SERIOUS CASE REVIEW

‘Billy’

SOUTHAMPTON LOCAL SAFEGUARDING CHILDREN BOARD

Graham Bartlett, Independent Reviewer

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1. Introduction

1.1. On 27th February 2018 at 07:34 Billy's father, Luke contacted South Central Ambulance Service (SCAS) when Billy was found to be unresponsive. Paramedics arrived at the scene at 07:41 and noted that Billy was supine on the floor unresponsive and floppy. Billy was immediately picked up and taken into the ambulance where CPR was ongoing during which. paramedics did not note any further injuries.

1.2. Billy was taken ambulance to Southampton General Hospital (SGH) arriving at 07:55. Resuscitation was attempted at the hospital but Billy was pronounced deceased at 07:58.

1.3. Initial enquiries revealed that Billy had been sleeping on a sofa with his mother, Chloe. He was fed at 02:30 as usual and was 'gurgling' and happy. He brought up a small vomit after his feed, which was normal for him. Luke woke at approximately 07:30 and looked across but could not see Billy. He then pulled back a blanket and saw that he was face down under it. He had rolled into the frame of the sofa in the gap between the cushion and the back. Luke picked Billy up and could see he was a blue/ purple colour.

1.4. It appeared that Chloe had overlaid Billy whilst sleeping, pushing him down against the edge of the sofa area. There was nothing to indicate that the death was suspicious in nature and was not treated as such.

1.5. Following Billy's latest discharge from hospital, Chloe told police he was unable to sleep in the Moses basket and would scream through the night. As a result, she said she would sleep with Billy on the sofa to allow the rest of the family a normal sleep. She put this down to him withdrawing from his medication following discharge. She said she had never previously slept with a child in her bed and that Billy was the first.

1.6. The sofa was a L-shaped corner style sofa. The wooden frame was only covered by a thin layer of material. which Chloe would cover with a duvet in the area where Billy would sleep. She would lay under the duvet on the outside edge of the sofa facing in. She would then have a pillow which she would cover with a blue blanket. Billy would then sleep on this, between her and the back of the sofa. It was from here that he appeared to have rolled into the frame.

Subjects of the Review[1]

Name	Age on Date of Billy's death	Relationship
Billy	4 ¾ months	Deceased
Alex	7 yrs. 5 months	Sibling
Elly	6 yrs. 4 months	Sibling
Robbie	5 yrs. 1 month	Sibling
Kieran	3 yrs. 8 months	Sibling
Tommy	1 yr. 7 months	Sibling
Chloe	26 yrs.	Mother
Luke	25 yrs.	Father

2. Terms of Reference

2.1. Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulations 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

[1] All names are pseudonyms

5 (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

5 (2) For the purposes of paragraph (1) (e), a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either —

(i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

2.2. Given that Billy had died and, from the scoping information obtained by the Southampton LSCB, it was established that there may be concerns as to how partners worked together, this serious case review (SCR) was commissioned.

2.3. This review requested relevant background and contextual information regarding key factors and significant events about the family that was known or knowable from the start of the review period. This was to include any relevant agency knowledge outside of the period of review.

2.4. The agencies which had relevant involvement with Child R or his immediate family were:

- Pre-School (since closed and no information was available)
- Hampshire Constabulary
- Solent NHS Trust (to include Health Visiting, School Nursing, CAMHS)
- South Central Ambulance Services
- Southampton City Clinical Commissioning Group regarding Primary Care
- Southampton City Council Children and Families Service
- Southampton City Council Housing Services
- Infants School
- Junior School
- University Hospital Southampton NHS Foundation Trust

2.5. The SCR Group acted as the reference panel for this review.

2.6. Mr Graham Bartlett was appointed as lead reviewer and author for this review. He is the Director of South Downs Leadership and Management Services Ltd and Independently Chairs the East Sussex and Brighton and Hove Safeguarding Adults Boards. Until recently he was the Independent Chair of Brighton and Hove Local Safeguarding Children Board. He has undertaken the Social Care Institute for Excellence Learning Together Foundation Course. He is experienced in overseeing Serious Case Reviews, Safeguarding Adult Reviews and leading and writing Domestic Homicide Reviews. He is a retired Chief Superintendent from Sussex Police latterly as the Divisional Commander for the city of Brighton and Hove. He had previously been the Detective Superintendent for Public Protection which entailed being the senior officer responsible for the Force's approach to Child Protection, Domestic Abuse, Multi-agency Public Protection Arrangements (MAPPA), Missing Persons, Hate Crime, Vulnerable Adults and Sexual Offences. He retired in March 2013. He had no involvement or responsibility for any policing in Hampshire or Southampton.

2.7. The purpose of this review is to understand the barriers to safeguarding, in order to establish whether agencies acted appropriately and in a timely manner. It will also review whether agencies worked well together, in a timely manner and accordance with policies and processes. It is also intended to allow lessons to be learnt for the future in similar cases.

2.8. The period under review is from 1st October 2014 to 27th February 2018.

Analysis issues

2.9. This review will consider all issues that could have a bearing on the circumstances of this case and will include:

- Co-Sleeping
- Disengagement from Services
- Concerns of neglect to Billy and 5 siblings

Involvement of Staff

2.10. The lead reviewer will consider from summary information provided the involvement of relevant staff in this case to ensure any possible learning opportunities are identified and acted upon.

Involvement of Family

2.11. The lead reviewer will notify the family members of the review and they will be invited to participate as and when appropriate.

Methodology

2.12. The methodology for this review will consist of:

- A review of summary information and chronologies provided by individual agencies where there was contact with the family
- Individual Management Reviews (IMRs) to be requested from agencies involved with family.
- Further reports from individual agencies where there are key lines of enquiry to explore
- A review of relevant policies, procedures and processes that are in place
- Meetings with a panel of representatives from the agencies involved to seek advice, guidance and approval of the review process and terms of reference, where appropriate.
- Interviews of key professionals, workers, colleagues of the family members, managers and service leads – individually and in groups where relevant
- Further panel meetings to discuss findings and finalise report and recommendations
- Review to be referenced as part of wider thematic review of Co Sleeping in Southampton.

2.13. The Lead Reviewer requested details and further information where necessary to support analysis and scope of the review. This may involve minutes of meetings, written assessments made and other relevant information.

2.14. Within the IMRs, agencies highlighted detailed recommendation for internal consideration. These have not been reflected here unless they relate to the matters discussed.

3. Overview of Family

3.1. The family lived together in a first floor three bedroom flat provided by Southampton City Council. Each child has the same mother and father and there is little obvious other family support. The parents are both unemployed and Chloe is a smoker. Both have a history with social care going back to their childhood and neither have any previous convictions.

3.2. Billy, the subject of the review, was born eleven weeks premature by emergency caesarean due to maternal infection, and had a six week stay on the Neonatal Unit (NNU) prior to discharge home. He was readmitted eleven days later with bronchiolitis and he was discharged after twenty-three days. He died on 27th February 2018.

3.3. Alex was aged four to seven years old over the review period, and, other than nose bleeds and skin complaints, had few health concerns. He attended Junior School who held few concerns about him.

3.4. Elly was aged three to six years old over the review period and had a health history of bedwetting and tonsillitis. She was referred to the Continence Service but not taken to appointments so was discharged. She attended Infants School who held few concerns about her other than sometimes smelling, but that was after Billy's death.

3.5. Robbie was aged one to five years old over the review period. He suffered from wheeziness and was once admitted as an emergency to SGH for this. He was subject of a child protection investigation in February 2015 which is discussed in detail later. He attended Infants School who held few concerns about him other than sometimes smelling.

3.6. Kieran was aged four months to three years old over the review period. He had a history of not being brought for appointments and immunisations and was subject of the same child protection investigation as Robbie. He also had a brief admission to SGH for febrile convulsions. During this admission a bite mark was seen on his back.

3.7. Tommy was born during the review period and was eighteen months old when Billy died. He was born at thirty-five weeks by emergency caesarean section due to suspected foetal compromise. He was kept in an incubator, given antibiotics for suspected sepsis and, as he was jaundiced, was given phototherapy.

3.8. Chloe was aged twenty three to twenty seven years old over the review period. As well as the live births, she had a miscarriage during the review period. Both this, and the pregnancy with Billy were late presentations.

3.9. Luke was aged twenty two to twenty six years old over the review period. His only contact with a GP was after Billy's death when he presented with anxiety and trouble sleeping He was referred to a counsellor for further support. Luke was the one who usually brought the children to the GP when they attended appointments.

4. Chronology

4.1. Prior to the period under review, both Chloe and Luke had contact with health and social care agencies during their childhood and surrounding the birth of their first four children. Following the birth of Elly, midwifery had concerns that Chloe was not coping. She was smoking excessively and was leaving the baby unattended on the ward. There were also concerns regarding her misusing medication; seemingly she had taken thirty paracetamol and thirty Anadin twelve days before the delivery to alleviate pain. This was referred to Children and Families Service (CFS) and, following an Initial Assessment, the matter was closed.

4.2. In November 2011, concerns started to grow when health visitors (HV) reported that Chloe had missed three appointments and was not at home for an unannounced visit. The lack of engagement was becoming a problem as they were unable to assess Elly's health needs. This perpetuated through to January 2012, aggravated by the fact that Elly still had not been registered with a GP. Worries started to emerge regarding the parents' ability to

supervise the children when Elly fell down the stairs in August 2012 causing her to sustain a spiral fracture to her leg. This was investigated but deemed to have been an accident.

4.3. During Chloe's pregnancy with Kieran, the hospital expressed concerns regarding Chloe's smoking and her unwillingness to stop. Just prior to his birth, the police were called following a report of a domestic dispute between Chloe and Luke. On attendance it transpired that it was a heated verbal argument over who would look after the children when Chloe went to hospital to give birth. The police tried to negotiate Luke from the house but he refused to leave. Given Chloe's mother had arrived and the three young children seemed settled with Luke, they allowed him to remain while Chloe went away with her mother.

4.4. Following Kieran's birth, on 12th June 2014, Chloe was offered the support of a nursery nurse, given this was her fourth child and that the pressures on her and Luke would have been intense. She declined this offer. She also refused entry to the health visitor for Kieran's primary birth visit. When the health visitor returned the following day, Chloe expressed a wish to have a nursery nurse support her. She was reminded of her previous refusal but this service was provided.

4.5. Throughout July 2014, further non-engagement was seen with health visitors being declined entry twice and an appointment cancelled once, together with Kieran twice not being brought for hearing assessments. Following the cancelled health visiting appointment a referral was made to the Multi-agency Safeguarding Hub (MASH). Whilst Chloe said she did not want any involvement from CFS, a Universal Health Assessment (UHA) was triggered. Early Help support was offered through this and, variously, accepted. However, it seemed that during the final UHA meeting, in November 2014, professionals were not aware the children were by then on Child Protection Plans.

4.6. Early morning on 2nd September 2014 a neighbour telephoned the police to report there were two small children running naked in the street. They were described as about two and three years old and were from this family's address. They had been taken back indoors twice – once by a neighbour and once by a school teacher - but had come straight back out again. The flats are maisonette style so they would have had to have come down several flights to find their way to the street.

4.7. The police attended and the door was answered by a naked small boy. He allowed the officers entry and they found three young children in the address unsupervised. On the floor were a pair of scissors and broken light bulbs which one of the boys told the officers to be careful of. Officers found Luke asleep on the sofa in the living room. On waking him he called upstairs and Chloe joined them shortly afterwards. Words of advice were given to Luke and Chloe. The address was found to have adequate food and clothing for the children. Police left having identified no offences and content that the parents could care for the children. Officers completed a Children and Young Person Referral (CYPR) form for onward submission to CFS, highlighting the risks.

4.8. Following a strategy meeting, it was determined that CFS would undertake a single agency investigation arising from this incident and the earlier Health Visiting concerns. There appeared to be some delay in CFS allocating a social worker as the health visitor raised concerns that it had not been possible to undertake a joint visit that had been planned.

4.9. When this visit did happen, on the 19th September 2014, professionals became more concerned. Kieran, then aged 3 months, was found upstairs on the parents' bed, unsupervised. The social worker recorded that the house was so noisy, with three other children and a loud television, that had Kieran fallen from the bed it was unlikely that anyone would have heard. Alex's bed had a heavily soiled mattress with no bedding apart from a sheet and a stained pillow. The toilet bowl was 'coated in faeces' and the bath was dirty. As the social worker came downstairs she saw that Chloe had left Robbie (aged 1) standing unrestrained in his high chair and attempting to climb out. Elly, aged just under three, was seen to be playing unhindered with a plastic carrier bag.

4.10. The social worker concluded that the parents had no level of awareness of the risks posed to their children and minimised the concerns. It was also noted that the parents were not engaging with health services. The health visitor stated that home conditions were normally poor and that Kieran was not having his health needs met as his parents had not been taking him to health appointments. The social worker concluded that the children were being placed at significant risk of harm through neglect. These further concerns were investigated singly by CFS.

4.11. On the same day as the child protection visit, CFS received a contact from Elly's pre-school, informing them that they had noticed a mark on her hand, which her parents were unaware of and did not know the cause. A single agency investigation was triggered and following a child protection (CP) medical examination, the cause of the injury was deemed inconclusive but accidental. The medical raised concerns relating to lack of supervision given the injury being unexplained, and noted that Elly was 'grubby' (toenails and dirty knickers) and 'needed a bath'. CP medicals in respect of Kieran, Alex and Robbie raised no concerns.

4.12. On 20th September 2014, during a health visitor visit, the flat seemed much cleaner. However, the parents reported that Alex had pushed Elly down the stairs and she had hit her face causing a small bruise on her left cheek. As a consequence, she was taken to the walk-in-centre but no follow up was required.

4.13. On the 22nd September 2014, Luke and Chloe were enrolled on the Incredible Years[2] course starting the following week.

4.14. During a child protection monitoring visit on the 26th September 2014, Kieran was found covered up to his chin with a blanket. The risks of suffocation were discussed and Chloe was advised just to cover him to his knees, to prevent this. Cleaning products were found stored under the sink in reach of the children and no safety locks were fitted. Chloe said she was due to buy some. Concerns remained regarding the children's bedding still being dirty.

4.15. During a further child protection monitoring visit, on 6th October 2014, the social worker again checked the kitchen cupboards which were still unprotected. Luke stated they purchased some child proof locks but were not yet attached. Concerns remained that the children were still dirty.

4.16. On 10th October 2014 an Initial Child Protection Conference (ICPC) was held in relation to the four children, under the categories of physical and emotional abuse and neglect. Following a unanimous decision, all four children were placed on Child Protection Plans under each category and a core group was established. It was also decided to seek legal advice regarding instigating Public Law Outline[3] (PLO).

4.17. On 23rd October 2014, the Orthopaedics Professor at SGH wrote to the GP highlighting that Kieran was not brought to the clinic and that the GP may wish to 'alert the authorities.' This was in line with the Was Not Brought (WNB) policy at the time however, no there was no evidence that the safeguarding nurse, health visitor or parents were informed/contacted as that policy requires. On the 29th October 2014, Chloe told her GP that she was awaiting contact from orthopaedics. These two conflicting pieces of information did not appear to have been linked.

4.18. At the first Core Group, on the 24th October 2014, it was confirmed that legal advice had been sought, the PLO process would be instigated and a letter would be sent to the parents to enable them to seek a solicitor. The group was also told that the health visitor had visited the family and noted a positive change and seen the parents putting their Incredible Years course into practice. Both parents were reported to be engaging with the course and while Chloe was seen as being 'a bit shy', Luke was supporting her.

[2] http://www.sftrust.org.uk/incredible-years/

[3] https://www.leeds.gov.uk/docs/149%20-%20Public%20Law%20Outline.pdf

4.19. Despite CFS having no record and no minutes of this, on the 26th November 2014, a health visitor recorded that she had attended a second Core Group. The health visitor notes say that CFS had permission to start the pre-legal process and that a new social worker had been allocated. As CFS have no record of this Group meeting, it has not been possible to understand what the basis and nature of the pre-legal process was nor why the social worker changed.

4.20. On 2nd December 2014, Chloe called the Housing Customer Payment and Debt Team to make a payment against her increasing rent arrears. She said she had missed payments as she said her six month old son had been in hospital. Records do not suggest this was true.

4.21. On the 7th January 2015, a Review Child Protection Conference (RCPC) was held and it was unanimously agreed that the children would remain on Child Protection Plans. However, this conference was not quorate as it only had CFS, Health Visitor and pre-school representation. Southampton LSCB Policy and Procedures provide that *"As a minimum quorum, at every conference there should be attendance by local authority children's social care and at least two other professional groups or agencies, which have had direct contact with each child who is the subject of the conference."*

4.22. On the 23rd January 2015, the nursery nurse discussed the housing situation with No Limits. It was agreed that No Limits would discuss this with the social worker. There is no record of this having happened.

4.23. On 3th February 2015, police were notified by Children's Services of a Section 47[4] child protection investigation with regard to Robbie, then aged two. A family support worker, on a home visit that morning, observed a dark-purple bruise on the soft cheek of his face. The explanation given was that some days previously he had climbed onto his booster chair when sitting to eat and had fallen forward hitting himself on the table. Furthermore, the support worker had been asked by the parents to examine a blood blister inside Kieran's mouth. They thought it might be the consequence of teething but the support worker was concerned about it. child protection medicals were arranged for both children that afternoon. Police and CFS agreed that a joint agency investigation would be carried out.

4.24. Due to resource constraints, police asked CFS to attend the medicals alone but to report back to them before any further decisions were made. Later that evening, the police recorded the update from the medicals being that Kieran's injury was of no concern. Robbie could not be medically examined until the following day, and Elly's and Alex's were to be conducted on Friday 6th February. The police recorded that they had spoken with the social worker who had 'no significant concerns of the children going back to the family unit' in the meantime.

4.25. The following day, a duty social worker called the police asking if they would be attending Robbie's medical that afternoon. Police replied that they would not but that the social worker should feedback the outcome to them.

4.26. On 7th February 2015, police recorded that they had contacted the social worker to ask for an update having received none. Police were told that a manager had reviewed the case and concluded that, as the parents would not allow a medical for Elly and Alex, and the other two medicals had revealed no concerns, it was decided not to apply for a court order as the further medicals would be *'best practice rather than needed for any investigation'*. Police recorded that, at this stage therefore, there was no need for any further police action.

4.27. On 21st March 2015 a copy of a letter dated 26th February 2015 was attached to the police file, by the same Detective Sergeant. This letter had been written by a clinical safeguarding nurse specialist and a consultant community paediatrician to the GP, Dr. Chandry, and covered the examination of Robbie on 4th February 2015. The letter commented *'a significant number of bruises with no consistent explanation were noted'*. An attached

[4] https://www.legislation.gov.uk/ukpga/1989/41/section/47

report, signed and dated on 11th March 2015, detailed a blue-grey bruise to the right soft cheek, a tiny red mark below the left eye and three tiny red marks on the left cheek by the corner of the mouth. For the first injury Chloe stated that he had 'slid down the table.' She offered no explanation for the latter injuries.

4.28. The report then itemised a further nine small injuries to Robbie's torso and one to the right arm. There was no explanation for these injuries. In commentary, the report stated that the cheek injury *'is of serious concern'*. With regard to two of the torso injuries, petechial bruises, the report commented that *'This type of bruising is more frequently see in abused children than non-abused children and is a cause for concern. The lack of explanation for the bruising increases the level of concern regarding this injury.'* Four more injuries, being bruises to soft tissue areas of the body which were covered by a nappy for the majority of the time were also *'of serious concern'*. Two further injuries were described as *'unusual for accidental injury although this cannot be excluded'*. Robbie was sent for a blood test in order to identify any clotting disorders which might accentuate apparent bruising. These tests were found to be normal. The conclusion of the report states that *'In the absence of a clotting disorder this number of bruises/marks represents a lack of adequate supervision. At worst, this may represent inflicted injury.'*

4.29. No other agency has reported the detail or findings of this report, with the reported outcome elsewhere being that the injuries were of 'no concern.'

4.30. The primary care record reports that *'there were a number of chronic social concerns for Robbie, many of which were present at the time he was initially made subject to CP planning. Both parents changed their mobile numbers and did not inform professional services. They missed home visits from social workers for a couple of weeks prior to Robbie's medical examination. Robbie's mother also recently cancelled his two-year development check with the health visitor, which requires completion.'* Over this period of time, Kieran had not been brought to a number of appointments regarding possible hip problems as a result of him being a breach birth.

4.31. At the Core Group held on 10th February 2015 (seemingly the first since the unminuted one of 26th November) no representative from CFS was present. Possibly as a consequence of this, no mention was made of the child protection investigation and medicals that took place the previous week. Certainly, there was no mention of the worrying findings later set out in the consultant community paediatrician's report of the 26th February.

4.32. On the 24th February 2014, the parents told the health visitor that they had no contact from their social worker since the last core group. This could have been the November Core Group (where it seems a new social worker was present) as the minutes indicate there was no CFS social worker at the one two weeks earlier.

4.33. CFS records confirm that social worker visits were not consistent, sometimes due to there being no response from the home, and others due to the pressure of work. Their records indicate that a successful visit was made on the 15th January 2015. There followed four, possibly five, attempts where there was no reply – three of these after the child protection medical in early February. Following a letter asking the family to be in for visits, subsequent attempts were successful on the 4th March, 21st April and 28th April, 27th May and 10th June 2015. CFS say that management were aware of the sporadic visits and the gaps between them but it is not clear what was done, other than sending the letter at the end of February, to improve engagement.

4.34. On 6th March 2015, the health visitor attempted a home visit. Chloe said she had not been aware of the visit and initially declined entry. The health visitor said she would not be long so was welcomed into the hall. She noted the stairs were covered in shoes and that both Alex and Elly were naked, eating their lunch prior to pre-school. Alex fetched a pillow to cover his genital area. Robbie was not seen but shouted 'hello/bye' to the health visitor from

somewhere within the home. Chloe reported their benefits had stopped as they had not attended job centre meetings.

4.35. There was a Core Group due on the 17th March 2015, but the health visitor was told, half an hour beforehand, that it was cancelled. It seemed the intention was to share the concerns from the 6th March visit but this was then not possible and it seems the concerns never were subsequently shared.

4.36. Following Chloe cancelling a health visitor visit on the 8th April 2015, another took place two days later on the 10th. On this occasion, both parents and all the children were seen. The home was clean and tidy yet the health visitor was becoming concerned that efforts to make it such were made only prior to visits and not at other times. The parents reported they had no communication from their social worker since the cancelled core group. This correlates with information held by CFS.

4.37. On 21st April 2015, Chloe called the Housing Customer Payment and Debt Team to make a payment. She stated she was in hospital as her baby had been born 5 weeks early and she was unsure when she would be discharged. Records do not suggest this was true.

4.38. On the 17th June 2015, Luke took Robbie to the GP as he had been wheezing. Inhalers were prescribed.

4.39. The following day, the 18th June 2015, the health visitor reports attending a Core Group. A set of minutes titled ‘CGM 15/07/15’ has been made available to the review but none for the 18th June 2015. There is nothing actually on these minutes which provides the date of the meeting, but from the content it is possible to infer these minutes relate to the 18th June and have been poorly completed and misnamed. The minutes suggest that the plan for a social work visit to be carried out every ten days has *‘on the whole …. been achieved.’* Records do not suggest this was correct. They also say that PLO will now *‘not go forward due to the improvements that have been seen.’* No reference is made to the child protection medicals in February or the subsequent concerning report, nor the questionable hygiene and lack of engagement with the health visitors. The health visiting notes of this meeting suggest that it was agreed that given ‘a drift since the last, a new assessment required.’ That is not minuted nor is there record of one being carried out.

4.40. On the 30th June 2015 a RCPC was held. Notable absences were the police, who submitted a report, and the clinical safeguarding Dr and GP who did not. The child protection medical held on the 3rd February was raised. The minutes note that *‘Robbie was observed to have a bruise on his cheek. A child protection medical was subsequently undertaken which raised no concerns and noted an improvement in the parent’s presentation and the children’s health conditions. A blood test was undertaken to establish whether there was any medical reason for Robbie’s apparent excessing bruising. The blood test came back clear.’* This differs in fact and tone from the report to the GP from the community paediatric consultant. Had those two professionals been at the conference and had the police included the concerns in their report, the conference might have been given a different view of the medical.

4.41. The conference heard a very rosy picture of how the family had improved and did not seem to hear of the underlying concerns re hygiene and non-engagement held by health visiting. As a consequence, those present unanimously agreed to step the children down to Child in Need (CiN).

4.42. On the 13th July 2015, Chloe saw her GP regarding a suspected urinary tract infection. However, a week later she was found to be pregnant. Just over three weeks after that, on the 14th August 2015, Chloe called 111 reporting that she was 10 weeks pregnant and was bleeding with clots. The 111 notes say ‘Speak to a primary care service within 2 hours - Hampshire Out of Hours (OOH) GP’ It appears she did so on the 17th August 2015 and was referred to the Early Pregnancy Assessment Unit.

4.43. That day, Kieran was taken to SGH Accident and Emergency department by ambulance, suffering from febrile convulsions, petechial haemorrhaging and with a bruise to his back which was said to have been caused by his three-year-old brother biting him. On admission it was discovered that Chloe was miscarrying and was transferred to the nearby Princess Anne Hospital. The bite was assessed in both the A and E and by the consultant paediatrician on the PAU ward round.

4.44. Because Kieran was on a CiN Plan, a message was left for the safeguarding nurse but this did not include the fact that he had also suffered a bite. The miscarriage was passed over which, in turn was communicated to CFS and the GP. CFS did not know Chloe was pregnant. Upon Kieran's discharge the febrile convulsion sheet was not given but it was noted that he would be brought back the following day, which he was, but there is no record of the sheet being given then.

4.45. On the 8th September 2015 the health visitor, other professionals and the family attended what was the first CiN meeting. However, the social worker did not as they had the wrong date so the meeting had to be postponed.

4.46. When the Group was reconvened on the 22nd September 2015, it was agreed that the family be stepped down to universal services. The minutes of the meeting comprise very brief bullet points so it is impossible to see, other than a few positive comments, what the discussion was that led to this step down after just three months. Health visiting still held concerns although these did not seem to have been shared. There was no visible management oversight of this decision.

4.47. On the 16th October 2015, Elly was taken to the GP due to her bedwetting. She had a suspected urinary infection but subsequent urgent messages for the parents to contact the surgery for a prescription went unanswered and a referral to the incontinence service was not responded to, leading to her later being discharged from the service without being seen.

4.48. On the 23rd November 2015, the health visitor visited the family but received no reply, despite hearing children's voices inside. It is not clear that the health visitor did anything about this, especially to check whether the children were there and if so whether they were safe.

4.49. On the 11th January 2016, Chloe was found to be eleven weeks pregnant with a due date of 20th August 2016. Throughout the pregnancy she declined to stop smoking, as well as declining a referral to Quitters and for the whooping cough vaccine.

4.50. On the 16th July 2016, the antenatal clinic at Southampton detected she was leaking fluids. As their own NNU was closed, it was suggested she go to Basingstoke NNU. Chloe said that she wished to self-discharge as she did not want to travel without a relative being with her. The nurse phoned Basingstoke and it was agreed this was acceptable. However, her relative declined to go with her so she eventually went in the ambulance alone. Whilst there, she was offered an ultrasound for measurements but declined this, declined to stay in Basingstoke hospital for observations and self-discharged.

4.51. The following day Tommy was born by emergency caesarean at 35 + 2 weeks due to suspected foetal compromise. He was kept in an incubator, given antibiotics for suspected sepsis and, as he was jaundiced, was given phototherapy.

4.52. Chloe visited and fed Tommy formula milk. Tommy was doing well, but Chloe insisted he be discharged on 20th July 2016. The risks of respiratory distress and increased risk of Sudden Infant Death Syndrome (SIDS), jaundice and weight loss were explained to her as were the reasons why it is best not to self-discharge against medical advice. She was advised of the Day 3 – Day 5 policy for babies born early, but she still refused to stay.

4.53. Staff highlighted their concerns to the consultant and she advised that, as *'the child is well and mother doesn't want to stay,'* she would be happy if the Home Team were requested to visit the following day. She was given advice on *'signs of unwell baby'* and 'discharging against medical advice' leaflets and advised of the following day's visit. The nurse also

documented that the safeguarding team will be 'updated and discussed' but there is no record of this happening.

4.54. However, as the Home Team car was in for service, the planned visit did not take place on the 21st July, and the earliest it could happen would be five days later, the 26th July, the same day as the midwife was due. Given this, it was decided that the midwife visit would go ahead and the Home Team would only be asked to visit if required. They were not.

4.55. On 27th July 2016, the health visitor was due to undertake Kieran's second health review. The health visitor undertook an opportunistic home visit to arrange Tommy's new birth visit. Chloe was seen coming out of her home to have a cigarette. It was agreed, due to Tommy recently being born, that Kieran's review would wait and that the health visitor would come back the following day for the new birth visit.

4.56. This visit happened and the HV observed positive interactions and attachment. The health visitor discussed safe sleeping, smoking and all other health promotion as per Healthy Child Programme[5]. The parents discussed previous social care involvement and stated, on reflection, it had made them better parents. Chloe reported feeling emotionally and physically well and the children were appropriately dressed and engaged appropriately. However, all still needed to be registered with a dentist.

4.57. On the 4th October 2016, Chloe saw her GP for a postnatal examination. She reported her moods being good and that her partner was around. She said she wanted to start on the contraceptive pill but it did not seem a prescription was issued. There were no notes to suggest that the GP enquired how Chloe was coping now she had five children.

4.58. The following day Tommy had his six-week check. There was no mention again as to how the parents were coping, especially given Tommy's prematurity and health problems at birth. However, he was being brought to his immunisations.

4.59. On the 9th October 2016, police received a 999 call from Chloe calling from her mother's address. She reported that her mother's partner had assaulted her by pushing her and had assaulted her fourteen-year-old brother by pushing him down the stairs. On arrival, Chloe's mother and her partner were intoxicated and police were concerned for her safety due to the controlling and abusive behaviour of her partner. Initially, Chloe and her brother wished to support a police investigation, so her mother's partner was arrested for two counts of ABH. However, they later retracted their support due to fear of repercussions from their mother and her partner. A Domestic Violence risk assessment (AD232r) was not completed as Chloe's mother did not wish to engage. A CYPR form was completed for Chloe's brother and five-year-old sister.

4.60. A joint police and social work visit was made to the family whilst the partner was in custody and safeguarding was discussed. Officers explained the video witness interview procedure to the brother to enable him to make an informed decision about providing evidence. However, this was conducted in the family home, with his mother, who strongly supported the suspect, in another room.

4.61. On 9th November 2016, Chloe called the GP surgery as she wanted an inhaler for Robbie. There were no GPs present so one could not be prescribed but Chloe hung up before the receptionist could conclude the call. The following day, Luke brought Robbie into the surgery and, given his wheezing, an ambulance was called and he was taken to the PAU at SGH. The hospital notes say the parents had run out of salbutamol but there is no suggestion he had been prescribed this since June 2015. Robbie was discharged on the 12th November with asthma advice and a referral for inhaler technique and symptom control. Luke had been with him throughout his stay.

[5] http://www.healthychildprogramme.com/

4.62. On 12th November 2016, 111 received a call regarding Tommy having an allergic reaction rash on his face chest arms and legs. The OOH GP received the 111 log but there is nothing on the primary care record which indicates what happened other than it was 'resolved.'

4.63. On 3rd January 2017, Chloe received a notice of seeking possession through the post for rent arrears.

4.64. On 2nd March 2017, Chloe called the 111 service as Elly had dental swelling/pain. She was not registered with a dentist. The details of the call were sent through to the Dental Advisory Service in Hampshire and this was received by them. In addition, the details of the call were sent through to the GP surgery and this was received but it seemed there was no follow up nor any check that Elly had been registered, or seen, a dentist.

4.65. On the 20th April 2017, Luke told Alex's teacher that he had fallen down a flight of stairs during the holidays and proceeded to show teacher the bruises. This concern does not seem to have been referred to any other service.

4.66. On 15th May 2017, Chloe's father jumped or fell fifty feet from her balcony having previously been intoxicated while at his nephew's wake. He was unconscious and bleeding heavily and was found to have broken his pelvis. There was no suggestion that Chloe, Luke or any of the children were involved but concern was raised that Chloe had been drinking while pregnant. This was a significant comment as she did not reveal this pregnancy to professionals for another two months.

4.67. On 25th July 2017, Chloe told her GP that she thought she was five to six months pregnant, her last menstrual period being in February or March. She was confirmed to be twenty weeks pregnant and was referred to midwifery but nothing of the family background or safeguarding history was highlighted. During her antenatal care, mention was made of her father having a learning disability or mental health condition. This had not arisen before, and the source of it is not noted but it possibly relates to his fall in May of that year.

4.68. Chloe disputes that she presented late, saying she had a twelve week scan but records are clear that she did not present until 25th July.

4.69. This late presentation raised concern but did not seem to trigger any enquiry regarding hidden pregnancy until midwifery reported their cumulating concerns to MASH on the 1st September 2017. This MASH 'contact' – as opposed to a referral - was made by the allocated midwife due to the previous safeguarding history. There is no record that the contact triggered the case being opened to CFS. The 4LSCB 'Maternity and Children's Services Unborn Babies Safeguarding Protocol[6]' provides that this should have been a referral, as should the late presentation in 2015 have been.

4.70. On the 18th August 2017, Chloe attended hospital due to PV bleeding. She thought she was miscarrying but the pregnancy was still ongoing and she was reassured. She later decided she would be sterilised following this pregnancy.

4.71. On 26th August 2017, a 111 call was made in respect of Kieran suffering swollen and bruised nose having fallen off a bed. The disposition was to speak to a primary care service within six hours and details of the call were sent to the Southampton GP's OOH Service. The primary care record notes this call but only says advice was given and that it seemed Kieran was alone in the room when it happened.

4.72. On 22nd September 2017, Tommy was seen for his first health review in clinic. His weight was 12kg plotted on 91st centile and was in line with his head circumference. He was not meeting his development milestones and the parents were given strategies to support his development. A further review appointment was made for November 2018. Chloe reported that Elly was continuing to have 'wetting' episodes and that they have tried all the interventions

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[6] http://southamptonlscb.co.uk/wp-content/uploads/2012/10/4LSCB-maternity-and-chidlren-services-unborn-babies-safeguarding-protocol-March-2013.pdf

offered them with no change. She agreed to a continence referral. Chloe had still not contacted the smoking cessation service.

4.73. Despite an ultrasound scan on 28th September 2017 showing no concerns, on the 3rd October 2017, Billy was born at 28+5 weeks by emergency caesarean. He was described as being in 'poor condition' with respiratory distress syndrome, feeding problems – prematurity, prolonged rupture of membranes with associated infection and moderate pulmonary artery stenosis.

4.74. He spent forty-five days in the NNU. During this time Chloe left the unit regularly and would often smell of cigarettes. She visited most days (Luke less so, but they had five young children at home) yet over one five-day period there was no contact with the unit from either parent. Billy was discharged on 15th November 2017 with Pulmonary Artery Stenosis and limited safe sleep advice was given.

4.75. Both parents deny infrequent visiting or contact. They say that the bus journey from their home to the hospital is long and complicated. They say that, still, they visited most days and called every day. They struggled to balance visiting with caring for the other five children at home. They say that no NNU staff made any attempt to understand their domestic situation nor how they were managing. Therefore, they did not feel there was anyone they could ask for help from.

4.76. Over this period and in to early 2018, Kieran was not brought for his immunisations on four occasions.

4.77. On the 21st November 2017, the Universal Plus Health Visiting service carried out a home visit following Billy's discharge from hospital. The health visitor explained their role as well as routine checks and local services. The flat appeared tidy but grubby. Chloe was observed to handle Billy responsively and with care and confidence. The health visitor offered advice regarding SIDS prevention. Chloe said she was well and happy and the 'Whooley' depression questionnaire[7] indicated no post-natal depression.

4.78. Two days later, on the 23rd November 2017, Billy was admitted to hospital initially with croup. On examination in PAU, he was found to have bronchiolitis. Chloe seemed disengaged and kept wanting to leave the ward. On occasions she would disappear without telling anyone. She maintained that she did not know he had Pulmonary Artery Stenosis, despite that being shared on his discharge following his NNU stay post birth. She seemed to have a low mood and declined to stay in hospital with Billy. A subsequent safeguarding discussion led to the belief that Chloe was just tired and that the health visitor would be asked to support the family. However, it seemed that the health visitor seemed unaware of this admission until the 14th December as was the GP, given that Billy was recorded as WNB for his immunisations, on 28th November 2017.

4.79. Chloe reiterated her struggles to balance visiting with care yet was very about Billy but felt communication from the hospital about his condition and progress could have been better.

4.80. On 29th November 2017, a crash call was made for Billy given his ongoing apnoea and bradycardia. He was anaemic and required blood transfusion. Chloe visited and was updated but left again, phoning at 23:30 for an update. Her infrequent visiting was a concern for professionals given their real worries over Billy's fluctuating health. Chloe says these concerns were never raised with her.

4.81. On 8th December 2017, the consultant on Paediatric Intensive Care Unit (PICU) spoke with Chloe on the phone regarding the head ultrasound carried out in October 2017 and the one that week identifying a 'bright spot deep in Billy's brain' and the need to investigate further with a more detailed MRI scan which was carried out that afternoon.

[7] https://whooleyquestions.ucsf.edu/

4.82. On 14th December, Billy was incubated due to tachycardia and low oxygen saturation. Neither Chloe nor Luke were present but Chloe rang at 02:00 for an update and then visited in the early afternoon by which time he was out of the incubator. During the evenings, hospital volunteers were on the ward to give Billy 'cuddles.'

4.83. The following day, 15th December 2017, the nurses asked for the MRI result although it was not clear if Chloe had asked for this or it was the nurse was requesting. When Chloe arrived at 16:00, she was reported to be 'anxious, due to not understanding why Billy was still in hospital'. The doctor explained this to her. PICU asked if NNU could support Chloe and Billy at home as he was an 'ex pre-term' baby from the unit. Although he did not meet the NNU's criteria, (that he would be followed up only if discharged from NNU) the Unit agreed they would contact the parents after discharge from PICU to offer support and signpost to the HV, GP and 111 if there were any concerns

4.84. On 17th December 2017, Chloe called 111 as Kieran (3 ½ yrs.) had sustained a penetrating finger injury from trying to cut a pear with a knife. A clinician from the 111 service called Chloe back and gave home management advice. At the end of this call the message was sent through to the GP surgery as a record of the call taking place. This was sent and received but no further action was taken.

4.85. The following day, the GP phoned and left a message for Chloe requesting contact with the surgery regarding Billy's post-natal attendance and outstanding immunisations. It seemed that they were still unaware that he had been an inpatient at SGH for three and a half weeks.

4.86. On the 19th December 2017, Billy was discharged from hospital. Chloe declined to wait for the discharge letter but was given 'safety net advice', such as withdrawal symptoms from morphine, bronchiolitis advice sheet and open access to ward. The concerns regarding the parents' infrequent visiting were not shared with the safeguarding team and the GP was not asked to review Billy.

4.87. On 20th December 2017, the nurse on NNU contacted the parents as arranged. Luke had no concerns with Billy's progress saying he was feeding well, was finishing his bottle and showed no difficulty with breathing. Luke said there was some difficulty in getting the pre-term milk prescription due to lack of supply. The nurse on NNU advised Luke to offer Billy an increase in milk. He was told there should be a 'delivery of SMA Pro Prem. Gold 2 at the pharmacy which should arrive by tomorrow.' Luke was advised that if there was any further delay they could use a term formula 'for a day or two if needed.' The NNU nurse asked for the health visitor to visit as soon as possible. The first health visit, post discharge, was on the 9th January 2018.

4.88. On 23rd December 2017, Chloe called 111 as Billy had been suffering from diarrhoea for three days. She said there had been a change in his stools since they changed formula. The primary care IMR author noted this change would have been against medical advice but seemed oblivious of the medical advice given by the NNU nurse in this instance.

4.89. This was causing the parents huge anxieties and it was only the help of their pharmacist, who advised they should have larger quantities prescribed that, in their eyes, resolved the issue

4.90. Billy was seen by the GP on the 2nd January 2018 due to feeding problems and being colicky but was not brought to SGH for an X ray on the 10th January 2018. The parents were concerned that his withdrawal from medication was affecting his ability to sleep, hence the other children were suffering too. Luke, did take Billy for his immunisations on the 23rd January but his WNBs were not discussed.

4.91. Again, he was not brought to SGH for an X ray on the 24th January 2018. Whilst the consultant wrote to the GP regarding the missed appointments, the hospital safeguarding team were not informed nor was it clear whether the GP called the family in to discuss their

missed appointments. The same thing happened in mid-February regarding an orthopaedic outpatient's appointment, as had previously happened with Kieran.

4.92. The same day Chloe cancelled a health visiting visit for Billy and, when she and he were not at home for a visit on the 31st January 2018, she was told to bring him to the Children's Centre. This was not written up until after his death.

4.93. On the 20th February 2018, Billy was seen in the cardiac clinic at SGH. He was reported to be currently doing well, feeding normally and gaining weight appropriately. Chloe did not report any episodes of breathlessness or cyanosis. Chloe was reassured that he remained stable from a cardiac point of view'

4.94. On the 27th February 2018, Billy died.

5. Analysis

5.1. Billy died at the age of twenty-one weeks old whilst co-sleeping with his mother on a sofa. He had a short and turbulent life prior to that. Despite Chloe disputing this, she did not present as pregnant until she was twenty weeks pregnant. This should have alerted professional to consider the reasons for this including possible attachment difficulties and risks both ante and postnatally.

5.2. He was delivered very prematurely in poor condition with a congenital cardiac abnormality, requiring a prolonged neonatal stay. He was likely to have associated increased care needs and, given the family history and circumstances, was at risk of neglect on discharge.

5.3. He was readmitted shortly after discharge with respiratory infection, again requiring intensive support. He was not taken to several hip screening appointments, his orthopaedic clinic appointment and did not have a six-week check by his GP, as would be standard practice. Although he was in hospital, the practice wrote to Chloe with appointments for a post-natal and 6-week baby check but these were not followed up.

5.4. Chloe had a consistent history of minimal and non-engagement with professionals, and presented significant risk factors as a smoking young mother with six children under the age of seven-years-old, historical concerns about levels of neglect and abuse, and two concealed pregnancies.

5.5. It was evident through the review period that Chloe and Luke struggled in their parenting with many examples of poor supervision, verging on the dangerous, being seen and responded to by professionals. There was also significant neglect and possible non-accidental injuries observed, none of which were effectively resolved or sometimes even investigated.

5.6. The lack of engagement by Chloe and Luke, both in respect of themselves and their children, whilst well known to most agencies, never sparked the curiosity that young parents, with a large young family and a number of well-known complex safeguarding and child protection concern should have. The failure to attend appointments and frequent cancellation of others should have triggered concerns but did not.

5.7. They dispute the volume of WNBs and the lack of engagement. They accept there were some occasions when they missed appointments but they maintain this was the exception rather than the rule, usually due to them struggling to bring up such a large young family with few resources and living so far from the hospital.

5.8. They say they did not feel they needed extra help, until Billy was born. They present as a couple who like to cope and see their experience of parenthood as a positive. However, clearly, they were not coping but no additional support was provided to them to help them do so.

5.9. The perilous situation the children were sometimes found in, and their dirty and unhygienic living conditions, should have prompted agencies to work intensively together to support the family to find long term sustainable solutions that would protect the children from abuse through neglect.

5.10. Agencies provided episodic, single agency responses and were too quick to regard any green shoots of improvement as being signs that Chloe and Luke's parenting capacity had sustainably improved, leading them to step down and withdraw support accordingly.

5.11. The child protection system was ineffective. Whilst the initial decision to make the four children subject of Child Protection Plans was correct, the decision to then step down was taken with the conference – and the preceding Core Group – oblivious to a consultant paediatrician's documented serious concerns of non-accidental injury.

5.12. It was only through this review that these concerns came to light despite the GP, the police and, presumably the social worker having the report. The very swift step down from CiN to universal services was also made without reference to the possible non-accidental injury and, it seems, without consideration how these young parents with four children, the oldest being only a few days past his fifth birthday would cope.

5.13. The review has highlighted several concerns which will be narrated more fully but, essentially, they fall under the following categories:

- Safe Sleeping
- Engagement
- Parenting Capacity and Neglect
- Social Care
- Safeguarding
- Multi-agency Working/ Information Sharing
- Child Protection System

Safe Sleeping

5.14. Clearly, Billy's sleeping arrangements on the night he died were unsafe and dangerous. The fact that, while sleeping on a sofa with Chloe, he slipped down into its mechanism indicates that the risks had not been recognised.

5.15. There was nothing within the review to indicate whether any agency actually examined the sleeping arrangements as the family grew nor questioned the parents about them, or if they did, this is not recorded. With eight people in a small three bedroom flat, the suitability of the housing and the arrangements should have been assessed on an ongoing basis. It is understood that the family were in rent arrears and may not have been a high priority for re-housing per se, but if a watching brief on its suitability was kept then concerns could have been raised. It did not seem that, despite being asked by the nursery nurse to raise the issue of housing with CFS in 2015, No Limits ever did.

5.16. When Tommy was born the family would have been eligible for rehousing to a four bedroom property. Whilst the waiting list can stretch to years, had anyone supported them in applying they may by now be housed in more appropriate accommodation.

5.17. This was a family that were very much at high risk of Sudden Infant Death Syndrome[8] with Billy being preterm, low birthweight, exposed to maternal smoking, Chloe having little antenatal care, Chloe having her first pregnancy while under 20, the family being in poverty, and bed-sharing. Nearly all of these factors were known to a range of professionals well before

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[8] https://patient.info/doctor/sudden-infant-death-syndrome#nav-2

Billy's conception let alone his birth. In previous pregnancies, efforts to persuade Chloe to give up smoking were unsuccessful and Billy's sibling, Robbie, had asthma.

5.18. Following Billy's birth, midwives would have been expected to have discussed safe sleeping with the parents and, indeed, they indicated they had. The midwives have a laminated crib sheet which includes a section on baby safety and directs them to advise parents on how a baby should be positioned when lying down and that a cot should be used.

5.19. Midwifery do not provide any handouts on safe sleeping (as they seemed to have done when Child R was born[9]), instead parents are given a discharge pack. On the envelope of the pack is a QR code that links to support and information including safe sleeping. It would be an expectation that parents are shown the QR code.

5.20. In addition, safe sleeping advice is in the Child Health Record (red book) and this should be given out at the antenatal visit from the health visitor. This is not always achieved and is, at times, given out postnatally by the health visitor at the new birth visit. It is sometimes not possible to use it as an aid when discussing safe sleeping with families on discharge from hospital, as parents may not have one in hospital with them.

5.21. On discussion with the NNU they advised the IMR author that as part of their admission to discharge checklist there is a section that needs to be documented that a safe-sleep discussion has taken place and an information leaflet given. In Billy's case this was signed as being completed.

5.22. The Lullaby Trust Guidance[10] is part of Midwifery and NNU practice. The Children's Hospital Governance lead says that although advice maybe given on safe sleep, there is no current guidance and patient information leaflets on safe sleep available on the children's wards. In Billy's case, there is no documentation that safe sleep was discussed at discharge from the children's ward, however as previously mentioned, the NNU home team were contacted to follow up to offer additional support.

5.23. There is no documentation held in UHS to indicate where each of the children slept at home and where Billy would sleep on discharge, either from the NNU and hospital ward records. There appears to be no pre or post birth assessment made of the possible housing situation and sleeping arrangements. Assessments lacked the contextual situation for this family which, if it had, might have flagged up Billy's heightened risk to SIDS. Although smoking cessation was addressed at times with Chloe, this was predominantly in the pregnancy.

5.24. The reliance on generic guidance and signposting to support through a QR code seems to be insufficient for families of such high risk as this one. Given their history of non-engagement and, through Chloe's reluctance to stop smoking it was unlikely that they would access and implement the advice provided.

5.25. Once discharged, the increased risk of SIDS was also not picked up in the Health Visiting Service. There was an apparent lack of exploration of sleeping arrangements, given there were eight family members living and sleeping in a three bedroomed flat. One would expect mention of Billy's sleeping arrangements, given his vulnerabilities of low birth weight and prematurity. Neither therefore is it known what or where Billy slept nor if it was normal practice for him to co-sleep with Chloe on the sofa. This seems to differ from Tommy's new birth visit where safe sleep advice did appear to have been given alongside smoking cessation advice.

5.26. Advice was provided by CFS when a social worker saw Kieran with a blanket up to his chin and by NNU when Chloe wanted to discharge Tommy early. However, at the time of Billy's death there was an apparent lack of standardised information within the community in relation to safe sleeping advice and SIDS. Likewise, practices seem to differ between NNU and the Children's wards at SGH in terms of if and how advice was provided. Certainly, there

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[9] Child R/Reece Serious Case Review – Southampton LSCB 2019
[10] https://www.lullabytrust.org.uk/safer-sleep-advice/

was no evidence that any enhanced or targeted advice was considered or provided given this family's heightened risk level.

5.27. Chloe does not recall receiving any safe sleep advice, in any form. She said, with five other children, she did not need it but also says that no one spelt out to her that she was in a higher risk bracket.

5.28. Southampton City Council Family Engagement Workers have developed and delivered a Safe Sleep Workshop which is aimed at both parents and professionals. Whilst it covers many aspects of sleep related issues, including those experienced in older children and teenagers, it does provide accessible and essential information regarding Sudden Infant Death Syndrome. The awareness of and engagement with this training could be enhanced and, for both parents and professionals, targeted to those who need it most. It is understood that Solent Health Care have also developed in house safe-sleep awareness training. It would be helpful if these provisions are delivered on a multi-agency basis to promote consistency.

Recommendation 1

That health and social care providers review and enhance their single and multi-agency workforce development around the risks of safe-sleeping and Sudden Infant Death Syndrome, their assessment of families at higher risk of SIDS and develop accessible information, advice and support to meet families' needs so they are empowered to make decisions around lifestyle and sleeping arrangements thereby reducing the inherent risk to their children.

Recommendation 2

That health, social care and housing providers, should develop mechanisms whereby the suitability of housing and sleeping arrangements for those families who are known to be in need or at heightened risk of SIDS is regularly assessed alongside their needs and, if necessary, safeguarding concerns raised to enable a multi-agency response to mitigate the risk.

Engagement

5.29. The family's apparent reluctance to engage with professionals, keep appointments and follow advice ran throughout this review period, and beforehand, but was never picked up as being a safeguarding issue. This related to most agencies.

5.30. Primary care reported children were not registered or brought for immunisations. Within the community there were many occasions the health visitor reported being refused admission, appointments were seemingly cancelled or there was no reply to pre-arranged visits. Specialist services also experienced a lack of engagement such in orthopaedics, continence and hearing services. Chloe's late declaration of two pregnancies was rightly seen as unusual and concerning.

5.31. On top of this Chloe's reluctance to cease smoking, both within pregnancy and after demonstrated her deciding not to follow medical advice. She openly admits that she did not feel the need to stop smoking in pregnancy, as she had smoked through all her others, so the risk for one reason or another clearly was not being heard.

5.32. More concerningly was her insistence to self-discharge, discharge Tommy and refusal to wait for Billy's formal discharge from hospital.

5.33. Aside from health and social care agencies, Chloe reported to a health visitor that her benefits had been stopped as she had not attended job centre meetings. This should have

flagged a concern as there being another agency with whom Chloe had failed to engage, not to mention how the family would manage on a reduced income.

5.34. The only instance within the review period Solent NHS Trust guidelines for 'Family Disengagement and Child Not Brought for Appointments' was referred to, is through the children's continence service. Elly was discharged as she was not brought to her continence appointment. However, it is noted the initial referrer did not include previous safeguarding concerns and the family history of disengagement on the referral form, and consideration should be given as to whether she would have been discharged so quickly had this been included.

5.35. It was unclear whether professionals regarded being declined access to the family's home in the same category as 'Was Not Brought' and whether the same escalation protocols were applied. Policies, protocols and training should be reviewed and revised if necessary to make this clear.

5.36. The orthopaedics professor notifying the GP that Kieran was not brought to the clinic was in accordance with policy however, hospital safeguarding was not informed nor did the GP follow this up, even when met with an explanation from Chloe that she was still waiting for contact from orthopaedics.

5.37. Whilst relatively new, the March 2017 4LSCB Guidances 'for primary health care when a child is not brought or misses an appointment[11]' and 'for secondary and tertiary health care when a child is not brought or misses an appointment[12]' do not seem to have been considered or applied. These provide advice on thresholds for intervention and escalation and would have been useful had they been applied so that all agencies were apprised of the breadth of the concerns and their regularity.

Recommendation 3

The Southampton LSCB should remind agencies of their guidances on what to do if a child is not brought or misses an appointment and, in time, audit its use to reduce the opportunity for parents to either deliberately or inadvertently neglect their children's health.

5.38. Despite all this, the scale and nature of this disengagement was never widely shared or challenged in the round. Even now the parents dispute it. Sometimes various individual episodes of disengagement were questioned but no agency saw the theme that was emerging. Given the lack of recognition, no one considered whether it was hiding deeper vulnerabilities.

5.39. Chloe and Luke reported poor relationships with professionals, except one long-term health visitor. They describe infrequent and brief visits, a lack of consistent staff and little support. They highlight the social workers, while the children were on child protection plans, being of little help with long gaps between visits. They say that health visitors did not seem to appreciate that Billy was premature as little differed in their advice and support from previous pregnancies.

5.40. The nature of this disengagement is more concerning than in the case of Child R as here there are instances of direct challenge to medical professionals and advice which, in some cases, was accepted and in others was worked around. No-one saw the whole picture and enquired deeper into why a family with such chronic support needs would seek to distance itself from the very people who should be able to help them. No one recognised the part the struggle their life, and their pride, might have been playing in their capacity to engage.

[11] http://www.proceduresonline.com/4lscb/shared_content_SCB_php/shared_files/ch_fam_engage_guide_prim_care.pdf
[12] http://www.proceduresonline.com/4lscb/shared_content_SCB_php/shared_files/ch_fam_engage_guide_sec_tert_care.pdf

5.41. It is understood that CFS are developing Disguised Compliance training for their staff. Consideration should be given to extending this to other health and social care agencies to ensure a common understanding and a connected multi-agency response.

5.42. Many LSCBs have a specific procedure to guide professionals on recognising and responding to disguised compliance. Many are drawn from the paper 'Resistant Parents and Child Protection: Knowledge Base, Pointers for Practice and Implications for Policy' (Tuck V, 2013)[13] which describes the phenomenon alongside that of resistant parents/ carers (which can be two sides of the same coin) and provides policy and practice suggestions.

5.43. While Southampton LSCB have recently published guidance for health professionals on what to do if a child is not brought *(ibid)* supported in January 2019 by a 'Spotlight' for professionals[14], they do not appear to have a procedure on disguised compliance nor is it within their training programme.

Recommendation 4

That Southampton LSCB develops a multi-agency procedure to guide and support professionals in dealing with disguised compliance and resistant parents and carers, including when and how to share concerns with partner agencies.

Parenting Capacity and Neglect

5.44. Another theme that went throughout this review was that of Chloe and Luke's capacity to provide effective and safe parenting for their six children. This was a young couple, living in poverty with no obvious parental or other family support. Agencies ranging from the police, health visitors, acute hospital and social care had directly witnessed the children in unwise, even dangerous, situations as well as being grubby and unsupervised.

5.45. These included children running naked out of sight in the street, the floor being strewn with broken glass, a 3 ½ year-old injuring himself with a knife, cupboards with cleaning materials being left accessible, a child standing unsupervised in a highchair and unclean and unkempt clothing, bedding and bathroom. Some injuries were left unexplained indicating a lack of supervision being the norm.

5.46. These factors were rarely considered in the context of the whole family situation which, if they had been, might have prompted a deeper assessment of their needs and how they could be met. Despite it being clear the parents were struggling to meet the children's needs, the episodic way these concerns were approached meant that explanations and assurances were taken at face value with no further analysis, beyond that in the single assessment carried out between September and October 2014 when concerns were articulated.

5.47. Chloe did not have the ideal experience of parenting when she was a child so, arguably, did not have a blue-print of what good parenting looked like to draw on from her first child onward. This should have been identified and her and Luke's capacity assessed sooner, rather than waiting for a Section 47 child protection Investigation.

5.48. Chloe and Luke described this incidents and the ensuing interventions as a wake up call. They realised their parenting was not what it should be and the child protection system they found themselves in helped them realise that something had to change.

5.49. They did attend an Incredible Years course but, despite them reporting that it was helping their parenting, no subsequent assessment was carried out so no real change could be tracked as the family grew and the children's health concerns deteriorated.

5.50. Had more detailed parenting assessments been carried out on an ongoing basis, then a deeper understanding of the struggles Chloe and Luke may have been facing might have

[13] http://www.in-trac.co.uk/wp-content/uploads/2015/11/Resistant-Parents-and-Child-Protection-copy.pdf
[14] http://www.hampshiresafeguardingchildrenboard.org.uk/wp-content/uploads/2019/01/Spotlight-On-Child-and-Family-Enagagement-Guidance.pdf

emerged. This may then have led to a more bespoke and embedded service response which might have supported them bring up six children in trying circumstances.

5.51. The arrangements for parenting assessments within Southampton City Council Children's Service are that *'parental ability should be addressed in social workers' assessments and Children's Social Care managers should ensure that social workers update the assessment of risk for each review conference, clearly recording what work has been done on the assessment and how this has been analysed. Independent chairs should ask for this information which is then added to either risk or strengths as appropriate.*[15]' This did not happen at the RCPCs despite it being mentioned in the single assessment and raised as a grey area in the ICPC.

Recommendation 5 **That Southampton Children's Services ensure that arrangements for parenting assessments, particularly additional assessments, are clear and appropriately undertaken for each Initial and Review Child Protection Conference so that sustainable and positive improvements can be shared or support given elsewhere.**

5.52. Chloe presented late with the pregnancy that she sadly miscarried and then Billy's. This could have been a sign of lack of attachment, engagement or even that, after a number of previous pregnancies, she was under the impression she could cope. With the background of disengagement and the concerns professionals held regarding apparent detachment while Billy was hospitalised, the whole history should have raised questions about their ongoing capacity to provide good parenting.

5.53. Mechanisms should enable such assessments to take place, even if the family is closed to social work. Perhaps had the family been stepped down to Early Help rather than Universal Services, this may have been possible. Even so, professionals suggested that the Local Safeguarding Adults Board Multi-Agency Risk Management Framework[16] could have been invoked in respect of the parents, providing a Think Family approach to any outcomes was applied.

5.54. The police have identified that their investigation of neglect offences was not as it should be with enquiries being left to CFS rather than approached jointly with a view to potential criminal offences being explored.[17]

5.55. Neglect was long standing and entrenched however there is no documented use or reference to the LSCB neglect tool kit[18] or continuum of need[19] being used for assessment. There was a lack of evidence of sustained change and there was premature professional optimism voiced by all agencies within the core group. Even for the short period the children were on Child Protection Plans, little happened to engender change despite the swift and, arguably, overoptimistic step downs to CiN and universal services.

5.56. It is not evident that health agencies adopted the National Institute for Health and Care Excellence (NICE) Guideline 76[20] relating to child abuse and neglect. For example, there appear to have been no formal assessment in health, little appreciation of vulnerability factors and no attempt to speak to the older children alone to understand their experiences from their perspective and what life feels like for them.

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[15] Policy position given to review by a Children's Service Manager to Child R SCR
[16] http://southamptonlsab.org.uk/wp-content/uploads/4LSAB-Multi-Agency-Risk-Management-Framework.pdf
[17] http://4lscb.proceduresonline.com/southampton/p_ch_protection_enq.html
[18] http://southamptonlscb.co.uk/wp-content/uploads/2014/05/Neglect-Toolkit-2015.pdf
[19] http://southamptonlscb.co.uk/wp-content/uploads/2017/01/Continuum-of-need-combined-4.pdf
[20] https://www.nice.org.uk/guidance/ng76

Recommendation 6

Southampton LSCB should embed its newly updated policy and procedures around neglect[21], to include multi-agency audit of its application, multi-agency work-force development and assurance of partners' internal processes so that professionals become more able to recognise, respond to and resolve neglect wherever it might be identified.

Social Care

5.57. In April 2012 safeguarding and looked after children's services in Southampton were inspected by Ofsted[22]. They were then inspected in June 2014 under the Ofsted Single Inspection Framework.[23] That report said of the 2012 report that the *'inspection judged overall effectiveness for safeguarding to be adequate but quality of provision to be inadequate. The early signs of improvement identified by that inspection were neither consolidated nor built upon. This meant that in April 2013 the local authority's self-assessment found children were not safe or properly protected from significant harm, and looked after children received a service that was not consistently good enough. This analysis was supported by leaders in Southampton and by findings from serious case reviews.'* The 2014 report went on to say, *'from a self-assessment position where children were not being reliably protected or having their welfare promoted, leaders and managers have taken swift, robust and effective action to improve services. As a result, no cases of children receiving inadequate protection were identified during this inspection.'*

5.58. However, the 2014 report graded both the Local Authority and the LSCB as Requiring Improvement citing, amongst others, the following concerns:

- Strategy discussions do not always include all appropriate agencies and are poorly recorded.
- Case recording is often not sufficiently detailed nor purposefully linked to the care plan of the child.
- The supervision of social workers does not consistently promote reflective practice.
- Performance management arrangements are not sufficiently focused on improving the quality of work with children and families.

5.59. Ofsted pointed out the following areas for improvement relevant to this review:

- Ensure that all relevant agencies are involved in strategy discussions and meetings, and that these discussions clearly record decisions, rationale and planning of Section 47 enquiries.
- Improve the quality of assessments so that these reflect children's daily experiences.
- Improve the quality and consistency of recording of child protection visits so that they clearly reflect the aims of the child protection plan.
- Improve child protection plans so that they more clearly focus on key areas of risk and how this will be reduced and include contingency planning.

5.60. These findings were against a backdrop of a severe recruitment and retention crisis resulting in high turnover of social workers, multiple senior management changes and an agency staffing rate of over 50%.

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[21] http://4lscb.proceduresonline.com/southampton/p_neglect.html
[22] https://files.api.ofsted.gov.uk/v1/file/2753836
[23] https://files.api.ofsted.gov.uk/v1/file/2761550

5.61. The picture painted of CFS, by both themselves and other agencies, is at that time a department under strain, struggling to meet its commitments and who found it difficult to engage with families and partners alike. As highlighted by Ofsted, there were also worrying gaps in record keeping and retention.

5.62. The delay in appointing a social worker to the section 47 investigation in September 2014, the absence of any record or minutes of the core group of the 26th November 2014, the very late cancellation of the core group in March 2015 and the social worker having the wrong date for the first CiN meeting in September 2015 are examples of a less than ideally positioned agency to lead the child protection system.

5.63. Their apparent absence from the Core Group meeting in February 2015 may have been a reason why the serious concerns raised following that month's child protection medical were not shared, but no further opportunity was taken to dispel the previously held notion that there were 'no concerns.'

5.64. Chloe raised concerns that she had not seen a social worker for long periods of time and CFS themselves acknowledge that they struggled to meet with the family due to either there being no reply of their own resource constraints. It is not clear if and how this was escalated and points to the concern around supervision raised by Ofsted.

5.65. For some reason, minutes of child protection meetings do not suggest there was a huge issue in seeing the family. The minutes which probably refer to the June 2015 Core Group meeting record about the ten daily visits *'On the whole, this has been achieved. There was a gap during this six months period during to worker sickness and emergencies with other cases.'* Other accounts question this assertion. This was the number one point on the child protection plan and did not seem to have been achieved.

5.66. CFS maintain that management were aware of the struggle to visit the family. However, there seemed to be a lack of knowledge of some of the other symptoms of their stretch and, while the letter to the family did create a slight improvement in engagement, there was not an upturn in the capacity of social care to engage with families or partners until much later.

5.67. That said, other agencies were aware that social care were struggling to meet their obligations evidenced by the cancelled meetings, the lack of availability and being told of the lack of family contact. Despite this knowledge none seemed to have escalated their concerns, or even challenged the agency in core groups or RCPCs.

Recommendation 7

Southampton LSCB should widen its conflict resolution and escalation policy[24] so as to include escalation of concerns over another agency's capacity or engagement within the child protection or safeguarding systems.

5.68. Since then, the review has been told that the Local Authority has undergone significant organisational change to address the shortfalls and meet emerging demand, as is the case following an inspection outcome of 'requiring improvement' or 'inadequate'

5.69. Recently the Principal Social Work (PSW) team have been focusing on several of the issues highlighted in this review and recognised internally beforehand. To augment the post holder, a number of advanced practitioners work alongside her. As well as focusing on the standards of professional practice, the review understands that the PSW team have been developing the underpinning functions such as recruitment, retention, induction, assessment and supported year, supervision and workforce development. One key outcome is the Protection and Court teams are scheduled to be fully staffed, with no agency social workers, by March 2019.

[24] http://4lscb.proceduresonline.com/southampton/p_conflict_res.html#difference

5.70. In 2018, Children's Social Care introduced a revised Supervision Policy and Guidance[25] which sets out expectations, responsibilities and templates to guide and aid effective supervision. This is augmented by regular reports being made available to senior management indicating when case supervision has taken place.

5.71. In 2017 Children and Families Services reviewed their service quality assurance framework and published a delivery plan in 2018.[26] This was assessed as having 'Assurance' level by their internal audit team that year but, working with Ealing Borough Council as part of the Partners in Practice programme, they learned how a blend of core and thematic audits can work well and be well received. The resulting thematic audit on supervision and management has shown that where supervision takes place it can be shown to add value to practice, although timeliness needs to improve.

Recommendation 8

That the Local Safeguarding Children Board should assure itself, on an ongoing basis, that the developments within Children and Families Services are embedded, sustained, support the multi-agency safeguarding system and deliver better outcomes for children.

Safeguarding

5.72. All agencies who contributed to this review and who were involved with this family have dedicated safeguarding structures through which professionals make referrals and seek advice. They have policies and procedures in place to govern what should be referred to safeguarding. All are partners of the Local Safeguarding Children Board and therefore are signed up to both Working Together to Safeguard Children[27] (mainly 2015 in this case) and the 4LSCB Child Protection Procedures.[28]

5.73. Commentary of the multi-agency child protection system will form a subsequent section of this report. This section will address findings related to how agencies' own safeguarding systems worked as they are often the gateway into the wider child protection system.

5.74. In the main, concerns around potential neglect was recognised at the time. Professionals, saw the dirty and unhygienic condition of the flat, the signs of poor parental supervision, disengagement and rejection of services and questioned unexplained injuries.

5.75. However, on occasions, these were addressed on a case by case basis without the benefit of advice from or referral to agency safeguarding specialists.

University Hospitals Southampton NHS Foundation Trust

5.76. When Kieran was admitted with febrile convulsions in July 2015, the bite mark to his back was seen and assessed in the Emergency Department. An assessment of the bite mark was not made by the PAU doctor but was by a Consultant Paediatrician on the ward round the following day.

5.77. Kieran's admission, as a Child in Need with convulsions, was appropriately communicated to the hospital safeguarding team who relayed the information to Children and Family Services. However, the bite mark was not included in the safeguarding information. The IMR author was confident that the paediatrician would have satisfied themselves that the injury was not suspicious but their findings were not passed on.

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[25] Southampton City Council Children and Families Services Supervision Policy Guidance Manual 2018-2020
[26] Southampton City Council Children and Families Services Quality Assurance Unit Service Delivery Plan 2018 -2020
[27] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf
[28] http://4lscb.proceduresonline.com/

5.78. Had the presence of a bite mark been communicated to the hospital safeguarding team, that information would have been forwarded with the broader contact to CFS who may have seen it in the wider context of possible neglect and lack of supervision.

5.79. Likewise, the hospital safeguarding team should have been informed of the parents' lack of visits and contact while Billy was in hospital. With this information, they could have enabled other agencies to work with the family to improve bonding and attachment or at least get to the root of the absences.

5.80. There is no documentation suggesting that the hospital safeguarding team had been informed with regards to missed X ray and paediatric orthopaedic appointments for Billy nor regarding Chloe's insistence that Tommy be discharged early.

5.81. The review has been told that since 2015, more formal peer review meetings of paediatric consultant practice have been introduced at the Trust and cases such as these would be discussed in this forum to improve practice and allow reflection of unusual injuries in children. In addition, Safeguarding Children Facilitators are in post to be visible on the wards to review records and to advise and support staff, enhancing communication with the Safeguarding Team, considering the wider contextual information, enabling more holistic assessment and the identification of any safeguarding concerns and action required. This is supported with a new pro-forma to guide staff and the introduction of Child Protection Information System[29]. Furthermore, training on bite marks is included in Level 3 safeguarding children training and in the safeguarding children E learning package.

Recommendation 9

University Hospitals Southampton NHS Foundation Trust should assure itself that the new measures improve the awareness of contextual safeguarding concerns and that when these are recognised there is appropriate communication of these concerns with Primary Care and/or Children's Services, particularly in the assessment of physical health and wellbeing of children who present with, or have a history of, neglect or emotional abuse.

Solent NHS Trust

5.82. The NHS 0-19 Healthy Child Programme defines 'Universal' as the programme of interventions that will be delivered to all. 'Universal Plus' (UP) is a more intensive programme of interventions that are delivered by the HV/PHN team based on the needs of the individual and 'Universal Partnership Plus' (UPP) is a more intense programme of interventions still, delivered by a multidisciplinary group of professionals or agencies based on the needs of the individual.

5.83. The Healthy Child Programme recommends visits from a health visitor can be undertaken from 28 weeks' gestation and, in higher risk pregnancies beforehand. It is therefore not fully understood why there was no attempt to visit or contact this family up to the point Billy was discharged from hospital.

5.84. Although the Community Health Nurse (CHN) saw Chloe in September 2017 when she was 28 weeks pregnant, there seemed to be no liaison between the HV and CHN following that review. Chloe's pregnancy and emotional health were acknowledged by the CHN however this was done through the lens of her completing the health review. The CHN recorded there were no smokers in the home, this is despite only three days earlier the smoking cessation service documenting on Chloe's notes her being unwilling to give up smoking.

5.85. At the time of Billy's birth, the family were under a universal HV offer, having defaulted to that level when the family were stepped down to universal services in September 2015. Solent NHS Healthcare reflect that consideration should be given as to how health responds

[29] https://digital.nhs.uk/services/child-protection-information-sharing-project

when services step down to ensure the appropriate support remains in place for an appropriate time, be that UP or UPP, dependent on assessment. A UP offer in this instance would have seemed appropriate to avoid drift, and an apparent lack of monitoring which led to missed opportunities in identifying the need for early help intervention or even escalation with the expansion of the family.

5.86. A health visitor assessed the family on her first meeting in November 2017 and identified them as requiring a UP intervention, due to Billy's prematurity. This was an appropriate intervention but given the family history, UPP should have been considered. There is no clear guidance on the expected level of enhanced visits for families placed on UP, other than a management view that they may receive a further visit, phone call or clinic attendance, therefore it is not clear what benefit placing a family on UP, in this instance would provide. The enhanced level of UPP would have provided a multidisciplinary contribution to the support and a high level of oversight and scrutiny.

5.87. A specific concern highlighted by this review was the apparent inaction taken when a health visitor received no reply from the family home yet reported hearing children inside. There may have been more done than is documented but this should be further examined by agency management as, on the face of it, not following this up is worrying practice.

5.88. Given the concerns raised by Solent NHS Trust regarding the appropriate pathways being applied to families with complex and concerning safeguarding histories, there appears to be scope for more supervisory and managerial oversight of cases held by health visitors to ensure that thresholds for pathways are both appropriate and consistent.

5.89. Since these events, the Enhanced Child Health Visiting Offer (ECHO) has been introduced. ECHO is a voluntary, bespoke, locally developed programme of targeted home visiting of up to 30 contacts, delivered from pregnancy until the child is approximately 3 years of age. The aim of the project is to build relationships with families to enable high challenge and high support to improve the life chances of children. The interventions are delivered in a targeted way to support and enable families to undertake the change required. The Health Visitor is the family's lead professional and will draw a team around as required. The programme is supported by a bespoke supervision model and outcome frameworks.

Recommendation 10

Solent NHS Trust should review its policy and practice around The Healthy Child Programme to determine whether its application of the various health visiting pathways is appropriate to the identified and emerging needs of families especially where any multi-agency or multi-disciplinary oversight fluctuates, and whether ECHO is making the changes necessary for those families with high need.

Primary Care

5.90. Within Primary Care, this review has highlighted a less than robust system for identifying and sharing safeguarding concerns.

5.91. When Chloe was seen in January 2016, 9 weeks pregnant, involvement with safeguarding and social services was mentioned in the maternity referral but no details were given as to the nature of the concerns. She attended a postnatal check that October but few family or social details were recorded.

5.92. When she presented to a GP in July 2017, 20 weeks pregnant, she was referred to the maternity services with no mention of previous safeguarding concerns. These would have been highly relevant given this being a second apparently hidden pregnancy. Billy was not seen by the GP until he was thirteen weeks old, although he had been in hospital for much of this time, a fact the GP surgery seemed unaware of until his discharge.

5.93. Billy was not taken to several hip screening appointments, his orthopaedic clinic appointment and did not have a six week check carried out by his GP as would be standard

practice. A letter was sent by the practice to Chloe with appointments for a post-natal and six week baby check but these were not followed up and not discussed at subsequent contacts or appointments with the practice.

5.94. These would have been the opportunities for a review of the family, concerns, general child health and to identify any risks and support needed, but there is no evidence in his records that the impact of his prematurity in the context of his family situation was explored. There were no alerts in his medical record with reference to the historical safeguarding concerns about this family, which would have been highly relevant for his ongoing care and management after discharge.

5.95. There were significant concerns raised by this case concerning the administrative processes and management of this family by primary care. The appropriate clinical response from GPs was often lacking because they were not immediately and easily aware of information held by the practice regarding problems, needs and risks. The concerns related to the handling of information received about the children (safeguarding documents in particular) and the READ coding of that information in the medical record with corresponding alerts, as recommended in the RCGP / NCPCC Safeguarding Toolkit.[30] The lack of follow up from 111 calls was a particular recurring issue.

5.96. SCAS has been working with NHS Digital to access to Child Protection Information System. This will raise levels of safeguarding awareness among our frontline staff, including 111. Once SCAS is able to view CP-IS information it will give a greater understanding of children who are actively subject to safeguarding action plans across the country and will generate more referrals as the level of need and vulnerability dictates. There was no clear workflow for documents, all of which had been filed into the records by administrative staff without an appreciation of the safeguarding implications or being seen by a GP, so concerns were not immediately noted and responded to. There was no sharing of information or communication by the GPs either between the Primary Care staff, with Children's Services or health visitors during the review period and no appreciation of the difficulties that this family could have been facing.

5.97. There was no clear workflow for documents, all of which had been filed into the records by administrative staff without an appreciation of the safeguarding implications or being seen by a GP, so concerns were not immediately noted and responded to. There was no sharing of information or communication by the GPs either between the Primary Care staff, with Children's Services or health visitors during the review period and no appreciation of the difficulties that this family could have been facing.

5.98. There was no system in place for ensuring that postnatal and six-week baby checks were carried out, or that missed appointments were brought to the attention of a GP. There was little engagement by this family with their GP and this would have made it difficult to carry out a reliable assessment of the family circumstances and parenting capacity, but no pro-active attempts were made nor were opportunities taken when they arose.

5.99. The Review has been told that Southampton City Clinical Commissioning Group are delivering safeguarding training on a bi-monthly basis through the TARGET programme. This should be continued to ensure all staff, clinical and otherwise, are fully up to date with their responsibilities and the systems to keep patients safe.

Recommendation 11

Primary Care commissioners should assure that all practices follow the 2018 LMC guidance regarding the scanning, storing and reviewing of safeguarding documents all of which should be seen by a GP. Further, commissioners should assure that practices use the correct READ codes so that GPs are able to review

[30] https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/the-rcgp-nspcc-safeguarding-children-toolkit-for-general-practice.aspx

and take appropriate action either with the patients, their families or partner agencies and assure that all staff are up-to-date with their safeguarding training.

Police

5.100. During the course of the review, professionals questioned the rationale of the police officers who considered that the parents were able to care for the children after they had been found running in the street naked. The police representative undertook to review their neglect toolkit so officers can be better guided on parenting capacity and capability as well as checking for safe sleeping arrangements.

Multi-Agency Working and Information Sharing

5.101. This Serious Case Review is not alone in exposing concerns regarding the way agencies work together and how they share information.

5.102. Good multi-agency safeguarding arrangements have effective information sharing at their core. In the 2016 report 'Pathways to Harm, Pathways to Protection: A Triennial Analysis of Serious Case Reviews 2011 To 2014,'[31] Brandon M (et al) 2016, states, *'Of the 66 serious case review reports reviewed in depth, there was only one where information sharing was not specifically mentioned. All others identified issues ranging from direct failure to identify risk or protect the child to simply identifying information sharing as an area for improvement. In contrast, in over ten years of analysing serious case reviews, we have not come across a single case where a child has been killed or harmed because a professional has shared information.'* This case is no exception.

5.103. Several examples have already illustrated how agencies could have worked more collaboratively and shared information more readily. The following section (Child Protection) will highlight how this became a real and serious issue within the child protection system. However, outside of that, professionals could, and should, have had a greater understanding of the needs of these children and parents had they worked as one.

5.104. The sharing of safeguarding concerns, for example the bite on Kieran's back, poor parental attachment, the suitability of the housing arrangements for an ever-growing young family, the impact of the parents' refusal to give up smoking and the wide-spread disengagement from services did not happen as a matter of routine.

5.105. There were inconsistencies in the reasons given why the parents did not bring their children to appointments and why they were not paying their rent. There was a lack of professional curiosity as to what lay behind the presenting concerns, rather they were either taken at face value or responded to in an episodic and single agency fashion. No one saw the full picture, even when the opportunity arose through child protection or CiN frameworks.

5.106. A common gap in information sharing is that primary services were not informed of inpatient admissions until discharge. Likewise, acute settings were not able to access information held in the primary services. This was a two-way fracture in information sharing.

5.107. Here, when Billy remained in hospital after his birth and following his subsequent admission, this information was not shared leaving primary care and health visiting services to believe he was not being brought for appointments or the parents were absenting themselves from home visits. That said, NNU do have a record that a summary was shared with health visiting but the detail of that is not known and health visiting do not appear to have known about the admission until 14th December 2017 when they telephoned Luke.

5.108. In this case, having this information could have firstly explained the apparent disengagement from services and secondly should have raised questions as to what was

[31] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-__Pathways_to_harm_and_protection.pdf

underlying the acute health concerns and how the family are managing to cope. Neither occurred but also no one escalated their concerns around continued disengagement.

5.109. NNU asked for a health visiting visit as soon as possible following his discharge on the 19th December 2017. This did not happen until the 9th January 2018, three weeks later and after the Christmas and New Year period during which other avenues of support would have been sparse.

5.110. Questions remain over the quality of supervision across the system. Effective qualitative supervision provides professional with the resilience to hold and share risk as well as acting as a safety net against insular practice. There was little evidence of any impactive supervision throughout this case and nothing that the shortcomings around multi-agency engagement or information sharing, let alone partnership working was addressed.

5.111. A new Joint Working Protocol[32] has been agreed across Hampshire, to support agencies and professionals in taking a collective 'Think Family' approach to families presenting with various vulnerability factors. It is unclear whether this family would have fitted the current criteria but, if not, the principals could be broadened. This should support professionals and families where they fall below agency or intervention thresholds but require multi-agency support nonetheless.

Recommendation 12

Southampton LSCB should review the Joint Working Protocol to consider whether it should be applied to a wider range of families, broader than those currently within its criteria.

Recommendation 13

Southampton LSCB and Clinical Commissioning Group should undertake a joint review of the information sharing arrangements between health providers and between the health sector and the wider safeguarding system to enable a more systemic and timely flow of information within and between agencies regarding children and families under their care.

Child Protection System

5.112. In September 2014, following multiple concerns from the police, health visiting and social care a child protection investigation was commenced under Section 47 Children Act 1989 in respect of the four children in this family. The strategy meeting decided that the investigation should be carried out by CFS alone. On reflection, given the concerns around neglect, the police now take the view that this should have been a joint investigation with them. This review agrees with that renewed stance for reasons that will emerge over the following paragraphs.

5.113. This investigation culminated in an ICPC being held in October 2014. Here, all four were rightly placed on Child Protection Plans under the categories of physical, emotional abuse and neglect. It was also decided that legal advice should be obtained regarding the possible instigation of the PLO. The minutes say that *'Should health appointments not be kept, immediate legal action to be taken with a view to obtaining an Interim Care Order'*

5.114. Whilst this meeting was well attended, notable absentees were the GP and safeguarding consultant. Neither submitted reports which could have had an impact on the breadth of information available to the conference.

[32] https://www.hampshiresafeguardingchildrenboard.org.uk/wp-content/uploads/2019/01/4LSCB-and-4-LSAB-Proposal-A-Family-Approach-V11January-2019-1.pdf

5.115. A housing officer completed a report for the conference but did not attend. That decision was made by the report writer based upon the minimal level of involvement housing had with the family. However, the invite included concerns for the 'home conditions.' This suggests it would have been appropriate for the housing officer to attend.

5.116. There is no record to indicate that any agency contacted the housing officer regarding those home conditions and the minutes from the conference were not sent to the housing officer. The review has been told that the process for these invites is now managed through the housing MASH safeguarding coordinators who advise officers on whether they should attend a conference. In addition, for the last two years, housing have introduced an auditing system where the standard of reports is checked including the quality of the decision whether or not to attend the conference

5.117. A Core Group was established and first met on the 24th October and while no social worker could not attend, the assistant team manager, a health visitor, a student health visitor, the pre-school and parents did. The Clinical Safeguarding Nurse Specialist did not.

5.118. This was clearly very early in the child protection planning but a key development seemed to be that legal advice had been obtained, the PLO process would be instigated and the parents had been written to accordingly.

5.119. The following core group was set for the 26th November. Health visiting report having attended but Social Care have no record of the meeting nor any copy of the minutes. It appears that, at this early stage, the social worker had changed again but the pre legal process had commenced. Assuming a social worker did attend this meeting, it was the last one they did.

5.120. Attendance at the RCPC in January 2015 was low and not quorate. Police, GP, Safeguarding Consultant, Safeguarding Nurse, Housing and No Limits did not attend and none of the absentees were recorded as having submitted reports, although police say they did.

5.121. Whilst there were positives reports, there is no sense of any formal review of the Child Protection Plan as to compliance or whether it was improving outcomes for these children. All mention of the PLO had disappeared despite this being a specific and ongoing action at the ICPC and the Core Group.

5.122. Next came the Section 47 investigation into the unexplained injuries on Kieran and Robbie. This was not well responded to by the police who, having agreed to a joint investigation did not find anyone available to attend the child protection medicals. The intention had been for all four children to be examined but, for good reasons, all could not be completed on the same day. This should have presented an opportunity for the police to attend subsequent medicals but they did not, leaving it to CFS to feed back the outcomes.

5.123. After chasing, the police were told there were 'no concerns' arising from these medicals. Chloe and Luke refused to allow medicals of Alex and Elly. This should have rung alarm bells itself but, instead the matter was left to rest.

5.124. Subsequently a report was submitted by the consultant paediatrician which set out his significant concerns that should have dispelled any myths that all was well. Whilst this report was dated the 26th February 2015, the detail must have been shared verbally to the attending social worker at the time. This raises serious questions why agencies were led to believe that all was in order.

5.125. The true concerns never surfaced, be it through the Section 47 investigation, core groups, child protection conferences, child in need meetings or within agencies. The only way this these contrary findings have come to light was through the police reviewing their material for their IMR for this review and finding the report, unactioned, within their file. The police had 'filed' their report, seemingly, on the information provided by the social worker rather than the report itself despite it clearly being received. The closing summary bore no mention of the

report or its contents which later created issues in respect of their submission to the final RCPC.

5.126. The consequences of these collective oversights to share and explore the documented concerns of the paediatrician cannot be overstated. A core group, which appeared to have been held a week after the examinations, was not attended by anyone from CFS. Someone, and it cannot be gleaned from the minutes who, did say '*There has been significant concern raised by Robbie being witnessed with a bruise to his cheek. It was observed that he had too many bruises of an accidental nature and it was decided that it is important to continue with the PLO process.*' The minutes also say, regarding the PLO *'The letter is with legal services for approval.'* However, the minutes are of such poor quality that it is impossible to glean what was intended to happen as a result of these injuries in respect of the Section 47 investigation. It seems nothing.

5.127. In respect of child protection medicals, the review has learned that the 4LSCB have developed a pro forma for medical staff to be provided to the social worker at the conclusion of the examination. This, the review is told, is a clear and concise document, which should remove any misinterpretation regarding the outcome and opinion of the paediatrician at that time. This is a new process and the LSCB should assure the information it provides is targeted and distributed appropriately.

Recommendation 14

Senior Police, Social Care and Clinical Commissioning Group officers should review how this investigation was allowed to be drawn to a close when such serious child protection concerns had been raised, documented and shared among the professionals involved. This review should include assurance that this is not a system wide failing and should ensure that measures are put in place to prevent such oversights occurring in future.

5.128. Any mention of the injuries is missing at the next core group, believed to be in June 2015 although the minutes are filed as July. In fact, despite these unanswered questions, the meeting – which was again devoid of a social worker – heard that '*Legal advice was sought but due to progress being rapid, it was agreed that it was no longer needed.'* There is no indication what that progress was, how it was achieving outcomes and who had decided the PLO was no longer required. Certainly, agencies were still seeing poor living conditions and the family were saying they had no social worker contact.

5.129. Twelve days after this core group, the next RCPC was held. This conference was seriously misled significantly misrepresenting the paediatrician's findings (Para 4.40). Indeed, the last sentence, read in isolation, could be regarded as a reassuring factor whereas the paediatrician actually worded it as an aggravating factor; there was no benign pathology that would have explained the bruising.

5.130. The GP (who had received the report) and a paediatrician did not attend the conference nor did they submit a report. The social worker did not attend, although a manager did, and the police – who had the information – did not attend but submitted a report. The police report is drawn from the summary of the investigation, not the records themselves. So, the error on the closing summary led to the omission of any mention of the medical report in their submission to the RCPC. There is no mention of the decision regarding legal proceedings and no evidence that the plan had been reviewed in any way. The absences and, presumably the police omitting the concerns from their report, gave the RCPC the impression that all was well.

5.131. The review has been told that, despite a diligent search, legal services have been unable to find any record of them becoming involved in this family's child protection interventions. This is a significant concern given the apparent ongoing contact reported at multi-agency meetings and the sudden change of heart surrounding PLO.

5.132. Through poor attendance, misleading information and lax meeting management, together with otherwise promising progress reported, the children were stepped down to Child in Need plans. This was premature, overly optimistic and based on flawed information. It raises serious questions as to whether the child protection system, and its checks and balances were fit for purpose in Southampton at that time.

5.133. The establishment of a Multi-Agency Safeguarding Hub, and its multi-agency audit programme should now provide assurance around the whole system and, specifically, how joint investigations are conducted and resolved.

5.134. Primary care has identified for themselves that GPs do not regularly attend Child Protection Conferences or submit reports and, as a consequence, they were not being invited. The review has been told that work by the Clinical Commissioning Group has seen an increase in report submission from 20% to 80%. That is promising but it is important that this auditing continues to assure quality as well as quantity of the reports submitted. Further, a CFS service manager chairs a monthly child protection review meeting to which his child protection Advisor and primary care report.

5.135. The review has been told that as part of the CFS service restructure in 2017, budget is now set aside to enable monthly thematic audits, undertaken by one of the Child Protection Conference chairs, who are managed by the Child Protection Advisor. Feedback is given to senior managers through the CFS monthly performance board and is used to shape the service training and development offer that is managed by the Principal Social Worker team.

5.136. The Child Protection Advisor tracks all conference decisions on a weekly basis providing an update to service managers. She also produces a monthly analytical report looking at themes around such as conference decisions and attendance.

5.137. There is an alert system which chairs use if problems or issues arise with case management by the operational teams. This system is only for internal escalation but would be helpful if it were to be broadened to partners. Currently CFS send non-attendance letters to partners and this is tracked through the monthly report.

5.138. Primary Care have concerns that the documentation from CFS in respect of conferences requires review to improve clarity of content and highlight the most significant concerns. They suggest the date of the conference to which the minutes apply is often not clear in the paperwork, as evident in this review

5.139. In light of these previous concerns, the reported progress made and the suggestions for further improvements, there is a place for the LSCB to provide strategic oversight, scrutiny and assurance as to the quality, attendance, involvement and outcomes of Child Protection Conferences insofar as all agencies are concerned.

Recommendation 15

Southampton LSCB should develop assurance arrangements around Child Protection Conferences to enable it to provide strategic oversight, scrutiny and assurance as to the quality, attendance, involvement and outcomes of Child Protection Conferences insofar as all agencies are concerned.

5.140. The review understands that a weekly Legal Panel is now in place, given the need for better interface between CFS and legal services. Chaired by a designated service manager and with consistent legal services representation, consistency in oversight and recording has been achieved. All decisions are recorded on the client management system and progress is tracked. This case would now go through the Legal Panel process, eliminating drift and any ambiguity over decision making.

5.141. The only CiN meeting, held nearly three months after the family were stepped down, decided that they should be stepped down further to universal services.

5.142. The meeting does not appear to have discussed Kieran's admission for convulsions nor Chloe's miscarriage in July of that year. It did not discuss the fact that this pregnancy related to a delayed presentation given that it was only just before the miscarriage, at four months, that any professional became aware of it.

5.143. It also did not consider concerns raised by SGH regarding a sibling's attendance and the pre-school also highlighting concerns around neglect in respect of the presentation of two of the children.

5.144. There is nothing in the minutes that explains the swift step-down nor that describes how a family, about whom there were such huge concerns less than twelve months earlier and around whom in the meantime there had been serious worries raised following two child protection medicals, would be able to manage with such reduced support. These concerns should have generated consideration that there remained a level of risk from neglect which universal services may not adequately address.

5.145. The question remains whether the CiN plan was in place long enough to assure sustained change. There was little evidence the parents were empowered by the process or of them demonstrating self-support, e.g. equipment was often sourced on their behalf. Outcomes and interventions can be a challenge to measure particularly when professionals reduce support or withdraw. In this case it was not clear what the long-term plan of support would look like, which is crucial given there had been such long standing issues of neglect.

5.146. While an assistant team manager was at the meeting, there is no evidence of any management oversight of this decision nor any sense check it was the right one. This had implications going forward as to the level of support and oversight provided to this family.

5.147. As discussed in the section Social Care, the capacity and the effectiveness of Children's Social Care now is very different to that in 2014/5. Now, there is management oversight of all case closures and step down decisions. Additionally, if a child or children are stepped down to universal services, the case is heard at a step down panel which considers what additional resources, including community and third sector support, the family may need to sustain the improvements seen. This family should have had, at least, an Early Help Plan supported by a Team Around the Family.

Recommendation 16

Southampton LSCB should assure itself that its continuum of need is applied by multi-agency partnerships, especially those where decisions are made to step down children or families from high multi-agency levels of support to universal services. The LSCB, in this review, should examine the management oversight of such arrangements and decisions to ensure that thresholds are applied appropriately and consistently.

6. Conclusions

6.1. It is not possible to say whether anything done differently would have prevented Billy from dying the way he did but, as this review has shown, there were numerous missed opportunities to provide his family with the appropriate levels of challenge and support.

6.2. They were well known to a range of agencies, all who saw the same things; a family who were reluctant or unable to engage with services in a meaningful way, who either did not hear or rejected clinical advice, whose home was becoming more challenging as each child was born, yet no one appreciated the added pressure this was bringing on already struggling parents.

6.3. Billy and Tommy were premature and low birth-weight and, as a consequence had chronic health problems which could only have intensified the difficulties their parents faced.

Much was said about the perceived lack of attachment shown to Billy, particularly when he was in hospital, but this might have been how young parents with five other children coped with their competing demands.

6.4. Despite the evident risk factors, no enhanced or targeted safe sleeping advice was provided over and above that given to lower risk families. Given the history of the parents struggling to follow advice around their own health, it is difficult to predict a different response to generic advice which did not emphasise their real risk of SIDS, which sadly came to fruition.

6.5. At the time the children social care function was known to be failing and, as a consequence, but not solely for that reason, so was the child protection system. Conferences and other child protection meetings were poorly attended and lacked rigour, step down decisions seemed to have been taken with no management oversight or 'plan B' and decisions around legal interventions faded away. A child protection investigation categorically failed due to an unfathomable failure of information sharing and partnership working. That, by itself, could have put four vulnerable children at risk.

6.6. Internal safeguarding processes were unreliable so too was information sharing both within and across sectors. This meant that no agency or partnership ever had the full picture of what life was like for the children and what could be done to improve it.

6.7. That said, many gaps and concerns highlighted through this review have already been identified by the agencies, the partnerships and the LSCB. Significant change has taken place within Children and Families Service, the health visiting service has a new layer supported by bespoke supervision, the acute trust has developed its safeguarding support for clinicians and primary care has introduced standards to ensure GP oversight of safeguarding.

6.8. These developments are both necessary and welcome but the task remains to make the other necessary changes recommended in this report and to assure that those already in train are effective, embedded, sustainable and, above all, improve outcomes for children making cases such as this less likely.

APPENDIX 1 – SCHEDULE OF RECOMMENDATIONS

Recommendation 1

That health and social care providers review and enhance their single and multi-agency workforce development around the risks of safe-sleeping and Sudden Infant Death Syndrome, their assessment of families at higher risk of SIDS and develop accessible information, advice and support to meet families' needs so they are empowered to make decisions around lifestyle and sleeping arrangements thereby reducing the inherent risk to their children.

Recommendation 2

That health, social care and housing providers, should develop mechanisms whereby the suitability of housing and sleeping arrangements for those families who are known to be in need or at heightened risk of SIDS is regularly assessed alongside their needs and, if necessary, safeguarding concerns raised to enable a multi-agency response to mitigate the risk.

Recommendation 3

The Southampton LSCB should remind agencies of their guidances on what to do if a child is not brought or misses an appointment and, in time, audit its use to reduce the opportunity for parents to either deliberately or inadvertently neglect their children's health.

Recommendation 4

That Southampton LSCB develops a multi-agency procedure to guide and support professionals in dealing with disguised compliance and resistant parents and carers, including when and how to share concerns with partner agencies.

Recommendation 5

That Southampton Children's Services ensure that arrangements for parenting assessments, particularly additional assessments, are clear and appropriately undertaken for each Initial and Review Child Protection Conference so that sustainable and positive improvements can be shared or support given elsewhere.

Recommendation 6

Southampton LSCB should embed its newly updated policy and procedures around neglect[33], to include multi-agency audit of its application, multi-agency work-force development and assurance of partners' internal processes so that professionals become more able to recognise, respond to and resolve neglect wherever it might be identified.

Recommendation 7

Southampton LSCB should widen its conflict resolution and escalation policy[34] so as to include escalation of concerns over another agency's capacity or engagement within the child protection or safeguarding systems.

[33] http://4lscb.proceduresonline.com/southampton/p_neglect.html
[34] http://4lscb.proceduresonline.com/southampton/p_conflict_res.html#difference

Recommendation 8

That the Local Safeguarding Children Board should assure itself, on an ongoing basis, that the developments within Children and Families Services are embedded, sustained, support the multi-agency safeguarding system and deliver better outcomes for children.

Recommendation 9

University Hospitals Southampton NHS Foundation Trust should assure itself that the new measures improve the awareness of contextual safeguarding concerns and that when these are recognised there is appropriate communication of these concerns with Primary Care and/or Children's Services, particularly in the assessment of physical health and wellbeing of children who present with, or have a history of, neglect or emotional abuse.

Recommendation 10

Solent NHS Trust should review its policy and practice around The Healthy Child Programme to determine whether its application of the various health visiting pathways is appropriate to the identified and emerging needs of families especially where any multi-agency or multi-disciplinary oversight fluctuates, and whether ECHO is making the changes necessary for those families with high need.

Recommendation 11

Primary Care commissioners should assure that all practices follow the 2018 LMC guidance regarding the scanning, storing and reviewing of safeguarding documents all of which should be seen by a GP. Further, commissioners should assure that practices use the correct READ codes so that GPs are able to review and take appropriate action either with the patients, their families or partner agencies and assure that all staff are up-to-date with their safeguarding training.

Recommendation 12

Southampton LSCB should review the Joint Working Protocol to consider whether it should be applied to a wider range of families, broader than those currently within its criteria.

Recommendation 13

Southampton LSCB and Clinical Commissioning Group should undertake a joint review of the information sharing arrangements between health providers and between the health sector and the wider safeguarding system to enable a more systemic and timely flow of information within and between agencies regarding children and families under their care.

Recommendation 14

Senior Police, Social Care and Clinical Commissioning Group officers should review how this investigation was allowed to be drawn to a close when such serious child protection concerns had been raised, documented and shared among the professionals involved. This review should include assurance that this is not a system wide failing and should ensure that measures are put in place to prevent such oversights occurring in future.

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