able to provide for their needs. However, in hindsight she recognised that she might have been selfish and not always prioritised the children. She affirmed how much the trauma of losing Child E had caused her and her husband to review their lifestyle, their use of drugs and alcohol and that their parenting responsibilities were now much more clearly acknowledged. They appreciate the support that that been provided by their current social worker to help achieve this. Speaking on behalf of both parents Mother stressed that she felt there was learning about the dangers of co-sleeping that should be brought more strongly to all parents' attention.

26. The family were in contact with specialist health services at Birmingham Children's Hospital in respect of Child E's half –sister T's health condition. The family were known to routine, universal health visiting services from T's birth in 2009. The children were consistently assessed to have universal needs (Level 1) where care is delivered to families with little or no identified health needs and additional support is not required. The family proved at times difficult to contact and all of the children missed one or more developmental assessments despite attempts by health visitors to undertake these. There does not appear to have been contact between the health visiting team and primary care and other agencies.

27. The family was largely dependent on benefit income. Father was unemployed at the time of Child E's death.

28. When interviewed Mother acknowledged that the parents had been selfish and focussed on their own needs, and that their use of alcohol and drugs had been a risk for the children. She spoke of the strong family support that she drew on for child

care, and said that her experience as a mother had perhaps made her complacent about the risks of co-sleeping. It was clear that Child E was a much loved child and that the impact of his death had led to both parents reconsidering their lifestyle and working hard to provide the care that their children needed.

29. The other children were initially removed after Child E's death to the care of maternal grandparents. Further assessments concluded in February 2015 that parents had made sufficient progress for rehabilitation to be considered and the children were accordingly returned to the care of their parents in September 2015 where they are now doing well. The children are currently supported through the child in need process. They are happy and settled in the care of their parents and there have been no concerns since their rehabilitation. Parents appear to be cooperative and have engaged in supportive measures such as 'Triple P' parenting support to assist them with their parenting. Mother acknowledged strongly that they had sought to turn their lives around as a result of losing Child E.

Circumstances of Child E's death

30. The following account of the circumstances of Child E's death is drawn from the police report. On a date in May 2014 there was a party at the family home. There were about 10 adults and 8 children present – including Child E and his three siblings, and the four children of Father's brother and his partner, aged between 8 years and 10 months.

31. Alcohol and class A (Cocaine) and class B (Cannabis) drugs were used by some of those present. Child E spent the evening in the living room and was held by family members or sat in a baby bouncy chair. It is unclear whether he was fed, although witnesses say that he had a bottle of formula milk at around midnight and had his nappy changed.

32. Mother stated that she consumed approximately six to seven 440 ml cans of lager. She made a conscious decision not to breast feed as she was drinking. Almost all the adults were smokers, but this appears to have been restricted to the garden.

33. In the early hours Father fell asleep on some bean bags in the downstairs living room. Mother's brother went to sleep in the parents' bedroom upstairs. At approximately 04.30 Mother took Child E, who was asleep and remained so, out of the bouncy chair and took him upstairs to her bedroom. She placed him in the same bed, rather than in his crib, which was in the same room. She placed the duvet on Child E up to his waist with his arms over the top of the cover and lay down to sleep between her brother and him.

34. Mother's brother was the first to wake at about 09.00 and observed that Child E appeared lifeless and unresponsive. His mother's arm was draped across his stomach. Mother awoke to the sound on her brother screaming child E's name. He alerted others in the house and there was a confused and upset reaction. Father appears to have reacted with anger, hammering a door with his fist. Father's brother ran upstairs, and attempted basic life support before taking Child E downstairs where ambulance staff took over. His statement to the police suggested that his first thought was that Child E's mother had lain over him.

35. Ambulance and Police were called and arrived within a few minutes. On their arrival the crew confirmed that Child E had no heart beat and was not breathing. He was taken by ambulance to the UHCW children's emergency department where attempts were made to resuscitate him. He was pronounced dead at 09.40. He arrived at hospital appearing grubby. The post-mortem confirmed that he had dirt in his ears, armpits, fingernails and navel and had marked cradle cap. He was found in a full wet nappy.

36. The post-mortem results identified low concentrations of drugs within Child E (as cited in paragraph 4 above). The other children had no traces of illicit substances in their systems. The inquest also noted the history of co-sleeping.

37. The police subsequently discovered that cannabis was being cultivated in the loft area, with access by an uncovered hatch in one of the children's bedrooms. The smell of cannabis would have been prevalent in the house. A large knife was reported to be stuck into the door frame of the living room. According to the police, the address was untidy and dirty, with no bath, and the shower did not appear to have been recently used. The kitchen was dirty with grease, and the bedroom where Child E slept was damp, dirty and cluttered with food. There were also used nappies and unwashed clothes in piles. The chair that Child E used was described as 'filthy'. The entire address was reported to have a strong aroma of urine.

<u>Summary</u>

38. This was a family that had intermittent contact with universal services for children, except for the specialist treatment provided for T. Separate episodes of treatment and support for members of the family appeared appropriate and satisfactory. There were no specific indications or records of concerns prior to Child E's death. However, the circumstances surrounding his death, and the poor home environment, evidence of domestic violence, substance misuse and cultivation of drugs that then emerged suggested that there were a number of factors which

could, in hindsight, be viewed as risky, and which, if known, might have raised safeguarding concerns. It is therefore reasonable to ask whether these risks might have been known or shared, and what can be learned from this.

39. It is clear that there was limited sharing of information between agencies and there were few practitioners who had consistent contact with the family, but that more information about the family was known to separate agencies and workers. In practical terms it is not clear what more might have been shared as concerns about the children were not evident. This is very much a case where the extent of risks and the dangers of neglect were only sharply brought into focus at Child E's death. Parents have acknowledged that their lifestyle was selfish and chaotic and that their use of drugs and alcohol, and the poor home conditions might have resulted in a neglectful environment at times for their children, but they have been determined to address these issues and not to make similar mistakes.

40. Where agencies did have contact with this family, there was little consideration of the whole family unit – so for example the impact of T's treatment was not considered in respect of the other children. There was no contact between the GP surgery responsible for the children's health and the health visiting service. The Father's GP surgery was not aware of his stepdaughter's serious medical condition and operations, in order to consider whether this might be a factor in his own health and wellbeing. Although the Birmingham Children's Hospital provided a description of the type of outreach support provided by their Family Support Workers there is no evidence that this was offered to this family or any exploration of whether there might be undisclosed support needs. There was a lack of professional curiosity from the Birmingham Children's Hospital Foundation Trust Family Support Workers, and the team there focussed solely on the medical care of T and did not enquire about the wider family context or possible support. The parents' consumption of alcohol and/or drugs was not known by agencies or family as a possible risk factor in their parenting. Police information which indicated aspects of Father's behaviour was not available to others working with the family. It is not clear whether the Hospital were clear about the respective roles of T's biological and step fathers, or even if they knew who was who.

41. The GP Agency Report identified a number of general factors for risk of neglect that are seen in many cases and which there was no identified opportunity to consider holistically in respect of this family until after T's tragic death. These factors are soundly based on evidence from research and include:
    - Young parents;
    - More than three children, particularly when relative close in age;
    - Worklessness, or disrupted employment;
    - Depression and anxiety in a parent;

- Multiple children with different parentage;
- Child with a significant illness, including the additional stress this may cause parents;
- Nonattendance for routine screenings (antenatal checks and six-week development check) and repeated missed appointment, even where contact was made;
- Poor home conditions, especially shared or co-sleeping arrangements;
- Children observed as scruffy and dirty (although seen as happy).

All these can be identified in hindsight in Child E's family environment in the investigations after his death or as result of the enquiries for this Serious Case Review. This reinforces the extent to which these remain risk factors.

42. Given the post-mortem results and inquest findings there is no justification for viewing Child E's death other than a tragic occurrence. However, it is clear in hindsight that his lived experience was subject to a number of risks. The report will next consider these against the issues included in the terms of reference for this SCR to identify the learning to be gained from this case.

ISSUES FOR CONSIDERATION

What was the context for family support and child care in the wider family circle? How were the children supervised and their safety ensured?

43. The presence of eight young children at the party when Child E died, and the evidence of drug use raised initial concerns about the child care provided. There is no direct evidence to suggest that the children were not looked after adequately, but the presence of cannabis plants in the home, and the use of drug and alcohol use are issues of concern. There was also evidence that the home conditions were poor and that Child E was dirty and had cradle cap. However, these are not unique occurrences, and there is little corroborative evidence to suggest that the supervision and safety of the children was compromised on a regular basis. Mother maintained that she did not breastfeed at the party, as she knew she would be drinking. The routine contact with midwifery and health visiting services does not indicate Mother was neglectful. Child E was her fourth child and there had been no previous concerns about her parenting. Mother has said that the wider family network was close and supportive. Maternal grandparents were involved in the children's care and looked after the children in the period after Child E's death.

44. The police evidence from the scene after Child E's death suggests that the house was dirty and that sleeping arrangements were crowded and bathing facilities limited. There is no evidence that prior to this incident any professional had concerns about

the home environment. However, only five home visits had been successfully completed (one in December, two in January 2014 by Community Midwife or Midwife Support worker, and one in February and one in March 2014 by Health Visitors) so there was no opportunity for professionals to assess home conditions in the two and a half months before Child E's death. It is not clear from the records of these visits what workers were able to see and whether they viewed sleeping, kitchen and bathing facilities. There were also a number of missed appointments.

45. Child E shared a bedroom with his parents and brother, with a double bed, single bed and crib in the same room. Mother acknowledged that she had frequently co-slept with Child E, sometime falling asleep after feeding. She did not feel that she had been aware of the risks of co-sleeping before Child E's death.

46. Little is known about the day-to-day care and child-minding arrangements for this family; although it is known that they did not make use of nursery provision, except for T who attended the nursery provision at her school in the year before entering reception class. Mother reported that she felt she could cope and was not aware that there might be additional support in her community to assist her. She relied heavily on support from her immediate family.

47. T required on-going support and treatment for her health condition, and from the clinical perspective, she received an appropriate service from Birmingham Children's Hospital. She was brought to all her appointments and one or both of her parents supported her in-patient episodes on the ward. It appears that they considered this an important part of their parental responsibility. However, it appears that little was known about the care arrangements for the other children when T was in hospital. All these episodes occurred before Child E was born (in June, October and December 2013). The hospital team includes two full-time Family Support Workers to work with families who may require additional help, and it would appear that there was no extra support identified or provided to parents at any point. It is not clear from the hospital records whether T was supported by her biological father and/or her stepfather during her treatment.

48. The hospital provided details of the support provided in general terms by two fulltime Family Support Workers. From the description of their work it would appear that T's family might well have benefited from their support. There is no record that T's family required or received any additional support, or that there was any assessment of whether some level of family support might have been appropriate.

49. The children were fully vaccinated; their attendances at primary care and on two occasions at A&E were appropriate and did not give rise to any concerns, although they did not make as many calls on primary care as many families with young children. When asked, Mother said that she had not felt any need to ask for further appointments or help. Discussions with the practice staff and midwife confirmed

that there were no apparent issues for their safety or well-being. The midwife had attended Mother's previous pregnancies and had no concerns about her antenatal care, although she did miss some appointments.

<u>What were the home conditions in which the children were living, and did these raise concerns about their welfare and safety?</u>

50. The home conditions as recorded after Child E's death raised concerns about the welfare and safety of the children. However, there were no previous concerns. The community midwife visited in January 2014. She observed a busy household with several children running around, but no concerns about their care or the home environment. She explicitly recalls that she had no concerns about substance misuse, and it is documented in her notes that advice was given, as would be routine, on the risks of sudden unexpected death in infancy and on the risks of co-sleeping.

51. The GP and the Practice Nurse confirmed that the children were "scruffy and at times a little dirty, but appeared well-cared for, happy and boisterous". Again, no concerns were recorded or action taken.

52. The family was considered to be well-engaged with school in respect of T. The mother contacted school with regard to medical appointments and parents engaged with parents' evenings. There was felt to be a good relationship with the school and regular contact with Mother. However, the extent of proactive management of attendance was accepted as being poor from the school, so greater contact with the family would probably now occur, but there is no evidence that this would have identified any further issues. There was perhaps an over-reliance on verbal assurances from Mother about the reasons for T's low attendance. School staff did not feel that T was at risk of significant harm and did not meet the required threshold for a targeted intervention.

<u>What opportunities were there to observe and assess the levels of care and support, and possible risks of neglect, through contact with the family and particularly home visits?</u>

53. As stated above (paragraph 44) five home visits were successfully undertaken in the period following Child E's birth and none after early March 2014. It is not clear what opportunities there were to discuss the home environment with parents, or to view the property and the facilities available. However, no concerns were recorded in any of the visits that were completed.

54. There were frequent attempts by the Health Visitors to arrange visits, but these did not take place. There are a number of explanations for this, including the fact that records were not updated; the Health Visting team had an incorrect address (which continued to be used despite information to correct it); and that Mother was unavailable. There seems to have been an assumption that the demands of care for T, with her medical appointments and travel to Birmingham Children's Hospital, explained Mother's unavailability. This was not tested or explored, nor was there any consideration of what the consequences for the other children might be if this was a valid factor in explaining missed appointments.

55. There is no record of a six-week developmental check for Child E or a post-natal check for Mother by the GP. These are key times for assessing a mother and baby's well-being and bonding. It does not appear from practice records that developmental or post-natal checks were carried out for the older children either. These were missed opportunities to explore whether there were concerns within the family unit. It is not clear why these did not occur, and this was compounded by the lack of contact and interaction with the health visiting service. The practice confirmed that they had not seen a health visitor since July 2013, and there is no evidence of the practice attempting to contact the health visitor service or pass on any concerns they might have.

56. Although T attended nursery and then reception class, there were no home visits from the school. This was surprising in the context of extremely low attendance rates for T, and shows a lack of professional curiosity as to whether this low level of attendance suggested that additional help or support might be appropriate. The medical explanation of the treatment for T was taken as providing sufficient reason for authorising absence.

57. It was reported that nursery staff might carry out home visits if there were concerns and the school undertakes home visits automatically for all new pupils starting in reception who have not attended the on-site nursery. Because T was already known there was no trigger for a home visit when she started school, and because there were no concerns identified (despite her medical needs) the nursery had not visited. This resulted in an unintentional gap in the contact through home visiting with parents of a new pupil. It is a significant omission that a young child with significant health needs did not have a home visit and there was not an opportunity to assess the family context, or perhaps to identify whether other children might require support.

Why did this family not access greater early help and support from children's centres and pre-school settings?

58. It is not clear why this family did not make use of early help and other support, or the extent to which agencies offered these services. When interviewed Mother acknowledged that they had lived "in their own little bubble", and that she recognised that this had made her selfish and not always able to prioritise the children's needs. The use of drugs and alcohol was, accordingly to Mother, to some extent hidden from other family members, and it appears that the family was focused on themselves. The involvement with drugs and the cultivation of cannabis discovered at Child E's death probably increased this isolation and disengagement from community and agency support.

59. Mother did not feel that she was aware of any offers of wider support and felt confident in her own experience as a mother of 4 young children. She now recognises that she might have needed or sought some additional support and help through a children's centre, or other universal or targeted services.

What was known about any episodes of domestic violence, substance misuse or criminal activity that might have indicated safeguarding risks for the children?

60. The police were aware of a series of domestic incidents and threats and violence from Father. One incident occurred between Father and his previous partner during the period of this review, which was graded at standard risk and resolved with a verbal warning.

61. Statements taken after Child E's death indicated that Mother and Father had shared cocaine previously, and there was no attempt to conceal the drug use of various individuals attending the party. However, it is difficult to see how this information could have been known earlier and therefore indicated any safeguarding risks before Child E's death.

62. The cultivation of cannabis at the property was clearly against the best interests of the children, and presented a significant risk and hazard to them. However, there does not appear to have been any intelligence to suggest that this was suspected or known to the police or other agencies before the discovery of the plants at Child E's death.

Were there aspects of the medical and home care required by Child E's sister for her health condition that may have affected the care provided to other children?

63. As suggested above, the medical care and support for T was appropriate and Mother and stepfather appeared to prioritise this and support her. It does not appear that any agency considered what the wider family context might be and whether T's condition and any priority given to her needs might have affected the care provided to the other children. Equally, there is no indication that this care was compromised.

64. There is circumstantial evidence that stress levels within the family were raised by her illness and treatment. This is not surprising. Mother did not attend appointments at these times citing T's operation as the reason. It is not clear whether this affected the care of the other children. Mother was pregnant with Child E at this point.

65. The school discussed T's low attendance with the Children and Family First Service in January 2014, but there are no notes detailing the subsequent follow-up with Mother, who had advised that T would require further medical attention. At the time the school did not have the medical certification for authorised absence so there is no reliable basis to assess whether all T's missed schooling was due to her medical needs, or whether it reflected any reluctance for her to attend, or any other underlying issues. As T was under compulsory school age during the academic year 2013-14 the requirement for the local authority to ensure suitable full-time education did not apply, but it would be good practice to ensure that the consequences of missing significant education is actively managed in co-operation with parents.

What aspects of previous contact with members of this family might have indicated any needs for the children?

66. In retrospect there appear to be a number of factors which if considered together might have suggested needs for the children and some level of risk. These are summarised in paragraph 37. However, it is clear that these were not identified consistently before Child E's death, and that the routine but limited contact from agencies with the family did not give rise to any significant concerns. While these issues identified in hindsight might have suggested that greater attempts to engage with the family were appropriate, there is no indication of whether these service offers would have been accepted or relevant. There is no indication that any of these issues were material to Child E's death, or that the circumstances surrounding it would have been mitigated.

67. Health visiting records demonstrate that the separate records for each child were not effectively linked, and the wider failure to complete developmental checks, to arrange home visits, and to review siblings' records together, meant that there was not a clear picture of the whole family and its circumstances available to practitioners and therefore a view of their collective needs. This hindered appropriate future care planning.

Were there opportunities for the concerns that have led to the subsequent creation of child protection plans to be identified or shared between agencies at an earlier stage?

68. In my view, there were not significant opportunities for the concerns recognised in retrospect to be identified prior to Child E's death. There is no indication that this would have affected his tragic death – a family party with drugs and alcohol and risks of co-sleeping would not have been altered or changed. The contact with this family was infrequent and episodic, but no agency possessed clear evidence prior to Child E's death that would have provided grounds for intervention or for escalating concerns.

69. The lack of a proactive engagement from the family support Workers at Birmingham Children's Hospital Foundation Trust with this family was a missed opportunity as the contact with the hospital, while not extensive, was consistent and clearly the parents gave this some priority. Together with the school, the contact around T's medical care was the point at which agencies had contact with this family with the greatest impact and the possibility for constructive engagement. There is a mismatch between the support described as available in general terms from these workers and any evidence that it was offered or considered for this family.

70. The development check at six-weeks was missed and this was an opportunity to assess if there were significant concerns and whether additional input from any agency might have been appropriate.

71. As a point of learning it is suggested that consideration of the neglect risk factors identified in paragraph 41 might have prompted a more curious engagement with this family from school, health visitors, primary care, and that the Family Support Service at Birmingham Children's Hospital could have considered more assertively whether this family needed support. But again, it is unclear whether this would have confirmed whether these risk factors were significant, or whether the family would have been open to acknowledging the possible risks and concerns for their parenting.

Summary and conclusions

72. There is little information in this report about Child E. There was minimal contact with agencies during his short life – three midwifery home visits, two health visitors, and an attendance at A&E. There were missed opportunities to assess his needs and to provide support to his parents, including the primary care 6-week developmental check. The circumstances of his death highlighted areas of concern and possible risks of neglect, but there is little to suggest that these had a direct and material effect on his well-being or his death. The evidence of a neglectful environment, poor home conditions, drug and alcohol use, cannabis cultivation, and a context in which the parents admit that they did not always prioritise their children's needs, were only apparent after Child E's death. There was no obvious occasion for these factors to be assessed by professionals, and indeed in the contact during the first three months of his life there were no recorded concerns, and Child E was reported as thriving and well-cared for.

73. Child E's death was an accidental occurrence that has had a profound effect on his parents, and which they regret deeply. Mother was adamant and passionate about her commitment to her children and their well-being. They have acknowledged many factors in their previous behaviour that were not ideal, and have made strong efforts to change their lifestyle, to reject alcohol and drug abuse, and have attempted to build a new family life after Child E's death.

74. The key learning from this case comprises the following points:
    - It is good practice to manage school attendance proactively, even where there appears to be a long-standing medical reason for a child's absence. The school setting needs to be assured that the appropriate support is available to parents in these, often difficult, circumstances, and that the impact on other members of the family is understood. Changes of arrangements within school have addressed these issues, and there is evidence of appropriate senior oversight of attendance issues, better recording of absence and explanations, and prompt follow-up with home visits for all absences.
    - Where a child with known needs moves from nursery to school it is good practice for a home visit to be undertaken to assess any possible additional support and to agree with parents on the plan for transition. Previous attendance at nursery should not prevent this taking place.
    - Schools need to recognise the support and advice that Children and Families First Service can provide on issues of attendance and vulnerable children.
    - The organisation of health visiting services in large teams made record keeping and continuity of care difficult to maintain. This has now been changed in the establishment of local Health Visitor teams more closely linked to primary care.

It was a significant gap that there was not regular liaison between the health visitors and the GP practice. The number of failed appointments should have triggered a conversation between the child's GP and health visiting.

- 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. It is not my view that this would have changed the circumstances of Child E's death, but the case illustrates that understanding of neglect is underdeveloped and not shared across agencies.
- Regular consideration should be given by the Family Support team within Birmingham Children's Hospital as to whether families with a child who has complex medical needs would benefit from a family Common Assessment Framework as a matter of routine, to ensure that the needs of all family members are assessed.

Recommendations

75. The Coventry LSCB should:

75.1. Seek assurance that the arrangements for each GP practice to have a named health visitor for regular and consistent contact, provides for the accurate and timely sharing of information about families in need.

75.2. Request the Birmingham Children's Hospital Foundation Trust to review the work of the Family Support Workers to ensure that they proactively engage with families attending for ongoing medical treatment, and record clearly what offers of support have been made and explored.

75.3. Promote multiagency training on the combination of early risk factors that can arise for families and how these can be better recognised and assessed and incorporate the learning from this case in developing better awareness of early risk factors, neglect and accessing early help.

75.4. 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.

75.5. Ensure that school attendance policies and guidance for all schools promote a more rigorous questioning of the reasons for absence, and that where medical reasons are provided these are explored to ensure that the family is receiving the best possible support to encourage attendance.

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