Nottinghamshire Safeguarding Children Partnership

A local child safeguarding practice review (LCSPR) commissioned under

The Child Safeguarding Practice Review and Relevant Agency (England) Regulations 2018

Tom (TN20)

Overview Report

June 2022

Index

1 Executive summary

1. Two-week-old Tom died on a sofa where his 44-year-old father was sleeping; his 30-year-old mother was asleep upstairs[1]. Tom lived with his mother and five older siblings aged between 12 years and 3 years old. Tom's parents were separated and never married. The family are white British. The paternal grandmother lived locally and is where Tom's father lived when not living with the family. Tom's father was employed. There is no record of religious affiliation.

2. Multiple and complex adversities confronted Tom's family living in a very deprived area[2]. The older children attended schools with good pastoral care and extracurricular support made available (although not used). The CIN, CPP[3] and MAPLAG[4] involved education, health and social care services in giving advice and help over several years.

3. Professionals were told at different times that the parents were separated although continued to have children who moved between two or more households when the father was not living with the mother. Just before Tom's death, the two eldest children had been living with their father at the paternal grandparent's home and the father had just secured a tenancy on a house. He told various professionals he would live with Tom's mother and the other children to "help out" after Tom's birth. According to both parents' accounts, after Tom died, Tom's mother had asked the father to stay overnight to care for Tom including feeding him because she was tired.

4. The review examines the involvement of the eight organisations listed in the appendix from October 2019 until Tom's death. The use of acronyms and other devices is kept to a minimum. Birth family members are referred to by their relationship to Tom such as mother, father, or paternal grandparent. Professionals are referred to by their job titles such as GP, health visitor, midwife, police officer, social worker or teacher.

5. The long history and knowledge about the family's circumstances and the fact that from birth Tom was seen as being at risk of neglect made safe sleeping advice from the midwives and the health visitor a priority

[1] Both parents were arrested on suspicion of causing the death of a child by overlay whilst co-sleeping under the influence of alcohol or drugs. The death was suspected to be linked to neglect as well as an overlay. They were subsequently charged and criminal proceedings were ongoing parallel to the review.
[2] 87.2 per cent of English post codes are less deprived than where the family lived. ONS Postcode Database http://geoportal.statistics.gov.uk/
[3] Child in need (CIN) and child protection plan (CPP).
[4] The Nottingham Multi Agency Pregnancy Liaison Group (MAPLAG) is a multi-agency forum of relevant professionals to share responsibility for decision making about the social and health needs of pregnant women and their families affected by drug and alcohol misuse.

who ensured that information was included during the pregnancy and following the birth. The pregnancy was discussed at the MAPLAG two months before Tom's birth. Safe sleep advice was provided with the knowledge that the mother struggled with alcohol and drug misuse and a safe sleep assessment was completed by the midwife following local and national professional guidance.

6. Father was absent from several of these discussions although was involved in the discharge planning following Tom's birth where safe sleeping was discussed. He remained influential in how the family's narrative was understood by professionals. Regarded as a 'protective factor' his difficulties with mental health and substance misuse were not disclosed even when asked directly implying a degree of control of professionals and of Tom's mother who did not contradict information. He was employed and appeared supportive of Tom's mother, telling children's services that the mother was reliant on him to care for the children when she drank or used drugs. Referrals had been made to domestic abuse services when the police had responded to incidents that occurred before the timeline of the review. There was no engagement and parental accounts of their relationship were accepted. The need for maintaining professional curiosity is an area of learning. The panel felt that there could have been more curiosity about the mother's drug use and mood appearing to be adversely affected when Tom's father lived in the house. It remains unknown if the domestic abuse was a reflection of coercive control or was reactive situational abuse[5]. The mother's adverse childhood experience and the fact that she did not hide her difficulties with substance misuse are thought to have influenced risk assessments that viewed the mother as trying to overcome her personal history with the support of the children's father and the family's circumstances of living in an area of high deprivation.

7. CGL[6] offered help and support to Tom's mother who declined it as she did with family support in early 2019. She did not consider her substance abuse a problem and asserted that she was controlling it. None of the professionals queried this at the time and focussed more on things that reassured them. Neither the MAPLAG nor the core group identified barriers to better levels of engagement.

8. A pattern developed of the parents responding enough for professionals to not escalate but not enough to feel they could disengage. The lengthy

---

[5] Johnson, M.P. (2008) A Typology of Domestic Violence: Intimate Terrorism, Violent Resistance, and Situational Couple Violence. The Northeastern series on gender, crime, and law. Lebanon, New Hampshire, US: UPNE cited in a Policy Briefing from Tavistock Relationships http://www.tavistockrelationships.ac.uk/images/uploads/policy_use/policybriefings/Situational_Couple_Violence_Nov_2016__FINAL.pdf

[6] Change Grow Live (CGL) provides the local substance misuse service.

CPP and the extended use of CIN and PLO before the review's scoped timeline are symptomatic of this. Tom's family needed longer-term support to help with the multi-faceted challenges that they faced. Relationship-based help that can be sustained over longer time horizons rather than episodic interventions is better if children's best interests are best served by remaining in the care of their parents.

9. The Nottingham City and County multi-agency safer sleep steering group has been working on developing and improving safer sleep policy and practice and developed a training package that incorporates learning from the National Panel's report[7] which is also reflected in this review.

10. Publication of the review was postponed until parallel proceedings were completed. Tom's parents were convicted of cruelty. The coroner provided a narrative conclusion that Tom died from positional asphyxia arising from unsafe sleep arrangements.

2 Focussed chronology before the incident of overlay and relevant context

11. Contact with safeguarding services began in the mother's neglected childhood. She was pregnant and gave birth to her first child aged 12 who was adopted. Child 1 was born when she was 18 and Tom's father was 32[8]. Mother's substance abuse was a focus of concern from the birth of Child 1 with short periods of engagement with specialist substance misuse services. Her mental health was poor although she was never diagnosed with a mental illness or disorder. Father also misused substances and had poor mental health; the panel agreed there should have been more curiosity and enquiry as to the impact of this. Domestic abuse included father's assaults on Tom's mother aggravated by alcohol or drug use. It received little attention in recorded risk assessment and professional discussion.

12. Child in Need (CIN) plans between March 2011 and July 2014 were stepped up to a child protection plan (CPP) until July 2017. During the CPP the public law outline (PLO) was used although proceedings were never issued in the Family Court[9]. At the time mother was thought to be

[7] The Child Safeguarding Practice Review Panel (2020) Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm. London: The Child Safeguarding Practice Review Panel https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

[8] Tom's father was not known to CSC before 2009. The relationship with mother had begun in 2007.

[9] The Public Law Outline (PLO) sets out the duties local authorities have when thinking about taking a case to court to ask for an order. The PLO sets out, amongst other duties that local authorities must ensure they identify concerns they have about a child early and where possible provide support for the

more engaged with counselling support and it was thought that her substance misuse had reduced. Tom's father was working away from the area and this appeared to have reduced the level of concerns.

13. In July 2018, further CIN plans were made following domestic abuse incidents and closed in November 2018. Further concerns led to a CPP in August 2019 before Tom's birth and remained in place when he died.

14. In April 2019 the Family Service[10] support was declined after several attempts. Following further incidents of domestic abuse and concerns about the mother's alcohol usage and mental health, a CPP was agreed upon in August 2019 under the category of neglect. Tom was included after his birth in June 2020. Although the parents told professionals that they planned to separate it was apparent that they continued to have a lot of daily contact and at the time this was seen as a positive effort to co-parent.

15. In early September 2019 mother asked CGL[11] for help with alcohol, cocaine and cannabis use. Support was offered but not taken up.

16. In late September 2019, the health visitor and the social worker in separate home visits were told by the mother of further domestic abuse; a DASH[12] that would have focussed on the domestic abuse was not completed with the mother. This would have enhanced multi-agency follow-up and support.

17. In early October 2019 mother's pregnancy with Tom was confirmed. The review CPC[13] in October continued the CPP believing both parents were open and honest and recognised there had been improvements in school attendance and home conditions. Residual concerns centred on the ambiguity about the parents' relationship and the mother's substance misuse. Less than a week later CGL ended their involvement; mother had not attended any scheduled contacts.

18. In late October 2019, the health visitor described the house as warm and "fairly clean" although the children were not dressed and needed a bath.

19. The specialist midwife's first visit included a routine enquiry about domestic abuse; mother disclosed being "a previous victim" but not the perpetrator's identity. She disclosed taking cocaine and alcohol

---

family to address those concerns. This is pre-proceedings work and it is often what is referred to when social workers talk about PLO. This process does not prevent urgent applications to the court if there is a risk of imminent and significant harm to the child.

[10] The targeted early help support service

[11] Change Live Grow substance misuse service

[12] Domestic abuse stalking and harassment risk assessment

[13] Child protection conference

asserting that she had cut down because of being pregnant. She described being depressed.

20. In November 2019 two of the older children were kept away from school because of no footwear; on another occasion three of the children were seen in a car without wearing seat belts or harnesses; one of the children was referred for additional behaviour support at school; there were reports of the mother being seen under the influence of alcohol for example when collecting the children from school. In late November 2019 mother told the SPHP[14] that she had been experiencing bleeding and had bruising. She said that she had attended a pregnancy scan at the hospital about the pregnancy and do not have a record of bleeding or bruising. The SPHP did not record any further exploration about the bruising to clarify whether she saw the bruises.

21. In January 2020 the MAPLAG discussed the pregnancy and mother's history of using alcohol and cocaine and involvement from several services. It is not recorded whether the CPP was discussed or how the MAPLAG linked to that and the work of the core group. Father was noted to be 'working and functioning'. No specific plan was recorded. A service manager or a representative should be present at all the MAPLAG meetings. Information should be shared both into and out of these meetings with relevant professionals which should include social workers involved with the families discussed.

22. The core group meeting in February 2020 discussed mother's "deteriorating mental health" and that CGL was not involved. The four older children were described as "having worries on their shoulders".

23. In late February 2020, an ambulance responded to an emergency call from mother who mistakenly thought she had begun labour. Although there was no imminent birth, Tom's mother had disclosed drinking an unspecified amount of alcohol. Although the ambulance crew spoke with the midwife there was no safeguarding referral about the mother being intoxicated.

24. In early March 2020 mother told the social worker that she "overdid it on alcohol and cocaine" at the weekend; the father was back living in the house. The mother described struggling with her emotions. This is an example of where the panel thought there could have been an opportunity for a more focused curiosity about domestic abuse and its impact on the children.

[14] Specialist public health practitioner based in the health family team was absent from work during the review and was therefore unavailable for discussions.

25. The review CPC in early March 2020 (not attended by the specialist midwife) confirmed a CPP would be in place from Tom's birth. A report was sent to the social worker however and after the ICPC the specialist midwife tried to speak to the social worker for an update on the 13th of March 2020.

26. In March 2020 the national lockdown required the family's self-isolation; the father continued living with the family. Contact with all professionals was by telephone. A core group discussed the mother's emotional and physical health being informed that the mother had stopped the CGL service having met "her own target of using cocaine once a month". She had self-reported that she was drinking 7-8 pints on a night out before the lockdown.

27. In late March 2020, Child 1 was offered five days a week access to the school Hub services for vulnerable children. Shortly afterwards the other younger school-age children were also offered school-based support.

28. The core group in late April 2020 heard that mother had told the social worker about a recent "blip" of drinking alcohol and taking cocaine. Mother was ill in bed so the father participated alone; he was seen as a protective factor for the children who had not attended school.

29. In early May 2020 mother told the health visitor about a relapse in using alcohol and drugs when she met up with friends. She wanted help; she was anxious and distressed. The information was discussed with the specialist midwife and GP. Tom's mother had also spoken separately to the social worker about this. It is not clear whether the relevant professionals discussed this information together or at the review child protection conference.

30. The review CPC in May 2020 continued the CPP. The parents did not participate. Mother was on anti-depressant medication (Sertraline), was continuing to use alcohol and cocaine and continued to decline contact with CGL.

31. The mother's misuse of substances continued to be the focus of core group discussion in early June 2020; mother said that she was using cannabis daily.

32. The pre-birth planning meeting in mid-June 2020 was held virtually without either parent who did not answer the phone-in invitation. Mother did not attend an appointment with the specialist midwife five days later and was followed up with the health visitor and social worker.

33. Tom was born full-term in June 2020. A discharge planning meeting included a discussion about safe sleeping which referred to the mother's previous history with an earlier child when she had fallen asleep holding

her baby. She was advised to sleep at night when Tom was asleep. Tom had no symptoms of withdrawal from opioids. The discharge plan included detail that the mother was going to sleep downstairs with Tom in a Moses basket. Father would stay at the house.

34. Tom's mother told the health visitor after returning home with Tom that she would bottle feed in the evening to allow her to smoke a cannabis joint. She was also continuing to take Sertraline which had been increased. Another midwife who was part of the same team completed a routine home visit on day two which included a discussion about safe sleeping with the mother; the father was in the house but remained in the kitchen and was not involved in any of the discussions. The social worker visited the same day and described the home as calm and clean and Tom was seen in the Moses basket.

35. Mother and Tom were seen in the postnatal clinic five days after his birth. Mother did not keep a scheduled GP appointment the following day. Mother participated in a virtual core group on day 8 when she reported all was good and acknowledged smoking cannabis.

36. The specialist midwife visited the home 10 days after Tom's birth and he was discharged from the service. Both parents were present. Tom's mother denied taking any substances but had safety plans if she decided to use them. Tom was gaining weight appropriately. The mother's mood was described as stable although she was understandably tired.

3 Application of relevant research, policy and other reviews

37. The sudden unexpected death in infancy (SUDI), also referred to as sudden infant death syndrome (SIDS)[15], remains a leading cause of infant mortality in the UK despite the significant reduction in cases from ongoing public health campaigns promoting safer sleep. The majority of SUDI cases in the UK occur in unsafe sleep environments and predominantly in families from deprived social and economic backgrounds as reflected in Tom's death.

38. National Institute for Health and Care Excellence (NICE) Guidelines for postnatal care originally published in 2014 and updated in April 2021[16]

---

[15] When a baby dies suddenly and unexpectedly this is referred to as Sudden Unexpected Death in Infancy (SUDI). Around half of the 600 sudden infant deaths in the UK each year can be explained by a post-mortem examination. Deaths that remain unexplained after that are usually registered as Sudden Infant Death Syndrome (SIDS), for which there is no known cause. The acronym SUDI is problematic for unexplained deaths as it is commonly used for 'unexpected' deaths some of which will be explained.

[16] National Institute for Health and Care Excellence. Addendum to clinical guideline 37, Postnatal Care: Routine postnatal care of women and their babies. UK: National Institute for Health and Care Excellence, 2014. Postnatal care. NICE guideline Published: 20 April 2021 www.nice.org.uk/guidance/ng194. Page 20/21 suggests that at the 6-8 week check GPs should discuss

recommends that parents should be made aware of the associations between co-sleeping and SUDI and be informed that the risks from co-sleeping may be greater when parents smoke or consume alcohol or drugs, or where babies are born with low birth weight or premature. This reflects the practice shown by midwifery and health visiting services in this case.

39. Factors associated with an increased risk of SUDI;

    a) Unsafe sleeping positions (parents are advised to always place their baby on their back to sleep and not on their front or side);
    b) Unsafe sleeping environment; (co-sleeping particularly after alcohol or drugs have been consumed, is a significant risk and is a factor in this case[17]; overwrapping, soft or second-hand mattresses);
    c) Smoking; during pregnancy and environmental exposure; (both parents smoked but no recorded observations about the home)
    d) An unsafe sleeping environment with particularly high-risk circumstances being co-sleeping (particularly on a sofa), temperature and overwrapping, bedding and mattresses, keeping head uncovered; Tom died on a sofa where the father fell asleep;
    e) Use of alcohol or drugs during pregnancy; (very high levels of consumption and father's was not disclosed)
    f) Poor antenatal care (inconsistent engagement in this case);
    g) Low birth weight (under 2,500kgs) and pre-term (less than 37 weeks were not a factor in this case).

40. The National Panel's SUDI report[18] refers to evidence from the supporting literature review that identified a variety of reasons why parents do not act upon advice and information; this included disrupted routines such as sleeping at a different property or not considering the advice to be relevant to them. The research shows that reliance "solely

---

with parents safer practices for bed sharing, including: • making sure the baby sleeps on a firm, flat mattress, lying face up (rather than face down or on their side) • not sleeping on a sofa or chair with the baby • not having pillows or duvets near the baby • not having other children or pets in the bed when sharing a bed with a baby. Strongly advises parents not to share a bed with their baby if their baby was low birth weight or if either parent: • has had 2 or more units of alcohol • smokes • has taken medicine that causes drowsiness • has used recreational drugs.

[17] Blair, P. S., Sidebotham, P., Evason-Coombe, C., Edmonds, M., Heckstall-Smith, E. M., and Fleming, P. (2009). 'Hazardous co-sleeping environments and risk factors amenable to change: case-control study of SIDS in south west England'. *BMJ, 339, b3666.*

[18] The Child Safeguarding Practice Review Panel (2020) Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm. London: The Child Safeguarding Practice Review Panel

on giving information is unlikely to produce meaningful change in this group". They describe parents who treated the advice as "a list of options" from which to choose the ones most appropriate to their circumstances. The research finds that parents give greater credence to advice and information from a trusted source such as a partner or peer or family member rather than a professional. They also identify that parents do not respond to advice that is couched as a list of do's and don'ts or they perceive it to be condescending and lecturing in tone. It has not been possible to speak with the parents about how they experienced the process of being advised about safe sleep.

41. There is an overlap with other sources of risk such as abuse and neglect which is reflected in this case and the findings of the national panel's report.

42. The neglect of children is the most prevalent form of abuse and also presents the greatest challenge for assessment, intervention and presenting evidence to courts. Children are neglected in very different ways and include failure to:

    a) Meet basic physical needs physical home conditions such as "fairly clean" although damage to the fabric of the house such as holes to internal doors was not recorded by all of the relevant services and the cause unknown (and the implications for example of domestic abuse given the history);
    b) Access to appropriate health care (mother missed some midwifery appointments and scans, flu vaccination and vaccination appointments for the children);
    c) Meet emotional needs (evidence of neglect recorded in school and health overview);
    d) Ensuring adequate supervision (evidence that it was not consistent);
    e) Provide appropriate cognitive stimulation [19](the developmental delay was identified in younger children).

43. Factors contributing to effective work with families experiencing higher levels of difficulty and adversity include:

    a) A dedicated worker; the health visitor and schools were the most consistent professional contact;
    b) Practical hands-on approach; family support was declined in April 2019 and was not available after Tom's birth;
    c) A persistent, assertive and challenging approach; contradictory information and evidence were accepted at face

[19] Horwath. J, 2007 Child Neglect: Identification and Assessment Palgrave Macmillan

value in this case and insufficient sustained change occurred as a result of CPP and CIN;

d) Considering the family as a whole; the complex and multiple needs and difficulties facing the family were not formally assessed and the intervention of different services could have been more consistently co-ordinated;
e) Common purpose and agreed action; further complicated by Covid in this case[20].

44. Disadvantaged and vulnerable families tend to be less likely to engage with sources of help. They are often underrepresented in services other than at the highest levels of statutory involvement such as child protection. Things that help increase engagement include:

    a) Designing service delivery around the needs of a targeted population;
    b) Considering intervention characteristics that are the best fit for the intended participants;
    c) Ensuring people working in the services have relevant skills, experiences and characteristics that promote a strong therapeutic alliance between practitioner and participant[21].

45. Adverse childhood experience (ACE) describes things that cause harm during childhood and into adulthood. It includes abuse from neglect, domestic abuse in the household, mental illness and problematic substance abuse of a parent or carer.

46. Adults who have experienced significant ACEs in their childhoods are more likely to present with a range of needs and difficulties such as poor learning and employment history, illness and substance abuse which can influence how they meet the needs of their children which can bring them into conflict with people and services focussed on safeguarding children. Interventions have to develop responses that can help adults address the impact of an adverse childhood experience and prevent children from suffering harm. This has implications for how assessments of parents and children are completed and for encouraging greater curiosity and routine enquiry by people such as primary health care professionals.

47. The findings of the national panel's review of SUDI identify the need for local services to recognise a continuum of risk with support and interventions that are differentiated according to the needs of all families;

[20] Working with Troubled Families a guide to the evidence and good practice (2012) DCIG

[21] Pote. I et al, Engaging disadvantaged and vulnerable parents. An evidence overview (2019) Early Intervention Foundation

families with additional needs and families such as Tom's who are at risk of significant harm[22].

48. Depression and substance misuse are significant health problems associated with domestic abuse, particularly for women. Notably, in studies, the experience of domestic abuse is strongly and consistently associated with both depressive disorders, substance misuse and self-harm. Some research studies put the number of women mental health patients being subjected to domestic abuse as high as 69 per cent[23].

49. Domestic abuse can be associated with poverty[24], poor mental health[25] and substance abuse all of which contribute to a continuing cycle of abuse. Domestic abuse starts early in relationships, especially during pregnancy when domestic abuse becomes a repeated act. All domestic abuse harms adults and child victims irrespective of whether the behaviour is situational or reactive domestic abuse or more insidious coercive control[26]. Victims, children and adults, face multiple barriers to disclosing domestic abuse and are reluctant to seek the help of police and health services. The control of the narrative for influential professionals can be a manifestation of control and coercion which combined with euphemistic language such as 'conflict' or victim-blaming and a mother being afraid of losing her children can be powerful barriers to understanding the extent, nature and impact of domestic abuse.

50. Children can experience domestic abuse directly and indirectly; hearing the abuse, seeing injuries and parental distress, being hurt trying to stop abuse and experiencing a reduced quality of emotional and physical parenting. Research shows that children have a poorer attachment, development, educational attainment and mental health[27]. They can

---

[22] The Child Safeguarding Practice Review Panel (2020) Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm, London, HMSO, p 8.

[23] Khalifeh. H, Moran. P, Borschmann R, Dean. K. (2014) Domestic and sexual violence against patients with severe mental illness, Psychological Medicine, Volume 45, Issue 4 March 2015 , pp. 875-886

[24] Eldin, F. et al, (2016) Evidence and policy review: Domestic violence and poverty A Research Report for the Joseph Rowntree Foundation University of Bristol School for Policy Studies

[25] Campbell J, Laughon K, and Woods A. Impact of intimate partner abuse on physical and mental health: how does it present in clinical practice? In Intimate Partner Abuse and Health Professionals: New Approaches to Domestic Violence (eds G Roberts, K Hegarty & G Feder): 43–60. Elsevier, 2006.

[26] It has been proposed that two distinct forms of intimate partner violence exist: intimate terrorism and situational couple violence. Most women who experience physical assault also experience controlling behavior by their male partner. See for example Frye, V et al 2006 The Distribution of and Factors Associated With Intimate Terrorism and Situational Couple Violence Among a Population-Based Sample of Urban Women in the United States available at https://doi.org/10.1177%2F0886260506291658

[27] Holt, S., Buckley, H. and Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: a review of the literature. Child Abuse and Neglect, 32(8): 797-810. Stanley, N. (2011) Children experiencing domestic violence: a research review. Totnes: Research in Practice. Szilassy, E. et

present with aggression and challenging behaviour, depression, anxiety, mood changes, difficulties in interacting with others, withdrawal and fearfulness[28].

51. Children benefit from having good school experiences to help develop their resilience and to cope with stressors. A sense of being connected or belonging to a school is a significant protective factor for children that is well supported by research[29].

52. Evidence from other reviews nationally where children are neglected reveals the complex way in which links between domestic abuse, substance misuse and poverty are often interdependent and that addressing a single issue will not deal with underlying causes or other issues. Complexity and cumulative harm are almost invariably a feature of families where children experience neglect[30].

4 Single agency learning and conclusions

53. The poor sleeping practice at the time of Tom's tragic death was despite advice and information given by the midwife and health visitor in particular. The midwifery and health visiting services followed recommended good practice in giving information about safe sleeping. The difficulty in following advice combined with other information about potential safe sleep risk factors in the household and the history of maternal substance misuse and poor mental health was recognised and prompted the pre-birth referral to the MAPLAG. It did not produce a plan of action with the parents or between services.

54. The safer sleeping risk assessment tool[31] did not at the time encourage consideration of cultural and socio-economic conditions or history of

---

al (2017) Making the links between domestic violence and child safeguarding: an evidence-based pilot training for general practice. Health and Social Care in the Community, 25(6): 1722-1732.

[28] Diez, C. et al (2018) Adolescents at serious psychosocial risk: what is the role of additional exposure to violence in the home? Journal of Interpersonal Violence, 33(6): 865-888; Early Intervention Foundation (2018) Why reducing parental conflict matters for the NHS. London: Early Intervention Foundation.

[29] Resnick, M D., Bearman, P. & Blum, R. (1997) Protecting adolescents from harm: Findings from the Longitudinal Study on Adolescent Health. JAMA, 278(1), 823-832.

Local action on health inequalities: Building children and young people's resilience in schools (2014) PHE and UCL Institute of Health Inequality https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/355766/Review2_Resilience_in_schools_health_inequalities.pdf

Bond, L. et al (2007) Social and school connectness in early secondary school as predictors of late teenage substance use, metal health and academic outcomes. Journal of Adolescent Health 40(4) 9-18.

[30] Brandon. M, et al Complexity and challenge: a triennial analysis of Serious Case Reviews (SCRs) 2014-2017 Final report March 2020

[31] https://nscp.nottinghamshire.gov.uk/media/vxwfxywc/safer-sleeping-risk-assessment-tool.pdf

poor sleep practice in earlier births or neglect. The toolkit did not encourage checking that the family understood the advice and explored what might prevent them from following it. It did not encourage professionals to be curious and observant and to not rely just on what they might be told. Copies of the safe sleep assessments from the patient health care record (PHCR) were not incorporated into agency records; however, a copy of the assessment was left with the parent in the PHCR and a copy of the safe sleep leaflet was provided before the mother's discharge from the hospital. The recording of safe sleep advice and information by the midwife who visited on day 5 did include routine questions about safe sleep as well as parents' use of alcohol and drugs. There is no carbonised copy of this in the records held by the midwife due to the fact these are electronic. The safer sleep assessment has already been revised by the task and finish group responding to the National Panel's SUDI report[32].

55. Safe sleeping was primarily treated as an issue for health professionals to deal with. There is limited recording for example by CSC about the sleeping arrangements. Recorded information suggests health and social care professionals did not routinely see the upstairs of the property and therefore where the children were bathing and sleeping. On the day that Tom died there was variation in the description of the home conditions. A health professional described clutter but also found bedding in all of the bedrooms, evidence of hygiene practices such as toothbrushes, soap and shampoo in the bathroom, fresh food in the fridge and a steriliser for Tom's bottle. Prescribed medication was appropriately stored out of reach of the children. In contrast, a police officer who was at the home on the day that Tom died also described clutter but also remarked upon sparsely decorated bedrooms for the children and beds that did not seem to be very clean or have enough bedding.

56. Tom's mother's anti-depressant medication was increased in June 2020 by the GP at the request of the midwife. Neither service recorded any assessment in respect of safe sleeping implications and was not factored into the safe sleeping assessment or MAPLAG discussion. There was minimal contact between the family and the GP during the scoped timeline. Although there were examples over several years of the siblings missing an appointment there were no patterns or triggers for the 'was not brought' to appointments process reflected in the NCSCB

[32] The Child Safeguarding Practice Review Panel (2020) Out of routine: a review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (PDF). London: The Child Safeguarding Practice Review Panel https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/901091/DfE_Death_in_infancy_review.pdf

animation[33]; a chronology could have helped identify patterns and therefore be better reflected in an overall statutory assessment.

57. Although the GP practice had information about the mother's long history of substance misuse and poor mental health there is no record of domestic abuse. The GP was not included in the MAPLAG discussions and was unaware of the history of illicit drug misuse in the household. The GP practice was aware of the pregnancy and the history of CPP and CIN. MAPLAG minutes should be shared with the GP.

58. The school provided a safe place for the children to be encouraged to talk about their circumstances and attended breakfast clubs and were aware of domestic abuse. This helped schools to understand the complexity of the children's lives although the older children became warier.

59. Routine inquiry about domestic abuse recorded by the specialist midwife did not produce disclosures over and above the mother acknowledging historical abuse without clarifying the perpetrator. The social worker also recorded asking about conflict and disputes. A reluctance to talk about domestic abuse is not unusual reflecting many complex barriers for victims. When Tom's parents did talk about their relationship they normalised and minimised the impact on the children. Fear of children being removed into care is not uncommon when safeguarding concerns are being raised and can influence how women in particular frame or discuss any experience of abuse.

60. Tom's mother told the SPHP in September 2019 that she was not in an intimate relationship with Tom's father which remained 'volatile'. In the same discussion, she talked about her plans for a substance binge on her birthday. There is no record of further exploration of domestic abuse and the potential link between the mother's substance misuse and low mood. In November 2019 when the SPHP was told by the mother about bruising and bleeding there was no exploration about the cause of the reported bruising or whether the bruises were seen rather than just reported. The hospital has no record of seeing bruising when they saw her. The RCPC in March 2020 recorded no recent or new domestic abuse incidents since the start of the CPP. Although the school observed the parents arguing it was not considered to be abusive but rather just how they interacted with each other.

61. The substance abuse service collated a great deal of information about Tom's mother's history in 2016 and during the assessment in 2019, she reported being separated from Tom's father, declined further exploration about risk from abuse and disengaged from the service shortly

[33] The animation was produced by Nottingham City Safeguarding Children Board who shared with NSCB

afterwards. The correlation between substance misuse and poor mental health with experience of domestic abuse is a significant factor identified in research and DHRs.[34] The substance misuse service made efforts including a home visit to encourage the mother's involvement with the service. The significance of her declining contact was not discussed as part of multi-agency core groups or in the MAPLAG and professionals seemed to accept the variation of engagement as the way things were in this family.

62. The assessment completed by CSC[35] before Tom's birth acknowledged the complex history although along with other professionals it did not explore father's history or reveal his substance abuse and which is significant given the weight given to him is a source of positive support for the family. The social worker appeared to spend time with the children and parents although the recording lacked detail and analysis. For example understanding how the family's circumstances were experienced by each of the children, the parental relationship including domestic abuse or the cumulative pattern of ACE from the mother's childhood into her children's lives.

63. An earlier psychiatric assessment commissioned by CSC identified mother's unstable personality traits, problems with control of her emotions and poor coping skills. Although not diagnosed with a personality disorder the significance of understanding what might be contributing to a parent's behaviour is important. As an example, an emotionally unstable personality disorder can cause a wide range of symptoms which include emotional instability, disturbed patterns of thinking, impulsive behaviour and unstable relationships. The unstable personality traits were not explored in the record of assessment.

64. Other professionals had relevant information. For example in October 2019 the core group was told about three red cards issued at school for Child 1's assaults on other children and was subject to a behaviour plan, Child 2 and 4 were working below expectations despite improving their school attendance; Child 5 had delayed speech and toileting. An adult needs assessment completed by the health visitor in October 2019 recorded the mother's poor physical presentation with cuts and scabs on her face and hands; the children were unkempt and dirty. In November 2019 during therapeutic play at school Child 1 stated they were not 'proud of anything'. Child 2 could not identify a person they loved. A health visitor's environmental risk assessment in November 2019 recorded the property had few internal doors and those that remained had holes punched into them.

[34] Domestic homicide reviews

[35] The social worker could not be interviewed or join other discussions as part of the review

65. The CSC assessment concluded that Tom was 'sufficiently safeguarded' as part of the child protection arrangements. It has not been possible to explore this further in the absence of discussion with the social worker. Given the evidence that was discussed for example at the MAPLAG and the uncertainties for example about the parents' relationship, it is difficult to understand how 'sufficient safeguarding' could have been achieved. The social worker wanted to involve a family support worker although this was not possible because the service could not allocate a worker. It is not recorded if it had been discussed with the mother who had declined to have family support in early 2019.

66. The circumstances of Tom's siblings had been the subject of discussion under the PLO process as a precursor to opening proceedings in the Family Court. Those discussions had concluded that the threshold for the children to be removed from the home was not met. Some professionals were concerned as to whether changes were sustainable such as when the decision was taken to step down the CPP in 2018. The panel agreed that there was learning for professionals in providing professional challenges as part of effective safeguarding work with children. Services did not use the neglect tools or frameworks available on the safeguarding partnership's website[36].

67. After the lockdown restrictions were imposed in March 2020 and for example core groups became virtual contacts there was less contact with the mother.

5 Partnership learning and conclusions

68. National studies describe the importance of good quality relationships with families as the primary requirement for effective safeguarding practice. The triennial review in 2016[37] outlined the importance of moving from episodic incident-based interventions to more extended models of support that are rooted in a cumulative perspective on safeguarding needs and are informed by a historical understanding of family patterns including how services are used.

69. This means having the right people with the time and aptitude who are well supervised and supported and can develop effective relationships with parents whose lives are complicated and complex. Many factors combined with cumulative harm such as ill-health, substance misuse, poverty, criminality, and domestic abuse create the latent conditions for inconsistent and ineffective parenting.

---

[36] https://nottinghamshirescb.proceduresonline.com/local_resources.html and https://nscp.nottinghamshire.gov.uk/resources/for-professionals-and-volunteers/

[37] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final Report 2016

70. Parents who have a poor experience of professionals rooted in their childhood experiences which combine with potential psychological damage such as emotionally unstable personality traits can create the conditions for avoidance strategies with professionals that block communication or trivialise the significance of actions or information such as safe sleeping.

71. The co-existence of poor physical and mental health, substance misuse that can be denied or minimised, poverty and domestic abuse are factors that contribute to inconsistent parenting and disorganised lifestyles. It leaves parents with difficulty in controlling their emotions and problems for the parent in providing adequate emotional care for their children. It is why good history is important in assessment.

72. A good longer-term relationship with families is the primary pathway for protective practice so long as it is based on a sound grasp of the family's history, circumstances, roles and relationships that can find a way of addressing complex and cumulative risk. Parents with negative experiences will perceive practitioners asking questions as trying to blame or not 'hear' information or being filtered out and agreements not understood.

73. In this case, there was a tendency for professionals to seek reassurance and to be optimistic, counteracting the required balance between robustness and compassion. Longstanding and cumulative adversity becomes overwhelming for families and for those people trying to help. Conscientious people concerned about the level of mother's drug abuse for example sought reassurance without enough challenge. The relatively recent PLO process that had not resulted in any escalated action was a potential influence on subsequent judgments about what was good enough.

74. Using jargon or stock phrases can be a way in which professionals wrestle with compassion on one hand and uncertainty about whether harm is being done. The language used to discuss the circumstances of children and to communicate between different people can either clarify or make it more opaque. A 'volatile relationship' can be a euphemism for abuse. Some services such as CSC had less detailed recordings at times about the condition of the children and their home compared to other people. There was a notable difference for example in the police officer's description of the home on the day that Tom died which included reference to holes punched in walls compared to the apparent absence of concerns from other professionals who had visited the home describing it as 'acceptable' and at other times 'good'.

75. Tom's mother did not hide her substance misuse or low mood, reassuring various professionals that her use of substances was lower

and more controlled than was the reality. The father's mental health and use of substances were not known despite the parents being asked routine questions as part of the safe sleep assessment. He was accepted as a counterbalancing source of resilience and support. Some services such as the hospital assumed that CSC would have sought information as part of assessments; the social worker did seek this information as part of the assessment with the family.

76. The parents' apparent acceptance of advice and help and their acknowledgement of sources of risk convinced professionals they had strategies for mitigating the risk from issues such as the mother's drug use. In hindsight, some judgments were based on misplaced assumptions and information about both parents' difficulties with poor mental health and substance misuse. Mother was asked routinely about domestic abuse by the midwifery team and disclosed none; women who are in abusive relationships face multiple barriers to disclosing such information. Although there were no disclosures or third-party reports to the police during the timeline of the review domestic abuse could have been further explored by different professionals given the relationship history, observed damage to the family home, the co-existence with poor mental health and substance abuse.

77. Reasons for not wanting family support when it was offered or help from substance misuse services could have been clarified with more purposeful curiosity. It influenced how specific measures such as safe sleeping assessments were completed. There was not a collectively agreed and effective enough assessment of risk and protective factors.

    a) **Safe sleeping is an issue for services broader than health visiting and midwifery;** recognising the danger of co-sleeping has implications for any services visiting homes with infants under 12 months old; this would include any of the emergency services who may visit in response to calls for service or providing safety inspections such as the Fire and Rescue Service for smoke alarms or landlord services undertaking routine repairs or visits; substance misuse services ensuring that safe sleeping is routinely discussed as part of contact with pregnant women; prescribing of medication that can have a sedative effect has implications for prescribing and monitoring practice by GP and substance misuse recovery services; early help assessments including specific sections about sleeping arrangements or general living conditions; the importance of observation and recording by social workers and other social care staff.
    b) **Seeing and recording the world as seen through the eyes of children;** the compelling picture of neglect captured in the review evidence and how it impacted each

of the children is not reflected in recording and assessment; neglect in very young children has profound longer-term developmental implications; schools and school nurses will encounter behaviour and other evidence that needs exploring.

c) **Relationship-based practice; the importance of parents having an effective relationship with key health and social care professionals; timely trauma-informed early intensive help**; intervention is likely to be more effective through a service that can allocate a dedicated worker offering consistent relationship-based, hands-on and practical help informed by a well-informed assessment, considers the whole family and brings common purpose and action; parents who have experienced trauma or instability or abuse in their childhood are likely to display difficulties in how they respond to and understand the needs of their children; this can manifest itself in many ways including disorganised parenting, putting their own needs before that of their children, emotional unavailability.

d) **Domestic abuse in professional assessments and discussion;** insufficient curiosity about evidence of indicators of domestic abuse or to provide a good enough understanding of family life for the children; adults and children are often very reluctant to talk about domestic abuse for a variety of reasons; holes punched into doors for example that is not 'seen' by some services or the subject of any further inquiry[38]; the significance of coercive control.

e) **Using chronologies and enquiring into relevant history**; good enough chronology of contacts with the family to help detect patterns and cumulative indicators. The absence of a chronology across health limited the opportunity to identify cumulative patterns the children were not seen as in need or needing protection; the separate constituent health organisations have different recording systems and SystmOne does not have a chronology function; previous paper file systems in community health had a significant events page which has not been replicated in the electronic record systems; there was no single incident of significant harm. The family were not discussed at a GP Practice Safeguarding MDT[39] Team

[38] It is acknowledged that because of the parallel criminal proceedings it was not possible for IMR authors or the independent reviewer to speak to professionals who would be giving evidence in court proceedings and therefore there may have been discussion and explanations that were unrecorded

[39] Multi-disciplinary team

Meeting that could have provided an opportunity for a discussion of the concerns about the family.

f) **Using tool kits and evidence-based frameworks** to guide and inform the collection and analysis of cumulative information about neglect; none of the services used or referenced the tools and practice frameworks that are available to assist professionals to make a more informed judgment when dealing with complex and complicated family circumstances and often against a background of significant deprivation; poverty harms but is different to abusive neglect; some services were unaware of tools that have been promoted locally; the national panel's report describes toolkits developed in areas focussed on safe sleeping including Nottinghamshire which is being updated[40].

g) **Influence of group decision-making**; groups of people tending to focus on what is known by everybody and relevant information held by an individual is either unmentioned or unnoticed[41]. Groups have a tendency to not consider alternative viewpoints (groupthink) that leads to shared rationalisation; framing (the description of, labelling or presentation of information or problem) influences how people respond; it can lead to professionals normalising what they think is happening in families;

6 Learning already implemented

78. The safer sleep working group has revised the safe sleep risk assessment toolkit in line with the National Panel's SUDI review referred to in section 3 of this report supported by an action plan to publicise and implement the revised risk assessment across the county.

79. A revised neglect strategy has recently been launched by the local safeguarding children partnership which references safe sleep and the use of the neglect toolkit.

80. As a result of the review, the substance misuse service has identified the need to ensure that safe sleeping is routinely discussed as part of contact with expectant parents.

81. The CCG reiterated the safe sleep message and the associated resources at the June 2021 GP Safeguarding Leads development sessions. The CCG has reinstated representation at the safer sleep

[40] https://www.nottinghamshire.gov.uk/media/1494648/safer-sleeping-risk-assessment-tool.pdf

[41] Sniezek, J.A., Paese, P.W. & Furiya, S. (1990). Dynamics of group discussion to consensus judgement: Disagreement and overconfidence. In L.R. Beach & T. Connolly (2005). The psychology of decision making: People in organizations. Thousand Oaks, Berkeley, CA: Sage

working group and ensuring messages are shared with GP practices and any health providers who are not part of the group. This representation can make further links with the CCG functions of commissioning, contracting and quality monitoring. The GP national contract includes asking open questions about maternal well-being and pregnant women with identified risks are prioritised for face-to-face appointments. GPs are aware of and follow the NICE guidance NG194 published in April 2021 and should include promoting active reviewing of medication and safe sleeping when women are pregnant and following birth. The importance of routine enquiry about domestic abuse when patients present with poor mental health and substance misuse should be well understood.

82. The primary school has implemented fortnightly supervision to review safeguarding concerns and escalation. Both schools are keen to develop the use of neglect toolkits and transition arrangements when children move schools.

83. CSC is promoting the improved use of chronologies, capturing the voice of children including pre-birth assessments, improving analysis and including and involving family networks in assessment and support planning along with improving and developing relationship-based practice. CSC has implemented an improved tracking system for complex cases such as Tom's. CSC is rolling out training on analysis and has changed the child protection conference model to a strength-based approach and improved the links between the independent conference chairs and the operational teams with an improved alert system.

84. The NHFT is promoting safe sleeping with both parents, ensuring supervision identifies where a CPP is not sustaining improvements and promoting the neglect strategy across their workforce.

85. The NUH is promoting safe sleep with both parents, encouraging midwifery staff to consider the welfare of siblings as well as new-born infants and for midwives to seek relevant history from both parents including the use of substances and mental health.

7 Action timeline for implementation of learning and development

86. A learning summary will be issued. Additionally;

    I. The Nottinghamshire Safeguarding Children Partnership should refer the report to the Best Start Partnership Steering Group to ensure that relevant learning about the promotion of safe sleeping and identifying unsafe sleeping practices by services is supported through the Best Start Strategy.

II. The Nottinghamshire Safeguarding Children Partnership should consider what further measures are required to publicise and promote the use of the neglect toolkit with local professionals.
III. The Nottinghamshire Safeguarding Children Partnership should consider what further measures are required to improve recognition and response to domestic abuse by services working with children and families.
IV. A safe sleep assessment should result in a record being left with the family and be included in any other risk-based discussions or actions including child protection plans, MAPLAG and core groups.
V. The Nottinghamshire Safeguarding Children Partnership should commission a task and finish group to review and provide a report to the Safeguarding Children Partnership about the capacity of Early Help Services to provide the appropriate level of intensive support for children and families with higher levels of complex needs and vulnerability.
VI. Targeted learning should be provided to schools to include the use of the neglect toolkit and oversight by designated safeguarding leads in schools.
VII. The MAPLAG and Team around the Family (TAF) should ensure information sharing with the GP is routinely included and that records of MAPLAG and TAF discussions about the risk to children are translated into agreed action.

Agencies who contributed information to the review.

The following agencies have provided information and have participated in the learning events conducted remotely for the serious case review:

a) Nottinghamshire Police; responded to incidents of domestic abuse in July 2018;
b) Nottinghamshire County Council Children's Social Care; involvement since 2009 and had historical involvement with mother during her childhood; concerns have focussed on substance misuse, poor mental health, domestic abuse and neglect of the children; child in need (CIN) March 2011 until July 2014 stepped up to child protection plan (CPP) until July 2017; stepped down to CIN and closed in October 2017 until reopened in 2019 although several referrals in between;
c) Nottinghamshire County Council, Education, Learning and Skills about primary school attended Child 2, 3 and 4; Child 1 attended an academy school;
d) Nottingham and Nottinghamshire CCG on behalf of GP Primary Care Services; the family were registered at the same GP practice for several years; there was minimal contact by any of the family particularly after the referral in February 2019 when the mother disclosed daily use of alcohol, deteriorating mental health and using cocaine;
e) Nottinghamshire Healthcare NHS Trust (NHCT); intensive support from the Healthy Families Team (or equivalent historically); mother had mental health support from 2011 on different occasions from adult mental health and perinatal services; specialist midwifery service had intensive contact during Tom's pregnancy which included support coordinated through the MAPLAG[42];
f) Nottingham University Hospitals NHS Trust (NUH); had minimal contact with the family and all contacts were before the summer of 2018;
g) East Midlands Ambulance Service (EMAS); had two contacts in 2020; in February 2020 mother thought she had begun premature labour; the second contact was the day that Tom was found dead at home;
h) Change Grow Live (CGL) - drug and alcohol service; offered service to mother on three occasions between February 2016 and December 2019 to address her use of cocaine; the last referral was in September 2019 from children's services; at assessment, mother reported weekend use of alcohol and cocaine; she attended on session and referral was closed.

[42] Multi-agency pregnancy liaison and assessment group brings together health and social care services to identify pregnant women who have histories of substance misuse and to offer enhanced help and support.

The terms of reference

The family were informed of the review.

1. How did the knowledge gained over the previous 9 years influence the planning, risk assessment and response about the unborn baby? Was there a good enough understanding of cumulative factors associated with neglect? Is there evidence of the parents having adverse childhood experiences (ACE) and how was this factored into working with the family? Did professionals use any recognised assessment or risk tools to help inform professional judgments?

2. Was the added vulnerability of a new-born baby within a family where children were identified as being at risk adequately recognised and responded to? This should comment on knowledge about the safe sleeping practice including avoidance of co-sleeping, use of alcohol, drugs, medication or smoking, poor ante-natal care or engagement, and low birth weight.

3. Examine how information regarding domestic violence was considered and influenced decisions made. Were the risks of the father as a perpetrator of domestic violence fully understood?

4. To what extent has the current Covid-19 crisis impacted either the circumstances of the child or family or the capacity of the services to respond to their needs?

5. Examine the impact of language, ethnicity and culture on the way services responded to the needs of the child and the family. Are there lessons about how this family were given advice and information and were able to use advice and help?

6. Was there evidence of child focus and the voice of the child and family influencing how services were provided? Was there a good enough understanding of the lived experience of the children?

7. Were there any gaps in service that may have led to a different outcome? Were there opportunities to have escalated concerns about the level or the quality of response or service being provided?

Details of the independent author

Peter Maddocks has over forty years' experience in social care services the majority of which has been concerned with statutory services for children and families. He has worked as a practitioner and senior manager in local authority services and national inspection services in England and Wales and with the non-statutory sectors. He has a professional social work qualification and MA and is registered with

Social Work England. He has not been employed by any of the services contributing to this serious case review. He has completed training for overview authors and independent reviewers including the application of systems learning and participation in masterclass professional development.