SERIOUS CASE REVIEW

REECE

SOUTHAMPTON LOCAL SAFEGUARDING CHILDREN BOARD

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1 Introduction

Subjects of Review[1]

Children:
Child - Reece
Sibling - Ollie
Mother:
Beth
Beth's Partner:
Callum
Beth's previous partner
Harry

1.1 South Central Ambulance Service were called to an address in Southampton to a report that Reece, a non mobile baby under 3 months old, had been found unresponsive by his parents in his Moses basket. The flat is tenancy supported accommodation in which Reece, Beth, his mother, his half-brother Ollie, and Beth's partner Callum lived. The ambulance report recorded that Reece was in cardiac arrest and the family were commencing CPR. When the ambulance arrived, the paramedics found that Reece was stiff. He and his mother were taken to Southampton General Hospital where, following unsuccessful CPR, he was pronounced dead.

1.2 In accordance with the 4LSCB Rapid Response Procedures[2] the police were called. Beth explained that Reece had been placed to sleep in his Moses basket after a feed at about 01:30 and found shortly after 06.00. Information from Callum, comments from Ollie and evidence found in a search of the home, however, led police to suspect that Reece may have been sharing Beth and Callum's double air mattress on the floor.

1.3 Beth told police that she, Ollie and Reece lived in a single room and that Callum stayed two or three nights a week. The adults slept on the airbed, Ollie had a toddler bed in the room and Reece a Moses basket, also in the room. Reece had been formula fed since birth and would routinely take 6oz every two to three hours on demand.

1.4 Beth said she smoked about three to four roll-ups a day throughout her pregnancy and had smoked five to eight roll-ups a day since Reece was born. She said she did not smoke in the house but kept an ashtray inside.

1.5 Both Beth and Callum admitted occasionally smoking cannabis but not in the house nor in front of the children. A small amount of herbal cannabis was found in

[1] All names are pseudonyms
[2] http://www.proceduresonline.com/4lscb/shared_content_scb_php/shared_files/rapid_response.pdf

the house which Beth said that she found down the side of the sofa and did not know who it belonged to.

1.6 Reece had been well all day and had fed normally. He normally woke two or three times in the night for a feed but on the night, he died he did so only once. Beth maintained, and still maintains, she never took Reece into bed with her.

1.7 When Beth found Reece, his lips were blue, he was stiff and unresponsive. She picked him up and his head flopped. She took his vest and baby-grow off in an effort to wake him up but could not. She shook him a little but still could not wake him. She called 999 and, following instructions, commenced CPR. This lasted about ten minutes before paramedics arrived.

1.8 Police noted a large wet area in the middle of the airbed at the head end. One pillow was wet and had traces of vomit on it. The duvet also had a wet patch and traces of vomit. There was a baby-grow and vest at the foot of the Moses basket adjacent to where the foot of the air bed would have been. These were also wet and had what appeared to be vomit on them.

1.9 The Moses basket had a clean fitted sheet on the bottom, underneath which was a towel. Inside the basket was a toy, a remote control, a muslin and a fleece blanket. There did not appear to be any wet or vomit on these items, the sheets or the sides of the Moses basket.

1.10 Beth suggested that the police might have moved things around as the toys and remote control were previously not in the Moses basket as Reece had been sleeping there. Callum said that Reece had been asleep between him and Beth and that this was not unusual. He told officers they might have overlaid him. He added that Reece had a history of being sick after his feeds and would sometimes poke his tongue out and gag when laid down.

1.11 Beth was arrested and interviewed on suspicion of child neglect[3] and of causing or allowing the death of a child[4]. She maintained her account that Reece had been in his Moses basket when she found him unresponsive. She was not charged with any offences. Callum was not arrested and it is not within the scope of this review to enquire why.

1.12 The following week a post mortem examination was performed but the cause of death could not be ascertained. Given that investigations in the following months could not provide any more clarity, at the inquest, an open verdict was recorded. No criminal charges were pursued against Beth or anyone else in connection with Reece's death.

1.13 The death was investigated by the Southampton Child Death Overview Panel which concluded there was one modifiable factor being, '*Sleeping arrangements in social housing.'*

1.14 Reece, his mother, half-brother and extended family were well known to agencies for a range of health and welfare concerns which will be discussed throughout this report. Ollie had been subject to a Child Protection Plan twice, each time then being stepped down to a Child in Need (CiN) plan.

1.15 The last of these Child Protection Plans started when Ollie and UBB (unborn baby) - Reece - were made subject to child protection planning under the category of emotional abuse.

[3] http://www.legislation.gov.uk/ukpga/Geo5/23-24/12
[4] http://www.legislation.gov.uk/ukpga/2004/28/part/1/crossheading/causing-or-allowing-the-death-of-a-child-or-vulnerable-adult

1.16 Prior to the time Reece was born, at a Review Child Protection Conference (RCPC), both children were stepped down from Child Protection Planning to a Child in Need Plan.

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:

- 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 Reece 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 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 in accordance with policies and processes. It is intended to allow lessons to be learnt for the future in similar cases. The period under review is from 1st April 2012 to the date of Reece's death.

2.4 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.

2.5 The agencies which had relevant involvement with Reece or his immediate family were:

- Academy 1
- Academy 2
- Hampshire Constabulary
- Housing Services
- Solent NHS Trust (to include Health Visiting, School Nursing, CAMHS)
- Southampton City Clinical Commissioning Group including GP
- Southampton City Council Children and Families Service
- University Hospital Southampton NHS Foundation Trust

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

2.7 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.

2.8 This review considered all issues that could have a bearing on the circumstances of this case and included:

- The effectiveness of working arrangements (including information sharing and communication), between all professionals in all organisations and whether this could have been improved.
- How effectively agencies worked together to support Beth in light of what was known or knowable about the environment in which they were being brought up
- How agencies shared information regarding Beth to ensure her health and wellbeing needs were being met
- The agency(ies) response to Beth's pregnancies and any consideration given to her and her unborn children's health needs including her capacity to provide effective parenting
- The existence of any mental health issues which may have impacted on parenting capacity.
- The level and extent of agency engagement and intervention and whether this was appropriate to the assessment of Beth's, or the Grandparents', ability to provide adequate care and supervision of Ollie and Reece.
- Whether agencies worked together sufficiently to ensure that Ollie and Reece had all their health and developmental needs met by either effective parenting or by professionals.
- The recognition of safeguarding issues by all agencies and how these were addressed
- Given the escalation of concerns regarding Beth's ability to provide the necessary care to Ollie and Reece, whether agencies were responsive enough to the signs and worked together to safeguard them.
- The quality of assessments on which decisions and actions were taken.
- Whether the child protection system was effective in providing support and interventions to ensure the safety of Ollie and Reece.
- Whether the housing and support made available to Beth were appropriate to enable her to live and parent independently.
- Whether race, religion, language or culture was a factor in this case and had been considered fully.

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

2.10 The lead reviewer involved family members in the review and enabled them to participate as and when appropriate.

2.11 The methodology for this review consisted of:

- A review of summary information and chronologies provided by individual agencies where there was contact with the 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

2.12 Beth and her mother were interviewed for this review and both were supported by a friend and their Family Engagement Worker. The detail of their reflections of the service and support they received is included throughout the report. However, it is worth highlighting that neither felt the system and the agencies within it were particularly supportive and, on occasions, were just left to 'get on with it' or, on the run up to Child Protection Conferences, expected to undertake so many various different assessments and activities that their time to care for Ollie was affected. This was their view, and others may not agree, but their experience of the system was, in their words, 'too focused on judging and not enough on supporting.'

3. Outline

3.1 Beth was fourteen years old when she gave birth to Ollie. She had a troubled upbringing. Her parents were estranged and her father died of cancer. She once described herself as not having a 'proper mother daughter relationship.' Beth, and her sister, had previously been on the Child Protection Register (now referred to as being on a Child Protection Plan) under the category of neglect due to a longstanding history of domestic violence & disputes between their parents and issues of parental mental ill-health. They were stepped down to Child in Need and then to Team Around the Child. Both Beth and her mother said, when interviewed for this review, they felt social care 'walked away' after her father died.

3.2 A pre-birth assessment, carried out by Hampshire Children and Family Services, raised no immediate concerns for Ollie although he was made a Child in Need. Beth was seen regularly at the ante-natal clinic throughout her pregnancy. While most were routine appointments, others were due to her experiencing vomiting, bleeding or due to 'pre-existing risk factors' – her taking anti-psychotic medication.

3.3 Beth was referred to the peri-natal mental health team and her care was handed over to the young persons' team when she was 33 weeks pregnant.

3.4 Ollie was believed to have been fathered following Beth being raped by a boy who she went to school with. This was investigated and, on CPS advice, the offender received a final written warning as there was insufficient evidence to prosecute.

3.5 Beth was known to have been in a number of relationships with older men and agencies investigated her risk of sexual exploitation. As a consequence she was referred to Barnardo's, who worked with her and her mother for around nine months. After this time, Beth disengaged but the risk was deemed to have lowered as she changed her friendship group. No charges were brought against anyone for exploiting Beth.

3.6 Beth did not want to discuss this aspect of her life with the lead reviewer, other than to say that she did not feel she was receiving the attention she needed at home so looked elsewhere for it. She would not elaborate any further, nor would she comment on whether she felt she was being exploited.

3.7 Beth was known to use alcohol, cannabis and cocaine but maintained to professionals that she had given up the latter when she was 11 and was reducing her use of cannabis.

3.8 Ollie was born at 41 weeks. He was healthy and in good condition. Given Beth's use of medication for bi-polar disorder, withdrawal observations were carried out and, after consultation with Children and Family Services, Beth and Ollie were discharged to her mother's address.

3.9 During this time, Beth was being investigated by mental health services for both bi polar disorder and attention deficit hyperactivity disorder (ADHD) but her engagement with Child and Adolescent Mental Health Services (CAMHS) was, similar to her engagement with other agencies, inconsistent. It was later established she had ADHD but CAHMS struggled to keep her engaged in treatment.

3.10 During the period under review, there was an extensive pattern of Beth either not attending, not bringing Ollie or not being available for at least 60 arranged appointments with CAMHS (17), Health Visitor (14), home schooling (10), immunisation (8) and 11 others. Agencies have detailed their perspective on this but Beth explained that often the appointments were inconvenient and sometimes even clashed. Her current Family Engagement Worker reports that her engagement with services is very good now.

3.11 On top of this, Beth's school attendance was of concern dropping as low as 42%. After Ollie was born, agencies' felt that Beth and her mother could prioritise schooling better. That said, when it was later pointed out that her attending school was key to setting the right examples for Ollie, Beth recognised its value and promised to improve her attendance and her engagement in home tutoring. However, this did not happen and Beth told the review that she did not like school and could not settle there.

3.12 In the very early days of Ollie's life, Beth's parenting and her motivations were strong, however after about six weeks she started to find the responsibilities of motherhood overwhelming. There were reports of her arguing and fighting with her mother, resorting to consuming cannabis and running away with Ollie; a pattern that would continue over the next three years.

3.13 Ollie was seen twice at the hospital; once for a viral illness and once for a rash and runny stools. On both occasions, efforts were made to speak with the Child Protection Nurse Specialist before discharge. The second time this was successful, the first time not.

3.14 At home, Beth and her mother argued, predominantly around Beth's willingness or capacity to provide effective parenting for Ollie. This resulted in her

mother stepping in to the point that concerns emerged among professionals as to who Ollie regarded as his mother.

3.15 At one point police received a 999 call from Beth's mother reporting that Beth was attacking her. Police attended and established that Beth was believed to have consumed cannabis and behaved aggressively towards her mother. It was alleged that Beth had stolen money from both her mother and grandparents and stresses were running high. However, no evidence of any offences was found. Officers felt Beth was struggling to cope as a mother and her mother was undertaking the majority of care for Ollie, which was causing tension. Children and Family Services were reported to be aware of the situation which was felt to be deteriorating.

3.16 The following day, Beth's mother contacted Children and Family Services to report that her behaviour was placing Ollie at risk. She admitted that she has not been open and honest with professionals about her daughter's behaviour. The home situation had been deteriorating for several weeks and Beth had been taking Ollie with her while she had been drinking with friends. As child protection concerns were increasing, a signed contract of expectation was put in place including that Beth was not allowed to take Ollie out unsupervised.

3.17 The following day, Beth's mother called the police as Beth had run off from the home address after an argument. When she returned half an hour later, it was established she had also been out earlier in the day and returned smelling of alcohol and her pupils were dilated. Beth had wanted to see Ollie but her mother had refused this due to her state. Beth was said to have become aggressive, shouting and banging the door and had pulled the phone line out of the wall. When police spoke with Beth, she was agitated and shouting, wanting to see her son. Officers suspected she did not understand that her behaviour and demeanour may be putting him at risk. No offences were disclosed and Beth was advised about her behaviour, particularly with regard to Ollie. It was agreed that Ollie would stay with Beth's grandmother for the night to enable Beth and her mother some time to talk. Children and Family Services were notified and Intensive Support Service intervention commenced.

3.18 On another occasion, Police were called twice in one day due to violent disputes between Beth, her mother and grandparents. On the second occasion, Beth was arrested for criminal damage for which she received a final warning. The Children and Family Services visit that followed revealed that Beth was still struggling with her parenting role. Three days later the family moved to Southampton.

3.19 The process for transfer of the family from Hampshire to Southampton Children and Family Services seemed to be consistent with the 4LSCB Protocol for Protecting Children who Move Across Local Authority Borders[5] in that Southampton City Council were informed as soon as possible and only assumed responsibility to provide services once they had sufficient information to decide what those services should be.

3.20 On transfer from Hampshire, Southampton Children and Family Services did not feel that Ollie, Beth and Beth's sister met the Child in Need[6] threshold as there were other agencies already involved. However, at the end of April, there was a change of decision due to a social worker's concerns that there were 'many complex issues,' resulting in an initial assessment which progressed to a core assessment, the outcome being Child in Need plans for all three.

3.21 Ollie attended Southampton Hospital twice, once for diarrhoea and vomiting and once for an apparent head injury caused by hurting his head on the side of a baby-bouncer. No injuries were seen.

[5] http://southamptonlscb.co.uk/wp-content/uploads/2017/08/4LSCB-July-2017-Protocol-for-Protecting-Children-who-Move-Across-Local-Authority-BordersFINAL.doc.pdf
[6] https://www.legislation.gov.uk/ukpga/1989/41/section/17

3.22 When Beth started at Academy 1. She attended their offsite provision part time (10am-12pm) to allow her to remain involved with Ollie's upbringing. Her attendance started at 55% but over the year dropped to 42%.

3.23 That month, Beth called her GP to report that, 2 weeks previously, Ollie was on the living room floor and something, she was unsure what but possibly a remote control, fell off the coffee table on to him. She says she was not present but somebody else was, possibly her mother. Since then, she noted that he was not moving his arm properly and cried when Beth touched it. On examination, no injury was detected, he had full movement in all his limbs, was alert and playing normally. Children and Family Services appear not to have been notified of this injury.

3.24 The same day, Beth's mother called the police reporting an argument at the home with Beth being in 'a state of rage,' causing damage and trying to assault her. Upon police arrival Beth was not at the address. Her mother had tried to keep her there but this had led to increased tension and frustration. Whilst police were still present, Beth returned saying she had left to cool off. She said she did not wish to live with her mother and wanted to be placed in a mother and baby unit. Beth cared for Ollie whilst police were present, feeding and changing him. Beth felt that her mother was controlling and taking over Ollie's care and being critical of her. Children and Family Services were informed.

3.25 The social worker undertook to contact CAMHS to establish the reason Beth came off her medication, to refer her to Incredible Years[7], to refer her to a nursery nurse for help with routines and to find out about Young Mums' group. Beth and Ollie went to stay with a friend for a couple of days to give them a break. A request was made for the Health Visitor to become more involved. The referral to Barnardo's regarding risks of child sexual exploitation was made at this point.

3.26 At another time Beth's mother disclosed to the Family and Parent Team that Beth had been in a relationship with a 20-year-old man. The police spoke with Beth who was very hostile and did not wish to provide them with any information, apart from that she had slept with the man once, that it was consensual, initiated by her and occurred some considerable time prior to the information being passed to police. A criminal investigation was not progressed as no full disclosure or complaint was received from Beth. The man's details were added to the police's nominal tracker due to repeated concerns regarding his contact with young females.

3.27 Ollie was again admitted to hospital following an eight day history of coughing, wheezing and coryza. He was given creams for Eczema and nappy rash. It was noted that he had not been brought to his last two immunisations. Having spoken to out-of-hours Children and Family Services, he was discharged home after observations and basic life support training was given.

3.28 Further concerns emerged that Beth may be having relationships with older boys/ men. These were looked into and explanations provided that seemed to satisfy the concerns. There were also worries that Beth's mother was still providing most of the parenting for Ollie, risking that he and Beth may not establish an appropriate bond. ARC was commissioned to work with the family but they concluded that Beth and her mother would be better off separated.

3.29 Beth went to hospital with a fractured wrist, reporting that she had fallen. All agencies were informed and she was discharged after treatment. Children and Family Services allocated the case to a student but there is no record of what happened as a consequence. No specific mention was made of the fracture in a case

[7] Incredible Years programme aims to support parents in developing appropriate effective routines and boundaries, reinforcing positive behaviour through the use of praise and reward systems.

note dated two days later, which indicated that the CiN review decided to continue with the plan with fortnightly reviews.

3.30 Concerns were raised regarding Beth's relationship with another man which, the police were told, had been going on for four months. It was alleged they had been sleeping together in the room she shared with Ollie.

3.31 At the same time, housing were receiving complaints about the family, including reports that Beth's mother was drug dealing, as a result of which they were considering taking action. However, they drew up an Anti-Social Behaviour Contract which was to be signed by Beth, her mother and sister.

3.32 Indecent images had been found on Beth's phone and there were further concerns that she was at risk of child sexual exploitation. There is no evidence that, despite the work being undertaken by Barnardo's, any additional investigative or preventive activity took place as a consequence of these fresh suspicions.

3.33 Various social work visits to the house revealed concerns such as Ollie not being dressed warmly enough, Beth becoming verbally abusive in front of him, Beth being heavy handed and Ollie not reacting to Beth when she and her sister were shouting at each other.

3.34 Beth was still said to be smoking cannabis at this point, saying that she found it useful to help her 'mellow'. She admitted that she had smoked and drank during her pregnancy. A strategy discussion was held which resulted in the case going to Initial Child Protection Conference.

3.35 Given the concerns about Beth's mother's mental health issues and the continual physical and verbal arguments between them, together with Beth's involvement with older men and possible sexual exploitation, Ollie was made subject to a Child Protection Plan under the category of neglect. Beth was not considered, other than as a parent, through this process.

3.36 The plan itself was appropriate to mitigate the risks identified, covering Ollie's needs as a child and Beth's as his parent, including carrying out a parenting assessment.

3.37 Despite this plan, the problems did not abate with concerns remaining around the relationship between Beth and her mother, their poor mental health, Beth's involvement with older men, her school attendance and whether either were capable of meeting Ollie's needs. Children and Family Services referred Ollie to a behavioural specialist.

3.38 A separate Section 47[8] investigation was triggered as a result of an alleged assault on Beth by her mother. This left Beth with a facial injury. It was not clear whether Ollie was present at the time and, given Beth's reluctance to support police action, the matter was progressed by Children and Family Services on a single agency basis. No child protection conference was held in respect of Beth.

3.39 Ollie was seen with a bruise to his face that, separately, Beth and her mother gave different explanations within a few days. Both were accepted and, apparently, not cross referenced. These were not mentioned at the Core Group Meeting a few days later nor was the alleged assault from the previous month.

3.40 Shortly afterwards, a social worker saw finger-like bruising on Beth's breast. She denied they were caused by fingers and, although she was still a child, the matter was not progressed and there are no case notes about this.

3.41 At the first Review Child Protection Conference (RCPC), it was agreed that child protection planning would continue. ARC was stepping down due to lack of

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

engagement; Beth had been engaging but no relationship work between her and her mother had taken place. There were concerns that, despite Ollie needing a consistent care-giver with whom he can have a good bond, Beth was not considered to be fulfilling that role. There is no record in the minutes of the bruisings to Ollie and Beth the previous month being discussed or considered nor the alleged assault on Beth. The lack of successful visits by the Health Visitor and Ollie being behind with his immunisations were discussed. The fact that a parenting assessment had yet to be carried out was added more clearly to the plan

3.42 Immediately after the conference, social workers were still observing the fractured relationship between Beth and her mother, with the latter feeling she was filling the parenting gap left by Beth who, she said, put her own needs above Ollie's.

3.43 Another mother told her Family Engagement Worker that she was worried for Ollie's welfare. She said she had seen Beth shout at Ollie in the street telling him to do something and, when he did not, she said she saw Beth smack him very hard across his bottom. She said that this was done in front of Beth's mother and that she had seen Beth do this a number of times before. This was referred to Children and Family Services.

3.44 The following day, Children and Family Services made an announced visit as a result of this referral. Beth's mother tried unsuccessfully to delay it as she had just started decorating. On hearing the allegation, Beth insisted that the social worker examine Ollie. No evidence was found that Ollie had been smacked. During the visit Beth's mother said that things within the home had been OK and Beth had been caring for Ollie. With regards to her other daughter, she said she was worried about her behaviour lately, which may have been linked to the second anniversary of her father's death.

3.45 There was very little progress of the Child Protection Plan. The only part of the plan Beth engaged with was to attend her review appointment with CAMHS at Brookvale. The Family Engagement Worker, who was allocated to work with Beth and her mother said they had attempted over a number of weeks to arrange appointments and visited a couple of times but got no answer. As this was only a six-week programme, it could not continue. Although there were significant concerns in relation to Beth's level of engagement and the plan not being progressed, Ollie continued to meet his developmental milestones. A newly qualified social worker was allocated to undertake relationship work between Beth and her mother and they were said to have engaged well in this but there are no further details held.

3.46 It emerged that Beth had not attended school for 3 weeks. Academy 1 were under the impression that Beth had been told about the Alternative Pathways course which the school were applying for, in order for her to have home schooling the following year. This was subsequently provided through Academy 2.

3.47 At the next RCPC it was noted that there was a lack of consistent or long term improvement demonstrated. The reported volatility of the family relationships risked impacting on Ollie's emotional development, as well as potentially placing him at a physical risk if the situations got out of hand. Also, Beth had not been attending school regularly which was felt to be indicative of her lack of capacity to manage her behaviour and Ollie's parenting. There were some positives reported, including fewer arguments, no more complaints from the neighbours and Ollie developing well and having established a bond with Beth. She promised to take him for his immunisations, which she did later that month. However, given the ongoing risks, Child Protection Planning continued.

3.48 Preparations were in hand for Beth to transfer from Academy 1 to Academy 2. Soon after, Children and Family Services contacted the school to discuss Ollie being on a Child Protection Plan and to invite the school to the Core Group.

3.49 At the Core Group meeting, Beth's mother said that Beth was now caring more for Ollie. She said that she was moving on from the death of her husband, something that her mother-in-law was not happy about. This was causing arguments, which has resulted in her not allowing her mother-in-law into the house.

3.50 Callum appeared to have moved in to the family home. Children and Family Services submitted an information request to the police to gauge whether he would present a risk to the children. Records revealed no such concerns.

3.51 Beth started at Academy 2. The following day, Beth's mother mentioned that she thought Beth was to be home schooled. This may have been due to Academy 1's referral to Alternative Pathways. Possibly as a result of this, Beth did not attend school that day. The school were quick to deal with this and other unauthorised absences, including once checking whether the reason given for the absence, a child protection meeting, was true.

3.52 After almost daily contact to try to negotiate Beth's school attendance, the possibility of a home tutor was explored. Due to Beth being sick, the next session was not for another two weeks. Beth's availability for the sessions was sporadic over the ensuing months, sometimes with notice given to the tutor, sometimes with there being no reply when she called. Beth told the review that the tutor was easily persuaded that she was too tired for lessons and would leave at the first opportunity. Attendance letters were sent at various intervals and, where necessary, Children and Family Services were informed.

3.53 Beth did not attend her follow up CAMHS appointment at Brookvale. They wrote to her saying they would close her file if they do not hear from her within 2 weeks. Brookvale told Children and Family Services, highlighting that they had prescribed her Aripiprazole but did not know if she was taking this and had not seen her since to assess the response. They set out her diagnosis as ADHD and emotional dysregulation. Beth said that she had not received any communication from Brookvale and that she stopped going to Incredible Years as Ollie's father's sister was there. She was worried that she could follow her and tell her brother where she was living.

3.54 At a RCPC, under a different chair, it was said that Beth had stopped taking cannabis and was choosing not to go out, to avoid getting into trouble. It was said that there had been a big change in her and she had improved her relationship with agencies, was engaging better and wanted ongoing support and back up. It was said that Callum was not in a relationship with either Beth or her mother.

3.55 Because of the format of the minutes it is not easy to see whether there was any progress against the plan, if it had been tested and therefore what impact it had on Ollie's wellbeing. It is understood that the format has now changed, as this was a common complaint making ongoing supervision difficult. An independent chair reports that it is now clear how plans are progressed and their effect.

3.56 The relationship between all members of the family was said to be improving and the friction in the home was said to be reducing. Ollie was developing well, meeting his milestones and there were no health concerns for him. He was stepped down to a Child in Need Plan

3.57 It was revealed to Children and Family Services that Beth's mother was four weeks pregnant with Callum's child. This was despite what the RCPC was told eleven days earlier. Beth was said to have taken this very badly and became verbally aggressive and 'punched' her mother in her side. She then, apparently, attacked Callum, who sustained no injuries. Beth's mother said that Ollie was upstairs asleep when this happened. She added that she wished to have a termination. The police were not informed of these alleged assaults and none of this changed the Plan or agency response.

3.58 During a planned Children and Family Services home visit the following day, at which Beth's mother's mental health worker was present, Beth was extremely angry. She was shouting at her mother (with Ollie present) and told her mother that she had made her choice and that she was leaving and had Ollie's bag with some belongings. Once they had all calmed down, Beth accepted there was nothing she could do about the situation and they reached a compromise that Callum would not stay, but would come and take her mother out.

3.59 The home situation seemed calmer. Beth had accepted her mother and Callum's relationship, he was back living in the property and her mother had had a termination. Beth said she was still taking her medication and was attending a therapy course through Brookvale which she was feeling positive about. However, she did not attend on three occasions around that time and, during a telephone contact to explore why, told CAMHS that she was not taking her medication.

3.60 Later that month at a CiN meeting, while there were no concerns raised in relation to Ollie's development, his behaviour was of concern due to his aggression towards his mother. The Health Visitor agreed to make a referral for a nursery nurse to get involved and support Beth in developing strategies in managing Ollie's behaviour. This was the second time this had been decided and there are no records whether it happened or, if it did, whether it helped. The case was stepped down to Early Help as it was thought there were currently no safeguarding concerns.

3.61 Beth's mother said that Beth had been admitted to hospital the previous day and thus would not be available for tutoring. There is no record held by UHS that this was the case. The same thing happened in March. That month Beth's mother said that she had to go to the police to make a statement. This could not be verified either.

3.62 A college interview arranged for late April for Beth did not happen as it seems Beth and her mother did not know about it. However, Beth did attend a functional skills exam at the school. This was the last contact with the school.

3.63 Following a row with her mother, Beth presented as homeless with Ollie. After a failed attempt to mediate her back home, she was placed in bed and breakfast accommodation from which she was evicted the following day, due to reports of behavioural issues. She then returned home.

3.64 The following month she again presented as homeless and, while an urgent referral was made to a supported housing charity (Chapter 1), she moved in with her paternal grandmother. This change in her circumstances was referred to Children and Family Services.

3.65 Following an interview with Chapter 1, Beth telephoned housing as she had been asked if a joint application would be better. She was advised that would not be appropriate as she had only been with her current partner, Harry, for a month and her accommodation placement was for her and her child only. Nothing happened with that application and, the following month, Beth contacted the homelessness team once more to say that she was pregnant again (she miscarried early). A member of staff offered to alert Young Parents project and ask if they would consider taking her. Beth refused the accommodation offered and the case was closed as she was deemed no longer homeless due to refusing appropriate and reasonable accommodation.

3.66 The living arrangements with her paternal grandmother did not go well, with an allegation that Beth had stolen cash and conflict between her and Beth's partner (Harry, the father of the child she lost). Soon after, their relationship broke down, as did that of Callum and Beth's mother. The two men ending up living in a car together and Beth reported receiving threatening calls from Harry following the break up.

3.67 During a visit with Ollie to the GP, Beth revealed that he was physically violent, kicking, punching, mainly towards family but could be to strangers too. On one occasion he bit his teacher at nursery school. She felt that Ollie was hyperactive.

3.68 Callum was discharged from Hampshire Liaison and Diversion Service (HLDS) having been referred by probation after being found guilty of possession of cannabis and assault, for which he received a suspended sentence. He told professionals that he had diagnosed himself with paranoid schizophrenia and that he heard voices regularly. He said he had been severely depressed since he was 16, however he had not attended the GP as he was not registered. He disclosed having suicidal thoughts.

3.69 That same month, Beth attended CAMHS with a worker from No Limits[9]. She reported ongoing aggressive outbursts often provoked by involuntary angry thoughts or visions concerning hurting others which, she said, she had not acted on. She denied any psychotic phenomena, saying that the thoughts and visions have more of an obsessive quality. She described her mood as being low, not sleeping, sometimes struggling to get out of bed or motivated to do anything, but would interact with Ollie. She was prescribed fluoxetine with a follow up appointment being made for the following month.

3.70 Between Christmas and New Year, Beth discovered she was pregnant (with Reece). She was clear from the start that she wanted to keep the baby. Beth disputed that Harry was the father, as did Harry. The GP wrote to CAMHS to inform them of this development and to review the prescription for fluoxetine, given any possible impact on the unborn baby.

3.71 Beth missed a CAMHS appointment in January. She did not see them face-to-face until late April but did tell them, in a phone call when she could not make a February appointment, that she had ceased taking her medication.

3.72 Beth presented as homeless again saying that she could not remain at her grandparents' address as her grandfather was ill. Another referral was made to Chapter 1 for supported accommodation. In the meantime, she was mediated back with her grandparents until Chapter 1 had a vacant property.

3.73 Beth was suffering from morning sickness and a chest infection. Possibly due to this, she did not attend her follow up CAMHS appointment and therefore her fluoxetine medication was not reviewed. She also did not attend a Child in Need meeting. The social worker and Family Foundation Worker (FFW) visited Beth at her grandmother's house and witnessed a heated argument between the two.

3.74 During that month, there were strong smells of cannabis noted when Beth's mother dropped Ollie off at pre-school and when the Health Visitor visited the home. The same was noted when the midwife visited for the antenatal booking appointment. Advice was given during this visit and Beth said it was her partner who had been smoking it.

3.75 Harry's troubled upbringing and mental health issues were recorded when he was reviewed by HLDS. The letter they sent to his GP noted a previous suicide attempt and him being arrested the previous month for criminal damage at his mother's house. It noted his relationship with Beth and the fact that she was pregnant and, in his words, schizophrenic. It notes his use of alcohol and drugs being dynamic risk factors but arguments with families being the main trigger. His relationship with Beth was seen as a protective factor (it seems that he regarded the relationship as being ongoing while Beth considered it over). The police custody officer was informed of the HLDS concerns and a referral to Children and Family Services was made due

[9] A youth information, advice and counselling service.

to the pregnancy. The HLDS officer also informed the FFW that she had concerns about Harry's temper.

3.76 A decision was made by Children and Family Services that Beth and Ollie should be housed in Miriam House (a supported housing project run by Chapter 1 for young pregnant women and young mothers aged 16 to 25 and their babies) as soon as possible. This happened about six weeks later.

3.77 A referral letter, sent that month from midwifery to the Health Visiting service, set out the obstetric information regarding Beth's pregnancy but omits any reference to Ollie having been on a Child Protection Plan and now being a CiN nor on any of the complexities around Beth's socio-economic history or parenting capacity. A similar letter, with similar omissions was sent to CAMHS.

3.78 Throughout Beth's ante-natal appointments, her mood and demeanour differed from when she was pregnant with Ollie. She declined to provide samples for toxicology, she was said to have been verbally hostile to the midwife and she reported low moods. She also reported relationship issues and that her housing arrangements were unstable. She missed an ante-natal appointment.

3.79 During her appointment with a consultant obstetrician, Beth appeared to have said that she had ceased using recreational drugs and that she was no longer taking medication for her bi polar disorder but that it was being well managed between her and her psychiatrists. There is no reference to her having missed her recent appointment and medication review with CAMHS.

3.80 The same day as this appointment, and probably prior to it, Beth called the police reporting problems with Harry. She said that Ollie had come into the bedroom that morning and Harry had told him to go away, pushing him off the bed. Her grandmother then challenged Harry and he pushed her out of the room. Beth said she tried to separate them but Harry picked her up and threw her over the bed. When police attended both Beth and her grandmother did not wish to make any complaint and there were no injuries.

3.81 Harry maintained that Ollie had come into the bedroom as Beth had not wanted to get up. He told Ollie to go to another room. This had led to an argument between him and Beth's grandmother, resulting in her slapping him around the face. Beth separated the two and started hitting him so he pushed them both away and left the address. Ollie was seen and no concerns were identified. The police notified Children and Family Services. A strategy discussion was held and it was agreed that Children and Family Services would progress the Section 47 investigation on a single agency basis.

3.82 Soon after, Beth ended her relationship with Harry and, after some persuasion agreed to move in to supported housing. She remained there for ten days before moving back to her mother's as she said Ollie would not settle. She did not attend a CAMHS appointment (although she spoke with them on the telephone where it was agreed that she stop taking fluoxetine). Three weeks later she re-presented to her GP and was started back on mirtazapine. It was noted during this period, that she had not been completing her drug screening tests.

3.83 Following the incident where it was alleged that Harry had pushed Ollie off the bed, and ongoing concerns surrounding the breakdown in the relationship between Beth and her grandmother, with whom she was living, an ICPC was convened in respect of Ollie and the UBB (Reece).

3.84 The risks identified included domestic disputes. There were also concerns around instabilities in the home environment and the care provided to Ollie, volatile behaviour and dynamics observed in the relationships between maternal family members. There was information in the pre-school report that Ollie has witnessed arguments between his mother and Harry. Additional concerns were around the

instability of Beth's (and therefore the children's) housing, her mental health and her history of growing up in a violent and volatile setting. It was notable that CAMHS were not represented and it was unclear whether they had been invited or a report requested.

3.85 Concerns were raised and acknowledged over the lack of continuity of social workers and therefore interventions, including Ollie's behavioural therapy, were not happening.

3.86 Following discussion including a significant input from Beth and her grandmother, it was unanimously agreed among professionals to make both Ollie and the UBB subject of Child Protection Planning under the category of emotional abuse. The family disagreed with this outcome. A Core Group involving PACT (Parents and Children Together) social worker, Family Foundation Worker (FFW), Health Visitor, No Limits, Housing, Probation and the parents was established. It was also considered that either CAMHS, peri-natal mental health, or community mental health should be invited.

3.87 Two days after the ICPC, Beth was seen by her GP as she was feeling very low, had a lack of motivation and felt that she was not coping. She was having fleeting thoughts of self-harm, but said she was able to push those thoughts aside and felt safe. The GP wrote to CAMHS to ask them to contact her and noted that the peri-natal team should become involved. Beth appeared to have told the GP that she had been trying to contact CAMHS.

3.88 Three days later she went back to her GP with low mood, this time accompanied by her mother. She said she had a CAMHS appointment in about six weeks' time. She was prescribed sertraline, which she had taken during her pregnancy with Ollie. The plan was to review that after she had been seen by the Community Mental Health Team. The Core Group, to which Beth and her grandmother, but not Harry, attended discussed all of these matters as well as Beth and Harry's relationship ending.

3.89 Beth did not attend a community mental health appointment shortly after the Core Group but did attend a CAMHS appointment the following week. The notes from the latter show that Ollie and UBB were on a CPP, were well known but they do not set out any risks or vulnerabilities to the children which may arise from what was known about Beth, the circumstances under which she was bringing up Ollie or her poor mental health.

3.90 During May, Beth missed a Health Visitor appointment and an ante-natal appointment. When she did eventually see the Health Visitor, Ollie was not at home. Beth reported that he was out shopping with her grandmother.

3.91 Beth said that she had no health concerns about Ollie (although he had been diagnosed with Mesenteric Adenitis[10] the week before) and that his behaviour was much improved, although he still got angry There were concerns raised regarding Beth's possible drug use due to her reluctance to have drug tests. She was also reported to have made aggressive comments about her midwife. It was confirmed that Beth had resumed her relationship with Harry. Beth had previously informed her social worker about this and there were no immediate management decisions as a consequence.

3.92 Later that month Ollie was seen by the Health Visitor with Beth, her grandmother and the Social Worker present. He was overweight – above 99.6th centile - and there were concerns about his aggression. Advice was given regarding healthy eating and it was agreed to refer him to paediatricians for assessment for ADHD due to the family history.

[10] Inflammation of the abdominal lymph nodes

3.93 Prior to the RCPC, Harry did not attend a community mental health team appointment and a referral to paediatrics for Ollie was declined with the recommendation that he have behavioural support or be seen by CAMHS if required. Behavioural support was one of the concerns raised by Beth at the ICPC as needing to be progressed.

3.94 Three days later the RCPC was held and chaired by the same person who chaired the ICPC. The GP, Health Visitor, Family Foundation Social Worker, housing support worker, supported housing provider and the nursery were all absent from the conference. None of these provided a report. The minutes do not suggest that CAMHS were invited despite that being raised as a possible omission at the ICPC.

3.95 Despite the lack of information available to the conference, a majority decision was taken to step Ollie and UBB down to a Child in Need plan. The police dissented from this view. The chair commented that *'It is an unusual situation for professional to step down to a Child in Need plan as they usually like to see a period of sustained change. The evidence presented today has shown positive improvements. The pregnancy and the previous domestic violence are still present and could be a risk of significant harm.*' Reece had not yet been born so the impact of his birth on Beth's, and others, parenting abilities and capacities with two young children could not have been assessed.

3.96 In the three weeks following the step down, Harry was discharged from the mental health service due to lack of engagement, the Health Visitor reported difficulty in communicating with the social worker, Beth did not attend a CAMHS appointment, Harry and Beth split up again and Ollie sustained a broken metatarsal following an accident whereby he jumped off a kitchen unit. Beth still had not provided samples for drug tests, which were overdue. None of these events appeared to have triggered any multi-agency response.

3.97 It seems that Beth and Callum started a relationship as police received a report that Harry had assaulted Callum. It was said that the dispute was in relation to Beth who 'is Harry's ex and Callum's current girlfriend.'

3.98 Around the same time, a referral made by Children and Family Services to CAMHS in respect of Ollie was closed as 'no further action.' It appears that this was due to his age and not meeting the required threshold. There is no record of what options were considered in light of this.

3.99 Reece was born at 41 weeks' gestation. He was in good condition with Apgar scores[11] of 9 at 1 minute and 10 at 5 minutes and weighed 3.305kg. His 6-8 week review showed his weight was 4.1kg which was <9th percentile.

3.100 He was healthy and, other than observations being conducted for any withdrawal symptoms from Beth's medication, needed no intervention. Children and Family Services were informed but no discharge planning meeting was held as he was not subject to Child Protection Planning nor close to threshold. The following day, he was discharged with Beth to her mother's address.

3.101 Following the birth, it was confirmed that Beth and Callum were in a relationship resulting in Beth, Ollie and Reece leaving her mother's address to live with Callum's step-grandmother.

3.102 Initially, after Reece's birth, there were concerns about his feeding but these were resolved. At the last post-natal visit by maternity, Beth reported that her mood had improved since moving from her mother's house and that she remained unsure of Reece's paternity. Her good attachment was noted and safe sleeping was discussed with her.

[11] https://patient.info/doctor/neonatal-examination

3.103 Over the next two weeks Beth's mother started to harass Beth and Callum, the outcome being that they moved once more, this time to Callum's father's address. Meanwhile Beth was concerned regarding Reece's feeding, but was reassured by the Health Visitor.

3.104 Due to further disputes, Beth presented as homeless again, this time supported by her social worker. She asked for emergency accommodation but, as the only option was bed and breakfast, this was denied as this would be unsupported and Beth was still a child herself with responsibility for two children. The housing provider's notes say the social worker would try and find a foster placement and the homelessness officer agreed to refer to Young Parents' Project again, which was done the following day. The social worker, however, said that they did not discuss foster care as Beth would not have been eligible. She did, however, support the proposal for mother and baby accommodation.

3.105 Ten days later the social worker telephoned the homelessness team asking for accommodation again, as Beth was now living with Callum's grandmother. The position was reiterated that bed and breakfast accommodation was not suitable.

3.106 The Homelessness Unit called a professionals' meeting regarding Beth and her future housing plans and that Beth wanted Callum to live with her. Her social worker attended, along with a support worker, homelessness staff and a Chapter 1 staff member. Chapter 1 had concerns about housing the family as Beth had not managed in supported accommodation before, as she was dependent on her grandmother. There was concern that this dependency may be transferred to Callum. However, it was agreed that Chapter 1 would assess both Beth and Callum.

3.107 In mid-October during an opportunistic visit by the Health Visitor (Beth and the children were not present), Callum's grandmother said the family had moved out. She raised concerns about Callum being overbearing and that Ollie had carried Reece downstairs alone, although she felt that Beth was doing well with the new baby. Children and Family Services were aware of the visit but not what was revealed during it.

3.108 Callum attended a meeting with the Community Rehabilitation Company with Beth and Reece. The probation officer observed arguments between Callum and Beth regarding lack of trust in their relationship and saw them tussle with the baby in the reception area, but they did go into the appointment. Both had new tattoos dedicated to each other on their wrists.

3.109 The following day, during a health visit to Callum's father's address, where they were now living in the living room, advice was given on responsive feeding and to increase volume of feeds. Safety and Sudden Infant Death Syndrome was also said to have been discussed.

3.110 In late October, Chapter 1 assessed Beth and Callum and confirmed they would offer them supported accommodation within the Young Parent's Project and following them seeing the address, it was confirmed that they would move in on the 7th November. The property they moved in to had no parenting support. It was accommodation used as a step down from such accommodation and served the sole purpose of assessing tenants' ability to sustain a tenancy. It seemed this was not fully understood by other professionals who thought it would provide similar support to Miriam House.

3.111 Beth saw the GP due to her low mood and hearing voices. She said that while she was waiting to move into the mother and baby unit, she was living in cramped conditions with her and the boys sleeping in the sitting room. She had been referred to the peri-natal team and this had been accepted. The peri-natal team wrote to Beth confirming this.

3.112 In November, at a Child in Need meeting, the CRC reported Beth as seeming very depressed and Callum saying that they have been evicted from his step-mother's and are now living back with Beth's grandmother. Housing did not attend the meeting and the probation officer felt that nothing could be sorted and no plan decided upon because of that. Beth in particular became very frustrated. The officer held some concerns around the care of the children as it seemed that Callum had taken Ollie out 'trick or treating' in a dead clown outfit with a bullet wound to the head. Ollie was upset that not everyone was answering the door and was trying to open some of the doors. There was also mention of a reliance on energy drinks and someone – probably Ollie - escaping from the property.

3.113 Two days later the Health Visitor attempted a prearranged visit at the family's previous address only to be told they had moved. It is unclear why they were not told of this through professional channels.

3.114 Beth, Ollie and Reece moved into the tenancy-supported accommodation. No professional who knew the family checked the address for suitability. Also, they were never seen at that address by any professional as Beth cancelled the Health Visitor appointment scheduled for the as she was out shopping.

3.115 Beth told the review the accommodation was totally unsuitable, being too small, insecure and with drug users hanging around outside.

4. Emerging Themes

4.1 CO SLEEPING

4.1.1 Beth denied that she was, or ever had, co slept with Reece. Callum, on the other hand was equally emphatic that Reece shared the air bed with them the night he died and did so regularly. The evidence the police saw at the scene pointed towards that being the case. Beth, on the other hand, suggested the police must have moved the toy and remote control into the Moses basket as that was where Reece had been sleeping.

4.1.2 The quality of the accommodation in which Beth, Ollie and Reece were housed will be discussed further but Beth said it was very cramped – the airbed had to be moved to the bathroom during the day – and everyone slept in the same room. Whilst this was not the outcome of the post mortem or inquest, the risk factors around Sudden Infant Death Syndrome are well known and form the basis of safe sleeping advice provided to new parents[12] including the 4LSCB 'Every Sleep Matters leaflet distributed at Southampton General Hospital Maternity Unit.[13] It may be significant that Beth does not recall receiving this leaflet or any advice over safe sleeping as information provided to another Southampton Serious Case Review, Billy (2019), suggests this information is only contained and accessible through a QR code provided with discharge papers.

4.1.3 Beth's demographic, and the possibility of her and Callum smoking tobacco and cannabis near Reece, put Reece in a higher risk group for SIDS. However, there was no suggestion that she adopted unsafe sleeping practices with Ollie.

4.1.4 Given the ambiguity of exactly where Reece was sleeping, although the *evidence* suggests on the airbed, it is not possible to fully understand what the arrangements were on the night he died. However, it is possible that living in cramped accommodation, which had never been visited by a professional who understood Beth, Reece and Ollie, with little or no support may have contributed to a decision to co sleep with Reece. This may have been aggravated by a lack of accessible information.

[12] https://patient.info/doctor/sudden-infant-death-syndrome
[13] http://www.uhs.nhs.uk/Media/SUHTInternet/Services/Maternity/Every-sleep-matters.pdf

4.1.5 A Thematic Review of co-sleeping deaths in Southampton has been commissioned and completed alongside this and the 'Billy' SCR and makes eight recommendations aimed at reducing similar deaths in the future.

4.2 PARENTING ASSESSMENT AND SUPPORT

4.2.1 Beth was a teenager when she gave birth to Ollie, the pregnancy having resulted from a rape[14], or at least an offence of sexual activity with a child[15]. Two months prior to the birth she was stepped down from being a Child in Need and, pre-birth, Ollie was designated a Child in Need.

4.2.2 Beth had previously been on the Child Protection Register (now referred to as being on a Child Protection Plan) under the category of neglect due to a longstanding history of domestic violence & domestic disputes between their parents and issues of parental mental ill-health. Beth was still living with her mother in what can be described as a fractious and troubled relationship. Like her mother, she too suffered from mental health issues.

4.2.3 Around the time of the pregnancy, and after Ollie's birth, there were ongoing concerns that Beth was at risk of, or perhaps, suffering child sexual exploitation. Whilst, during the pregnancy, Beth seemed to be complying with the expected ante-natal regime, including extra monitoring due to her anti-psychosis medication, soon after the birth cracks in her parenting ability started to show.

4.2.4 Six weeks after Ollie was born, Beth started to argue and fight with her mother, consume cannabis and run away with Ollie; a pattern that would continue over the next three years.

4.2.5 The arguments with her mother were chiefly around Beth's inability to provide effective and ongoing parenting to Ollie. This was known to professionals, not least because her mother told them Beth was struggling.

4.2.6 Over a period of three days, Beth's mother called the police twice and Hampshire Children and Family Services once, due to Beth's behaviour and her ability to care for Ollie.

4.2.7 The response to this was for a signed contract of expectation to be put in place, including that Beth was not to take Ollie out unsupervised and for an intensive support service to be provided. However, by mid-February that year, the family had moved to Southampton, a different local authority.

4.2.8 The family's needs were reassessed by Southampton, resulting in Ollie, Beth and her sister being placed on Child in Need plans. The 'Parenting Capacity' section of the Initial Assessment was not completed, but in the Core Assessment it was said that *'I am not confident at this stage she (Beth) can put Ollie's needs before her own. Ollie has been subjected to many verbal arguments between Beth and her mother which is detrimental to his emotional wellbeing because of the arguments which are often attributed to the lack of care he receives from Beth.'*

4.2.9 Parenting was not assessed again until the Single Assessment for UBB (Reece) although it was widely acknowledged that a further formal parenting assessment was required. It was decided that Beth would be enrolled on the Incredible Years programme – she later disengaged. Referrals were also made to a nursery nurse for 'support' and at one point Children and Family Services were looking into appropriate 'Mums' groups.' It was again decided that Beth would enrol on Incredible Years and that a Family Foundation Worker would provide support. ARC tried to work with Beth and her mother to provide support but due to them not engaging with the

[14] Section 1 Sexual Offences Act 2003
[15] Section 9 Sexual Offences Act 2003

service effectively, they withdrew saying that the best solution would be for them to separate.

4.2.10 At no time during the period under review was any separate formal parenting assessment carried out. This was despite the enduring concerns regarding Beth putting her needs ahead of Ollie's, her ongoing fractious relationship with her mother – principally regarding her parenting role, the frequency of police calls, professionals observing a varying quality of parenting from Beth, the lack of stability in her housing arrangements and disengagement with services. The lack of parenting assessment was raised as a concern at Child Protection Conferences but still none took place.

4.2.11 Had a more detailed parenting assessment been carried out, in respect of both Beth and her mother, then a deeper understanding of the factors underpinning the struggle Beth, and her mother, were having in providing consistent good parenting for Ollie (and Beth) may have been achieved. This may then have led to a more bespoke and embedded service response which would have helped Beth, despite her background and young age, respond more positively to her role as a parent and for her engage with the services to improve. Equally her mother's parenting should have been assessed, given the role she had in respect of Beth and had assumed in respect of Ollie. Had this happened, it may have led to better outcomes for Beth, Ollie and latterly Reece.

4.2.12 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 and Family Services 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. In terms of asking for additional assessments, these are completed through the Children's Resource Service and the decision to refer into that Service for assessment sits with the Children and Family Services managers. If an assessment is requested through conference this would be reviewed as part of the plan.[16]'* This did not happen and, despite Independent Chairs reiterating the need for parenting assessments, they never happened.

4.2.13 There was a perception voiced to this review that a possible reason for no assessment taking place was because the resource to undertake these additional assessments comprises just one person. This is not the position of senior management but clearly a perception that persists.

Recommendation 1

That Southampton Children and Family Services ensure that arrangements for parenting assessments, particularly additional assessments, are clear and appropriately resourced so that social workers, managers and independent chairs understand how and when to access them, whether required through child protection plans child in need plans or any other social work provision.

4.2.14 Family Nurse Partnership (FNP) is a voluntary home visiting programme for first-time young mothers (under 19) and families, designed to help parents have a

[16] Policy position given to review by a Children's Service Manager

healthy pregnancy, improve their child's health and development, plan their own futures and achieve their aspirations.[17]

4.2.15 The criteria for Southampton first time mothers are *the client was 16 years old or under at LMP or the client is 19 years old or under and has AT LEAST TWO of the following additional vulnerabilities:*

- *Not living with own mother*
- *Current Smoker*
- *Has had/currently lives with mental health issues*
- *Domestic Violence*
- *History of drug and alcohol use*
- *Living in a disadvantaged area*
- *Low educational attainment/ currently not in education, employment or training*

Or

The client is under 24 and a care leaver.

It is also available to parents who have children on Child Protection Plans.

4.2.16 FNP did not start in Hampshire until 2015 so was not available when Ollie was born. However, it was available in Southampton when Reece was born. Beth fulfilled every one of the 'additional vulnerabilities' but as she was not a first time mother and Reece – as a UBB – had been stepped down to a Child in Need it was not a service offered to her. This is unfortunate, given her history and the well documented struggles she had with parenting Ollie. Clearly commissioned services need boundaries and FNP is a national contract which would be difficult to influence.

4.2.17 There was an obvious ambiguity of who had the capacity and capability to provide effective parenting for Ollie and Reece and the system did not appear flexible enough to respond to that. Needs were not assessed and the support offered was not suitable for complex families such as this. Beth's tendency not to engage in services may have caused professionals to struggle to understand what support she would engage with, but the question remains whether the system was flexible enough to meet the needs of those who need it or whether they are expected to fit in with it.

4.2.18 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. This programme should fill the gap left when families do not meet FNP threshold.

4.3 ENGAGEMENT AND DISGUISED COMPLIANCE.

4.3.1 During the period under review, there was an extensive pattern of Beth either not attending, not bringing Ollie or not being available for pre-arranged appointments. From the information provided to the review, these totalled at least 60; 17 CAMHS, 14 Health Visitor, 10 home schooling, 8 immunisation and 11 other. This was in addition to a school attendance being as low as 42%

[17] http://fnp.nhs.uk/about-us/how-fnp-works/

4.3.2 While Academy 2 were robust in following up on either unauthorised absences or Beth not being available for home tutoring, others were less responsive. CAMHS and Health Visitor appointments were the most frequently missed and the underlying reasons were never effectively explored. It is not clear whether Beth was actually asked about the reasons either. When asked for this review she was very clear in saying that many appointments clashed or they were at time otherwise inconvenient. Had this been picked up at the time then any such conflicts could have been addressed.

4.3.3 In terms of CAMHS missed appointments, often Beth would tell others that she was engaging well with them. It was clear that she would have preferred to have seen different professionals but her disengagement, rather than being explored, would result in letters warning of her being removed from their list and little else.

4.3.4 Sometimes, Beth would not be at home when the Health Visiting service had been due to meet with her and Ollie, Ollie would not be at home as he had been taken out by others or he was at home but Beth was not, having either forgotten and/ or decided to go elsewhere.

4.3.5 Ollie's immunisations were another cause for concern with at least eight appointments being missed. When he was not brought, new appointments were arranged with it being emphasised how important they were.

4.3.6 One other example of a lack of engagement was the request that Beth undergo a blood test during her pregnancy with Reece. The purpose of this was to establish whether Beth was drug-free. She consistently declined to take this, sometimes, it is said, being verbally aggressive to and about the midwife requesting it. This was an ongoing concern held not just by midwifery but by other services too. While she could not be compelled to undertake drug tests, it should have been more of a 'red flag' over her and her unborn baby's health.

4.3.7 Often Beth, or her mother, would provide professionals with reasons why various appointments had been missed, not attended or they had not been available, those reasons not checking out. On other occasions, particularly regarding the CAMHS appointments, Beth would maintain that she was attending them or otherwise engaging when she was not. Rarely were these explanations or assertions checked or followed up in any way.

4.3.8 It would have been relatively simple for professionals to have discovered the scale of non-engagement or to have ascertained the truth behind the reasons. However, this did not happen hence reasons or explanations were often accepted without question, even taken to be signs of improvement in the family. Were, at core groups or child protection conferences, multi-agency chronologies compiled and shared this may have provided a greater and more timely insight into the systemic lack of engagement and would have, doubtlessly, triggered the right questions, support and if necessary, challenges.

4.3.9 As a result of the scale and nature of this disengagement never being appreciated it was never challenged in the round. Various individual episodes of disengagement were questioned but no agency saw the theme that was emerging; that Beth and her mother may be reluctant, or unable, to engage in a meaningful way. Given the lack of recognition, no one considered whether it was hiding deeper vulnerabilities.

4.3.10 There may well have been genuine reasons why disengagement was at the level it was – indeed Beth told the review there were. Had it been understood and challenged those underlying reasons could have been resolved. There was little evidence that the lack of engagement was discussed in supervision and whether thought was provided to escalate the concerns that arose on a single agency basis so a broader picture could be gained.

4.3.11 Despite the theme of 'Disguised Compliance' featuring in many serious case reviews over the years, there was no recognition that this might be a factor in this case. It could have been used to conceal Ollie and Beth, who after all was still a child herself, from services.

4.3.12 Since the review period, in March 2017 the 4LSCB produced Guidances 'for primary health care when a child is not brought or misses an appointment[18]' and 'for secondary and tertiary health care when a child is not brought or misses an appointment[19]'. These provide advice on thresholds for intervention and escalation and seem useful so that all agencies can be apprised of the breadth of any concerns and their regularity.

Recommendation 2

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.

4.3.13 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)[20] 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.

4.3.14 Southampton LSCB appear not to have this within their procedures nor within their training programme.

Recommendation 3

That Southampton LSCB develops a multi-agency procedure to guide and support professionals in dealing with disguised compliance and resistant parents and carers.

4.4 EFFECTIVENESS OF MULTIAGENCY WORKING

4.4.1 Notably, when Beth and her family moved from Hampshire to Southampton it was recognised that there were already a huge range of agencies working with them. In fact, that was initially the reason for the proposal to step them down from Child in Need. However, it was the complexity of the family and the services that were involved that changed that view.

4.4.2 There were a number of good examples of multi-agency working. For example, the report from a neighbour that Beth had over chastised Ollie was quickly referred to Children and Family Services and a visit was carried out in a timely and effective way. The prompt referrals from the police to Children and Family Services was a strength as was the recognition and referral of safeguarding concerns by the Community Rehabilitation Company and the notification from Housing to Children and Family Services of Beth's second pregnancy.

[18] http://www.proceduresonline.com/4lscb/shared_content_SCB_php/shared_files/ch_fam_engage_guide_prim_care.pdf

[19] http://www.proceduresonline.com/4lscb/shared_content_SCB_php/shared_files/ch_fam_engage_guide_sec_tert_care.pdf

[20] http://www.in-trac.co.uk/wp-content/uploads/2015/11/Resistant-Parents-and-Child-Protection-copy.pdf

4.4.3 However, there were other occasions when joined up working could have been better. Some of these cross over with the section covering the Child Protection system.

4.4.4 CAMHS seemed to be absent from much of the multi-agency assessment and planning, despite their huge importance in the care of Beth. Clearly, they were actively involved in the family yet no one seemed to challenge where they were in the planning or whether they regarded Beth's needs as a safeguarding issue.

4.4.5 This lack of involvement meant that in many of the multi-agency meetings, professionals only had Beth's or her mother's word to rely on when trying to understand Beth's mental health treatment and engagement. Notably at the final ICPC it was unclear whether they had been invited as they had neither attended nor provided a report. At the following RCPC their absence went unmentioned. It seemed that the only service CAMHS engaged with in any meaningful way was Beth's GP.

Recommendation 4

Southampton LSCB should ensure that in multi-agency assessment, planning and delivery all agencies with significant and/ or substantial relevant involvement with the family and children concerned should become and remain actively involved so as to enhance the quality of provision across all aspects of need.

4.4.6 On occasions that other services or provision were considered, there was a lack of follow up regarding how effective they had been. For example, little is said as to what, if any, progress was made during the time that Beth was engaging with Incredible Years and what, if any, success was achieved in securing the services of a nursery nurse to support the family. In addition, there seemed to be no 'plan B' when Ollie was not accepted for CAMHS intervention and the matter appeared to have been left. Beth told the review this is an ongoing theme, an example being that she has been waiting for Non Violent Restraint training to help her manage Ollie, since Reece died and no progress has been made.

4.4.7 At Core Groups, despite the generally good attendance, it was notable that various relevant incidents were not mentioned and therefore opportunities to triangulate information were missed. For example, some bruising to Ollie had been explained differently by Beth and her mother to different professionals. A few days later a social worker saw a bruise on Beth's breast. None of these incidents, nor an alleged assault on Beth by her mother the previous month, were considered together, nor were they discussed at the Core Group or at the RCPC.

4.4.8 These events should have raised concerns and enquiries made into whether Ollie or Beth had suffered non-accidental injuries. This was a missed opportunity.

Recommendation 5

Southampton LSCB should introduce standards that ensure that, across the spectrum of multi-agency safeguarding arrangements, all relevant information is shared and considered so that ongoing risks and vulnerability can be assessed and understood. Further, that the outcome of services provided are critically evaluated in the context of the children and family concerned so as to avoid risks of repeating previous interventions which may have had little or no effect at the expense of accessing more promising provision.

4.4.9 Concerns raised at the learning event included the invidious position that professionals found themselves in in having to hold Core Groups at the family home.

This was necessary to ensure attendance but created difficulties as the environment was not conducive to an effective meeting.

4.4.10 The fact that Beth had different social workers from Ollie and Reece and that each did not attend the others' meetings created an avoidable information gap. Despite the different status of each member, a whole family approach should have been taken as, in this case, it seemed impossible to develop, implement and monitor effective plans without the knowledge of what was happening across the family. This prevented opportunities to consolidate provision to the benefit of all and represented an illogical silo approach. Beth was concerned too as to the volume of social workers she saw and would have welcomed more continuity.

Recommendation 6

Southampton Children and Family Services should enhance its Whole Family approach to social work so that, notwithstanding the differing status of various family members, at core groups and child protection conferences the collective picture can be shared and understood to aid effective multi-agency planning and delivery.

4.4.11 At the final RCPC meeting, the attendance and provision of reports was very poor. While the Conference was quorate, the GP, Health Visitor, Family Foundation Social Worker, housing support worker, supported housing provider and the nursery were all missing and provided no report. Additionally, it was not clear whether CAMHS had been invited but they certainly were not there. This must have impacted on the information available that led to the arguably premature decision to step Ollie and Reece down from Child Protection Plans to Child in Need plans.

4.4.12 In the three weeks that followed, a number of incidents occurred involving different agencies. If these incidents were seen together, that may have generated a reassessment of the Child in Need plan and its effectiveness. However, none, either on their own or together, changed anything; the plan just continued as before.

4.4.13 It is perplexing why, in light of the such a cluster of concerning incidents, as occurred also when Ollie was previously stepped down to Child in Need, action was not taken to re-evaluate the situation and shore up the supportive arrangements. It has already been noted that such incidents were not mentioned at core groups so the question must be asked, what would trigger escalation if these do not?

4.4.14 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.

Recommendation 7

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.

4.4.15 While, on the face of it, it may seem that Housing worked well with Children and Family Services (aside from the assessment issues discussed later) there were three occasions when their engagement could have been better.

4.4.16 Firstly, they misinterpreted that Children and Family Services would seek foster care of Beth and Ollie if supported accommodation could not be found. This could not have been the case as Beth would not be eligible for foster care and it is highly unlikely that it would have been presented as an option. Some store seemed to have been put on this as a fall-back position, which may have led to a false reassurance.

4.4.17 Secondly, the fact that no housing representative attended a multi-agency meeting led to frustration from the Community Rehabilitation Company who wondered *'what could be achieved in their absence*.'

4.4.18 Thirdly, there is no evidence that anyone actually checked the new address prior to Beth moving in with Ollie, Reece and her partner Callum. This should certainly have happened to assess its suitability, especially the sleeping arrangements.

Recommendation 8

Housing commissioners and providers should work together to enhance their understanding of, application of and engagement with the safeguarding and child protection system, especially when commissioning or providing accommodation for vulnerable children and young and vulnerable parents. This should include specific assessments of accommodation allocate to such clients.

4.5 SAFEGUARDING RECOGNITION AND INTERVENTION

4.5.1 The effectiveness of the child protection system will be discussed later but there were times more could have been done to recognise and respond to emerging safeguarding concerns and provide an effective multi-agency response to them.

4.5.2 It should be said that where safeguarding concerns were identified, often the response was good. For example, the circumstances leading up to the two ICPCs and the response to the smacking referral show how well the system can work.

4.5.3 Beth was a child until three weeks after Reece was born. However, there is little evidence, after the Initial and Core Assessment on transfer, that she was regarded as such. From the information provided to this review she seemed to have been seen as a troubled and struggling parent who would display challenging and sometime inappropriate behaviour, not a child with her own needs and vulnerabilities aside from being a new mum. She confirmed this to the review. She felt that as soon as she had Ollie the focus of all provision was on her as a parent only, not the child she was.

4.5.4 Her vulnerabilities as a child crossed over into her struggling as a parent but her own needs were never set out in the latter years, leading to a lack of understanding that the risks to herself were creating some of the difficulties transferred to her children.

4.5.5 Beth very confidently express her views and opinions and these would be listened to. Her mother took the same opportunities. However, some of the more intractable problems such as her parenting, relationship with her mother and her apparent lack of engagement could have been explored with her further to really understand her underlying wishes and feelings.

4.5.6 While she could in no way be described as being lost in the system, her childhood was. The choices she made about her own care and the services there to support her were respected. She was nearing adulthood, so in many circumstances this would be appropriate but while the impact of those decisions was rightly

considered as they would affect Ollie and Reece, little emphasis was given to whether they were detrimental to her own health or development or whether they would allow her to enjoy good outcomes. Additionally, little recognition was given to the possibility whether she was safe or being abused.

Recommendation 9

Southampton Children and Family Services should review its procedures, practices and supervision to ensure that young parents have their own needs as children recognised, assessed and supported rather than being seen as young adults who thereby fall outside of their scope, except as parents.

4.5.7 A theme throughout this review period was that Beth had a propensity to engage in relationships with older men and was at risk of child sexual exploitation. Whilst this was a very real risk, widely acknowledged, little was done in response to it. There were some police investigations, none of which resulted in anyone being charged. Beth was referred to Barnardo's for support but, other than that, no co-ordinated response took place.

4.5.8 While the understanding of the risk and prevalence of Child Sexual Exploitation has vastly improved over the last five years, from the chronologies, Beth was quickly identified as being at risk yet only an episodic response took place with no joint assessment or planning taking place to either protect her (or others) from harm or to pursue those exploiting her.

4.5.9 It was curious that the suspicions of Beth being subject to Child Sexual Exploitation and information that, as a fourteen-year-old, she was sleeping with a twenty-year-old man, were not considered as child protection issues, in that there is no evidence of any strategy discussion or section 47 investigation. The police were left to investigate but did not, as no full disclosure or complaint was received. This provides further evidence that Beth was not always regarded as a vulnerable child and the service she received reflected that.

4.5.10 Given the improvements that have been made nationally it is highly unlikely that the response today would be as patchy as it was when Beth should have been regarded at risk. She was seen by many – including herself - as being consensually sexually active as opposed to being abused and the police and other agencies' response reflected this erroneous perception. However, the LSCB should assure itself that procedures and practices mirror the expectations in its Child Sexual Exploitation procedures[21] and that such passivity would not happen now.

Recommendation 10

Southampton LSCB should assure itself that present day procedures and practices around Child Sexual Exploitation reflect a more proactive and responsive culture towards those deemed at risk of, or suffering from, CSE than in the period Beth was vulnerable to that and that the provision to potential and actual victims and the pursuit of offenders is effectively robust.

4.5.11 On a number of occasions, professionals smelt cannabis either in the home or on the clothing of those looking after Ollie. While these were noted, and sometimes challenged, they were never seen as a risk to the care of Ollie or Beth and the information was not raised in a multi-agency setting.

[21] http://4lscb.proceduresonline.com/southampton/p_ch_sexual_exploit.html

4.5.12 As previously discussed, the bruising to Ollie and Beth and the broken metatarsal that Ollie suffered did not trigger any concerns. It may well have been that the innocent explanations provided were correct (despite them being different in respect of Ollie's bruise.) However, they should have at least triggered some curiosity to satisfy professionals that physical abuse was not a factor in the family.

4.5.13 Because of the lack of recognition of what may be indicators of abuse or vulnerability, because events were reacted to on a case by case basis and because information was not checked or triangulated it is possible that this led to an over optimism that improvements were being made and the family were responding well, when in fact they were still struggling.

4.6 INFORMATION SHARING

4.6.1 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,'*[22] 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.

4.6.2 As previously mentioned, the communication between Hampshire and Southampton Children and Family Services, between the police and Children and Family Services, between Academy 2 and Children and Family Services were all strong. The same can be said of the information provided by the Community Rehabilitation Company to others.

4.6.3 However, elsewhere information sharing could have been improved. It has already been mentioned that CAMHS engaged with few, except Primary Care, and often that information was not passed on further. It is unclear whether this was because of an expectation that CAMHS themselves would have shared the information regarding Beth's care and engagement more widely but the fact remained that mostly it sat with either CAMHS or Primary Care.

4.6.4 In the referral letter from midwifery to Health Visitors, following Beth's booking in appointment regarding her pregnancy with Reece, while it contains a great deal of information, no mention was made that Ollie having been on a Child Protection Plan and then a CiN plan, nor were any concerns around Beth's parenting abilities or socio-economic circumstances. While this will have been known to the Health Visiting service, it is important information that should have been included given its relevance to Reece's post-natal care.

4.6.5 When spoken to for this review, it surprised the social worker that during the Health Visitor's opportunistic visit, Callum's step-mother raised concerns about Callum being overbearing and that Ollie carried Reece downstairs alone. Children and Family Services were aware of the visit but not what was revealed during it. It was also a concern that Health Visitors were not informed that Beth had moved out, nor again the following month when they had moved on once more, this time to their final address.

4.6.6 It seems that professionals are unable to rely on consistent information sharing. That is not something peculiar to Southampton, but had this been better, more would have been known about the success or otherwise of services being provided to

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

Beth and her family, key information which may indicate an escalation of need or even abuse.

4.6.7 In a multi-agency safeguarding and child protection system there can be a reliance on Children and Family Services to collate and manage all the information and plans. There can also be ambiguity around how, to whom and for what purpose information should be shared. Whilst 4LSCB have information sharing guidance as part of the multi-agency procedures, more clarity might be useful in setting information sharing expectations at an operational level.

Recommendation 11

That Southampton LSCB develop operational procedures to guide professionals on when, to whom, how and for what purpose to share information within the multi-agency safeguarding and child protection system so as to avoid ambiguity or misplaced expectations while ensuring that those managing any plan are in possession of all the appropriate material.

4.7 CHILD PROTECTION SYSTEM

4.7.1 The transfer from Hampshire came at a critical time in that Ollie was only two months old. The cracks in Beth's capacity and willingness to provide him with effective parenting were beginning to show and there had just been a sequence of Children and Family Services and police interventions which precipitated intensive support. The transfer process seemed to have been effective and in accordance with procedures and, despite the initial decision that Ollie did not meet the threshold for being a Child in Need, this decision was reversed and all three children in the household were made Children in Need.

4.7.2 It is not expected that a receiving local authority will always agree with the previous authority so no criticism can be levelled at that initial decision. It is noteworthy that given the concerns of the social worker and the appropriate Initial and Core assessments the decision was reversed.

4.7.3 This quickly escalated when, given the concerns about Beth's mother's mental health issues and the frequent physical and verbal arguments between them, Ollie was made subject to a Child Protection Plan under the category of neglect. This was a swift and robust response to an emerging situation and he remained on the Plan until November the following year. It was puzzling that, given the concerns around her being sexually exploited, Beth was not made subject of a Child Protection Conference leading to a Child Protection Plan.

4.7.4 Ollie's plan itself seemed to be robust, with substantial contributions to its development by Beth and her mother. However, because of the format of the RCPC notes, it is not possible to discern how the plan was progressing, what impact its various elements were having or the level of engagement with it. While it is likely the plan was tested in the review conferences, there is little evidence of that happening. The review has been told that the format has now changed for this very reason, and it is now possible for chairs to track the impact and outcome of the whole or any part of the plan.

4.7.5 That said, from other documents it is clear that after the first RCPC conference, the plan was not progressing well typified by a lack of engagement, although Ollie was meeting his milestones. As discussed, a parenting assessment had still to be carried out. At the second RCPC, there were still clear risks identified including volatility and poor school attendance.

4.7.6 It has already been mentioned that there was a worrying lack of information regarding key events discussed at Child Protection Conferences and Core Groups. It seems that either the information was not available, which is unlikely, or that

it was not considered to be indicative of changing risk which is concerning. The facts of police calls, bruising and fractures are entirely relevant at child protection meetings but there is no record of them being considered.

4.7.7 Conversely, the child protection response to the incident where it was alleged that Harry had pushed Ollie off the bed, and the ongoing concerns surrounding the breakdown in the relationship between Beth and her grandmother, with whom she was living, was swift and effective. Although no criminal offences were identified or investigated, a strategy meeting led to a joint decision that Children and Family Services would continue the investigation on a single agency basis. This led to an ICPC.

4.7.8 At that conference, there was a wealth of information from all agencies (except CAMHS who appear not to have been invited), with risks being clearly articulated and agreed. While Beth and her mother disagreed, the Conference professionals unanimously agreed that Ollie and the UBB (Reece) be made subject of Child Protection Planning under the category emotional abuse.

4.7.9 Between the ICPC and the RCPC, Beth's engagement with agencies continued to be sporadic, she was suffering from low mood and she split up with Harry, believed then to be Reece's father.

4.7.10 At the RCPC, to which few attended, the information provided appeared positive but the problems with engagement were not noted. The decision that both Ollie and Reece be stepped down to Child in Need was unusual, possibly overly optimistic.

4.7.11 The period between them being made subject to a CPP and being stepped down was less than three months. There had been one Core Group (a week after the ICPC) to which PACT, Housing, Family Foundation Worker, CAMHS, peri-natal mental health and community mental health were either not invited or did not send their apologies. Beth's housing arrangements had already broken down, the social worker had been on leave so had not visited (although she did before the RCPC) and a new Health Visitor and new referrals were just being put in place.

4.7.12 The independent chair of that RCPC expressed to the review her huge frustrations over the poor attendance, absence of information and that mainly, only very positive aspects of the previous three months were aired. She noted that, in this case, three months was an overly short time period in which to review the issues that led to the plan, despite the requirements of Working Together to Safeguard Children 2015[23] (and the revised 2018 version) and 4LSCB Child Protection Procedures.[24]

4.7.13 The key factor was that parenting capacity and capability had been an ongoing concern. As yet, Reece had not been born so, whatever green shoots may have been perceived they could not be shown to be sustainable and still no parenting assessment had been carried out. There is no suggestion that anyone felt the family could function without a co-ordinated plan but it was suggested that should be a Child in Need plan. A longer period of monitoring, certainly until after Reece's birth, would have provided greater confidence that this family really had turned a corner after many years of problems and interventions.

4.7.14 In respect of Reece, nothing could have convinced professionals that Beth's parenting of him would be effective, as he had not been born, yet the conference had to be held within that period. This seems unnecessarily inflexible and may have compelled the RCPC to come to a decision, despite having little information and no real signs of improvements.

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[23] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

[24] http://4lscb.proceduresonline.com/southampton/p_ch_protection_conf.html

Recommendation 12

Southampton LSCB, in conjunction with the Association of LSCB Chairs should consider whether the statutory fixed three month time period between Initial Child Protection Conference and the first Review Child Protection Conference is appropriate and whether to lobby the Department for Education for the introduction of some flexibility especially in the cases on unborn babies.

4.7.15 This RCPC was quorate but arguably, with this number of key absences, was ineffective. The Child Protection Procedures guide on the steps to be taken if the conference is inquorate but not if, in the view of the chair, it is likely to be ineffective given absences and missing information. The impact of this is that chairs do not feel empowered to postpone a conference even though only the bare minimum of professionals are present. This is especially in light of the three month (or six months for second and subsequent RCPC) time limit.

4.7.16 There seemed to be a powerlessness in holding agencies to account who do not attend Child Protection Conferences or provide information to them. The next conference date is always included in the minutes and acts as an invitation. Either this was missed or the conferences were not prioritised by professionals. Whichever, the escalation process to hold agencies and professionals to account was not clear.

4.7.17 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.

4.7.18 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.

4.7.19 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.

4.7.20 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 13

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.

4.8 HOUSING

4.8.1 Although Beth was a child herself during most of this review period, her relationship with her mother, while sometimes good, was peppered with discord and, sometimes, violent arguments. It must have been very upsetting for them both as they clearly wanted to make their relationship work and both had Ollie's interests at heart.

However, given the clashes which are narrated throughout this report, a healthy and sustainable arrangement which involved them living together was unlikely.

4.8.2 As a consequence, Beth's housing arrangements were chaotic. Following arguments, she would often leave the house, sometimes with Ollie sometimes without, on occasions making herself homeless. She reacted particularly strongly to her mother's relationship with Callum, a man who would later become her own partner. She stayed with a number of relatives including her grandmother and Callum's step grandmother. These arrangements were also not without their problems due to conflict, an allegation of theft and concern over the treatment of Ollie by Harry (Beth's then partner).

4.8.3 Beth presented twice as homeless to housing services. On the first occasion she was placed, with Ollie in emergency bed and breakfast accommodation.

4.8.4 The Statutory Guidance '*Provision of Accommodation for 16 and 17-Year-Old Young People Who May be Homeless and/or Require Accommodation'* (2010)[25] is clear that *'Bed and breakfast accommodation is not considered suitable for 16 and 17 year olds even on an emergency accommodation basis.*' Further, it states, *'For teenage parents it is particularly important that they are provided with accommodation which gives them the holistic support they require to meet their individual needs and improve their outcomes.'*

4.8.5 Beth was 16 when placed in bed and breakfast. She was evicted the following day due to reports of disruptive behaviour. Even though this was not intended to be a long-term arrangement, she should never have been placed there. Upon her eviction, she moved back home yet presented as homeless again the following month.

4.8.6 Children and Family Services were notified of the bed and breakfast accommodation but there is no record whether anything was actually done about either the inappropriate placement or the change in circumstances.

Recommendation 14

Southampton housing commissioners and providers should assure themselves that the expectations within *'Provision of Accommodation for 16 and 17-Year-Old Young People Who May be Homeless and/or Require Accommodation' (2010)* regarding not placing young people in bed and breakfast accommodation and the specific support required for young parents is adhered to in every case.

4.8.7 Following the second presentation, an urgent referral was made to Chapter 1, a supported housing provider. This was appropriate in that there was a recognition that Beth needed support if she was to live independently. It was noted that she was pregnant with Harry's child (she later miscarried) and the change in circumstances was appropriately referred to Children and Family Services.

4.8.8 While suitable accommodation was being sought, Beth moved back with her paternal grandmother. It is not clear whether anyone assessed this as suitable for her and Ollie.

4.8.9 Beth was offered accommodation in Miriam House but she declined this so was removed from the homelessness list as she had refused reasonable and appropriate accommodation.

4.8.10 The statutory guidance *'Provision of Accommodation for 16 and 17-Year-Old Young People Who May be Homeless and/or Require Accommodation'* (2010) *(ibid)*, says *'In considering whether a duty under Part 7 (Housing Act 1996)[26] is owed*

[25] https://www.gov.uk/government/publications/provision-of-accommodation-for-16-and-17-year-olds-who-may-be-homeless-and-or-require-accommodation
[26] https://www.legislation.gov.uk/ukpga/1996/52/part/VII

to a 16 or 17 year old who has refused section 20 accommodation, it is for the housing authority to satisfy themselves in each individual case whether the applicant is homeless or threatened with homelessness. Authorities should not adopt general policies which seek to pre-define circumstances that do or do not amount to intentional homelessness or threat of homelessness.'

4.8.11 There is nothing to indicate that a Section 20 Children Act 1989[27] assessment was carried out nor that the Housing Authority did anything but adopt a general policy that predefined circumstances of intentional homelessness. Beth (and therefore Ollie), having refused accommodation were subject to a criterion-based decision rather than the needs-based one they were entitled to. Once again, Beth was treated as an adult, rather than a child with her own needs.

Recommendation 15

Southampton Children and Family Services together with housing commissioners and providers should ensure that the provisions of *'Provision of Accommodation for 16 and 17-Year-Old Young People Who May be Homeless and/or Require Accommodation' (2010)* and Section 20 Children Act 1989 are adopted to ensure that children in need are not refused accommodation on the basis of general and, otherwise, criterion based policies.

4.8.12 In Ollie's CiN plan it is said that *'Ollie's care has suffered especially during periods of relationship breakdown between his mother and his maternal grandmother. He is currently in a stable environment with his paternal great grandmother and his mother. Observations and reports of routines suggest that this is working well for Ollie at this time but a more permanent living arrangement is planned by the family. Beth (nearly 17) is too young to take on a housing tenancy and may not yet be ready for full independence with Ollie. Some of these things will be tested through this plan.'* This was appropriately optimistic at that particular time, and the recognition that a more sustainable solution needed to be sought, was wise.

4.8.13 When Beth eventually moved into Miriam House she lasted just ten days as she said that Ollie could not settle there. It is unclear what level of support she was given in Miriam House as Chapter 1 are no longer commissioned by Southampton City Council and, despite efforts, did not contribute to the review.

4.8.14 Following Reece's birth, Beth initially lived with her mother, then Callum's step-grandmother, then Callum's father before presenting as homeless once again. This time she was supported by her social worker. It was made clear (as it should have been the first time) that bed and breakfast accommodation was not suitable as Beth was still a child herself. It was decided that Chapter 1 would be approached to see if they could accommodate Beth, Ollie, Reece and Callum. Initially they were reluctant to offer accommodation as Beth had not managed in supported accommodation before. However, they did agree and all four moved in and Beth furnished the accommodation herself.

4.8.15 The accommodation the family moved in to was not supported accommodation but a step down facility. Its purpose was just to assess whether tenants could sustain a tenancy. Other professionals believed it was more than this and that Beth would receive help in developing her parenting skills while living independently. This was a significant oversight and assumption by all agencies involved in these discussions as, normally, only those who had succeeded in supported accommodation or similar would be placed there. Beth had not so was left hugely vulnerable by the lack of support available at the new accommodation.

[27] https://www.legislation.gov.uk/ukpga/1989/41/section/20

4.8.16 This death occurred at a time of supported housing contracts which made no specific mention of co-sleeping. Safeguarding issues were referred to more generally in the terms and conditions and the Quality Standards 'QAF' which required providers to have 'Protection from Abuse' policies and procedures in place, which were monitored.

4.8.17 The new housing related support contracts commenced in July 2017 and have more specific reference to safeguarding procedures, policy and training but do not reference co-sleeping specifically.

4.8.18 Despite their needs and housing history, no one actually visited and viewed that accommodation from a safeguarding perspective prior to Beth and her family moving in. There was no assessment as to its suitability to meet Beth, Ollie and Reece's needs (although Beth was an adult by now). No Children and Family Services visit was made between them moving in and Reece's tragic death. A Health Visitor visit was attempted but was unsuccessful as Beth had gone out.

Recommendation 16

Housing providers and Children and Family Services should ensure that, prior to vulnerable families moving into supported accommodation, an assessment is made as to the suitability and safety of that accommodation, and its fixtures, fittings and furniture, for the children and family concerned.

4.8.19 The way in which Beth's housing needs were addressed appeared fragmented and reactive to presenting, rather than enduring, needs. Very often family accommodation broke down for recurring reasons. Yet, rather like the lack of parental assessment, little was done to assess and address Beth's and Ollie's housing needs so that they could live in safe, supported accommodation where they could thrive.

4.8.20 Beth was particularly frustrated regarding this when she spoke to the review. She did not feel that any of her housing needs were properly considered or addressed and she was required to 'make do' in inappropriate housing.

Recommendation 17

Children and Family Services should ensure that, as part of child protection and child in need planning, where appropriate, a holistic housing assessment be undertaken so that the child(ren) subject of the planning are accommodated and supported to meet their needs on a long term basis.

5. Conclusions

5.1 This review has not found any factor that would necessarily have prevented Reece's death and its cause was not ascertained; neither the post mortem nor the inquest could be conclusive. The evidence pointed towards co-sleeping but Beth said this was not the case. If it was, the arrangements and furniture were entirely unsuitable for any baby let alone one in a family at such high risk.

5.2 The family were well known to a wide range of services and there was a genuine concern about them. However, their complexity and level of need stretched and tested the system. On too many occasions they were either allowed to disengage without support/ challenge. Beth and her mother's parenting capacity and capability were never properly assessed nor was Beth's housing needs, except at the very end of the review period, but this had questionable outcomes.

5.3 There were few specific concerns over Reece during his short life but plenty regarding Ollie and Beth and individual agencies worked hard to mitigate these.

However, Beth was rarely seen as a child with her own needs over being a parent or as a 'consensually sexually active' young woman. She was being abused by older men, her living arrangements were not conducive to a healthy upbringing of any child, let alone a young parent and she struggled as a consequence.

5.4 Despite examples of good practice, the child protection system was not always responsive enough to emerging concerns that sometimes arose directly after step down. Beth said she did not feel supported through it. It also was undermined by fragmented information sometimes leading to over optimism and the full picture being missed. The arrangements for Child Protection Conferences were not well served by the lack of flexibility and by agencies not prioritising them. Provision was not always followed up or its impact assessed. Records were absent regarding some interventions.

5.5 The housing provision was not suited to young vulnerable families with complex and, sometimes, competing needs. On occasions an inappropriate criteria-based approach was taken rather than a needs-based one which could have helped Beth and her children settle more sustainably.

5.6 The period reviewed covered five years during which there have been three iterations of Working Together to Safeguarding Children and regulatory inspections have taken place across all agencies leading to huge change. The professionals who contributed to this review recognised the shortcomings and demonstrated a determination to improve services so that families such this are supported and provided for better in future.

APPENDIX 1 – SCHEDULE OF RECOMMENDATIONS

Recommendation 1

That Southampton Children and Family Services ensure that arrangements for parenting assessments, particularly additional assessments, are clear and appropriately resourced so that social workers, managers and independent chairs understand how and when to access them, whether required through child protection plans child in need plans or any other social work provision.

Recommendation 2

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 3

That Southampton LSCB develops a multi-agency procedure to guide and support professionals in dealing with disguised compliance and resistant parents and carers.

Recommendation 4

Southampton LSCB should ensure that in multi-agency assessment, planning and delivery all agencies with significant and/ or substantial relevant involvement with the family and children concerned should become and remain actively involved so as to enhance the quality of provision across all aspects of need.

Recommendation 5

Southampton LSCB should introduce standards that ensure that, across the spectrum of multi-agency safeguarding arrangements, all relevant information is shared and considered so that ongoing risks and vulnerability can be assessed and understood. Further, that the outcome of services provided are critically evaluated in the context of the children and family concerned so as to avoid risks of repeating previous interventions which may have had little or no effect at the expense of accessing more promising provision.

Recommendation 6

Southampton Children and Family Services should enhance its Whole Family approach to social work so that, notwithstanding the differing status of various family members, at core groups and child protection conferences the collective picture can be shared and understood to aid effective multi-agency planning and delivery.

Recommendation 7

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.

Recommendation 8

Housing commissioners and providers should work together to enhance their understanding of, application of and engagement with the safeguarding and child protection system, especially when commissioning or providing accommodation for vulnerable children and young and vulnerable parents. This should include specific assessments of accommodation allocate to such clients.

Recommendation 9

Southampton Children and Family Services should review its procedures, practices and supervision to ensure that young parents have their own needs as children recognised, assessed and supported rather than being seen as young adults who thereby fall outside of their scope, except as parents.

Recommendation 10

Southampton LSCB should assure itself that present day procedures and practices around Child Sexual Exploitation reflect a more proactive and responsive culture towards those deemed at risk of, or suffering from, CSE than in the period Beth was vulnerable to that and that the provision to potential and actual victims and the pursuit of offenders is effectively robust.

Recommendation 11

That Southampton LSCB develop operational procedures to guide professionals on when, to whom, how and for what purpose to share information within the multi-agency safeguarding and child protection system so as to avoid ambiguity or misplaced expectations while ensuring that those managing any plan are in possession of all the appropriate material.

Recommendation 12

Southampton LSCB, in conjunction with the Association of LSCB Chairs should consider whether the statutory fixed three month time period between Initial Child Protection Conference and the first Review Child Protection Conference is appropriate and whether to lobby the Department for Education for the introduction of some flexibility especially in the cases on unborn babies.

Recommendation 13

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.

Recommendation 14

Southampton housing commissioners and providers should assure themselves that the expectations within *'Provision of Accommodation for 16 and 17-Year-Old Young People Who May be Homeless and/or Require Accommodation' (2010)* regarding not placing young people in bed and breakfast accommodation and the specific support required for young parents is adhered to in every case.

Recommendation 15

Southampton Children and Family Services together with housing commissioners and providers should ensure that the provisions of *'Provision of Accommodation for 16 and 17-Year-Old Young People Who May be Homeless and/or Require Accommodation' (2010)* and Section 20 Children Act 1989 are adopted to ensure that children in need are not refused accommodation on the basis of general and, otherwise, criterion based policies.

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