March 2025

Summary Update - Baby C Local Child Safeguarding Practice Review 2022

Baby C tragically died on 16th February 2022 aged 7 months old, having been found unresponsive in the bath. He was living in his mother's care, initially in supported accommodation for his first 4 months of life, then in mothers own home. Baby C's parents were separated, and he never lived in the care of his father. After a criminal investigation and charges brought, Baby C's mother pled guilty to manslaughter. She was sentenced to seven years in prison in December 2024.

In March 2022, Durham Safeguarding Children Partnership began a Local Child Safeguarding Practice Review (LCSPR) in relation to the circumstances leading up to his death. The purpose of a Child Safeguarding Practice Review is to identify improvements to be made to safeguard and promote the welfare of children. The DSCP commissioned an experienced, independent author to undertake the review which was concluded in October 2022.

The publication of the Local Child Safeguarding Practice Review report was delayed in order to ensure that it did not prejudice the criminal investigation. The full findings of the review are set out in the overview report which has been published alongside this summary update. The learning the report identifies is based on the key findings recommended from the review.

The report and its recommendations were agreed and accepted by the Durham Safeguarding Children's Partnership.

Actions Taken to Address the Learning and Recommendations

There were recommendations from the review completed which were summarised in the report. Agencies completed a comprehensive multi-agency action plan. The multi-agency action plan was overseen by the Performance and Learning Group and reviewed at 6month and 12 month intervals, all actions were signed off as complete in March 2024 and assurance given to Delegate and Lead Safeguarding Partners. The action plan has been monitored by the Safeguarding Children Partnership to ensure that recommendations were completed, learning was embedded at the earlies opportunity, and practice improvement is ongoing.

Local Child Safeguarding Practice Review

Durham Safeguarding Children Partnership

Baby C

Independent Lead Reviewer: Dr Zoë Cookson

October 2022

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1. Introduction and Executive Summary

1.1 Purpose of this Review

This purpose of a child safeguarding practice review is to explore how practice can be improved to prevent, or reduce the risk of, a repeat of similar incidents. Reviews seek to understand both what happened and whether this reflects systematic issues in either policy or practice that could be addressed to better safeguard children. A review is not designed to hold individuals or organisations to account.[1]

1.2 Overview of Case

Baby C died aged 7 months, having been found unresponsive in the bath.

Prior to birth, baby C was placed on the Child Protection list under the category of neglect. This was because mother's three older children had been removed from her care (by two different neighbouring authorities).

The parents' relationship broke down while mother was pregnant with baby C and children's social care began assessments on both parents as potential sole carers. Father subsequently started a new relationship and confirmed he was happy for mother to have care of baby when born. However, he wished to continue to be involved and pro-actively sought contact after baby C was born.

Following his birth (preterm at 36 weeks), baby C was discharged to the care of mother in supported accommodation with a high level of oversight by staff.

Baby C and mother moved to their own tenancy after four months in supported accommodation and input from children's social care was gradually reduced.

Two and a half months after moving to their own home, a multi-agency Review Child Protection Conference unanimously agreed the Child Protection Plan should be de-escalated to a Child in Need plan.

Baby C died one week later. The joint Police and Health examination of the scene following baby C's death found home conditions to be poor. Mother admitted using cannabis on the morning of baby C's death and blood tests confirmed that mother had used drugs a short time prior to baby C's death. Cannabis and a set of weighing scales that could indicate drug misuse were also found inside the house.

1.3 Summary of Learning from this Review

1.3.1 Information Sharing

Cross Boundary Information

- This case highlights the importance of obtaining relevant information and analysis from out of area agencies who have had recent or ongoing involvement with the subject child or family. This could include requesting attendance at key meetings at significant points.
- This case also underlines the importance of sharing this information with all professionals working with the child and family to enable full participation in multi-agency discussions and to ensure opportunities for professional challenge are not lost.

[1] There are other processes for this purpose including employment law, disciplinary procedures, professional regulation and – in exceptional cases – criminal proceedings.

Accuracy of Information

- Information should not be accepted at face value and should be questioned and challenged. This case highlights the importance of all agencies checking facts against the information available to them and sharing this to ensure discussions, and decision-making, are based on an accurate understanding of the family circumstances.

Exploring Risk Factors

- There is a need to improve the follow up and use of historical information and to fully explore any previous risk factors. This information needs to be shared with all professionals working with a child/family. In this case it was apparent that many professionals working with mother did not have sufficient knowledge of background information or concerns.

- For all substance misuse – including cannabis – there needs to be quality and timely assessment of the impact on the child and on mother / father's parenting. Relapse prevention work should be undertaken.

Cumulative Harm

- The Durham Safeguarding Children Partnership have already identified cumulative harm as an area for learning for the Partnership and have developed dedicated tools around this issue. This case highlights the importance of ensuring this learning is embraced by professionals across the system.

Single and Multi-agency Handover

- There needs to be a more robust handover process to ensure that previous information is shared and there is continuity of understanding. Effective handovers are essential to empower professionals to contribute to, and challenge, conversations and decision making. This includes when a worker is leaving or absent, when a new agency joins an existing multi-agency process, or when a child moves to another area.

1.3.2 Assessing Home Conditions

Assessing Home Conditions

- Regularly monitoring the home environment in which the child lives is crucial to effective safeguarding and it is important to see all areas.

- The Durham Safeguarding Children Partnership's Home Environment Assessment Tool (HEAT) tool was not used by all practitioners involved in this case, reducing the potential to identify issues and deterioration. The absence of a HEAT tool makes it difficult to determine the rigour of any examination of the home environment and to determine what areas have been seen.

- There may be benefits in multi-agency training on how to complete a HEAT assessment, including standards of what should be considered 'good enough' in terms of home conditions.

- The only unannounced visits were undertaken by children's social care and the case file does not record which visits were announced or unannounced. Recording of home visits in case files – particularly whether announced or unannounced – could be improved.

1.3.3 Multi-agency Working

Membership of the Core Group

- All agencies with relevant knowledge of, or involvement with, a child and their family need to be invited to multi-agency meetings. The Core Group needs to have a good understanding of the child and their family's vulnerabilities to ensure effective multi-agency planning. Similarly, parent(s) engagement and progress can only be accurately reported if all the agencies involved are present at meetings.

Professional Challenge and Scrutiny

- While gaps in the information shared around mother's vulnerabilities potentially limited opportunities for professional challenge around these risks, it is surprising that more questions were not asked in order to understand the rationale for decisions made outside of multi-agency meetings. Professional challenge and scrutiny within and between agencies could be strengthened in order to better safeguard children. This could be done through greater use of reflective supervision.

Decision Making

- It is important that there is a clear step-down plan when decisions are made to transfer a child from a Child Protection Plan to a Child in Need Plan. Professionals working with the child and family should have the opportunity to discuss this in advance of the Review Conference to ensure a shared understanding of the actions, aims and objectives of this work. Parents should be clear of the expectations of the new Plan.

Case Recording

- Recognising the context of workload pressures, minimum standards for case reporting need to be adhered to. It is important to record when meetings took place, who was in attendance, what was discussed and the rationale for the decisions / actions agreed including who is responsible for these.
- It is important that child protection alerts are correct and up to date, and that vital information – such as the address at which a child resides – is shared with all relevant agencies.

1.3.4 Other Learning

Unseen Men

- Although father was involved, and an assessment of his potential to care for baby C was commenced, the information about father available to agencies and at multi-agency meetings was limited. Meaningful engagement with fathers is important to successful safeguarding. It is crucial fathers, and any other men in the child's life, are considered in both the assessment and safety plan.

2. Methodology and Process

A systems-based approach, consistent with *Working Together to Safeguard Children 2018*, was adopted for this case. Throughout the review efforts have been made to understand how actions and events were perceived at the time and to avoid hindsight bias.

An independent Lead Reviewer (Dr Zoë Cookson) was appointed to manage the review process, chair all relevant meetings, facilitate the Learning Workshop and author the final

report. She was supported by a Review Team made up of local safeguarding professionals from key agencies.

The Review Team agreed the focus of the review should be the date of the pre-birth referral to the date of the multi-agency Child Protection Conference that agreed the move from Child Protection to Child in Need plan (1st February 2021 to 10th February 2022). Information prior to these dates was considered where relevant.

The review drew on the detailed information and analysis submitted by agencies to the Rapid Review of this case. This initial information was supplemented by a timeline document which was completed by all agencies and by analysis of the minutes of all multi-agency meetings and the local authority Public Law Outline (PLO)[2] meetings.

A five-hour Learning Workshop was held with frontline practitioners and managers. This sought to obtain first-hand experience from those working with the family, and to also understand the context that practitioners were working within.

Both mother and father were invited to contribute to the review. Father declined. Mother has not replied. It will not, however, be possible to engage mother until the police investigation has been completed.

3. Analysis and Identification of Learning

3.1 Introduction

The initial review of this case prompted questions about **disguised compliance**. (Where parents appear to co-operate with professionals in order to allay concerns and stop professional involvement).

The available records showed inconsistencies that could be seen as potential indicators of disguised compliance. However, these anomalies were investigated as part of this review and the explanations provided by mother were mostly verified. For example, mother reported having Covid-19 numerous times and was not, therefore, able to attend appointments or allow professionals into her home. All but one of these was consistent with positive swabs for Covid-19 in her medical records. Mother's self-reported engagement with domestic violence and mental health services was also confirmed despite the fact she had previously failed to engage well with similar services in other areas.

Despite baby C's tragic death, front-line practitioners who worked with mother, and those who had been present in meetings with her, still largely felt that mother's engagement had been genuine.

From the time the safeguarding concerns were first raised, mother demonstrated an ability to reflect on her past parenting and expressed a strong motivation to change. For example, at the Pre-Birth Strategy meeting, mother is reported to be *'open and honest about the significance of the neglect and abuse'* related to her older children. It is possible that this positive perception at an early stage led to a degree of **professional optimism** that lasted throughout the case and which was reinforced amongst practitioners.

This optimism was made possible because key historical information about mother was not shared with all practitioners and some key agencies were not involved in the multi-agency safeguarding process. Mother's openness about her history also meant that professionals

[2] The Public Law Outline (PLO) sets out the duties Local Authorities have when thinking about taking a case to court to ask for a Care Order to take a child into care or for a Supervision Order to be made.

tended to accept information from mother as a fact without displaying professional curiosity and investigating further. These, often significant, gaps in the information shared between agencies reduced the opportunities for effective professional scrutiny and challenge and, instead, led to a sense of everything going well.

4. Information Sharing

4.1 Cross Boundary Information

4.1.1 Gathering information from agencies outside of Durham

When children and families move across local authority boundaries there is a heightened risk of safeguarding issues being overlooked. This can only be overcome by effective cross-boundary working.

The Pre-Birth Strategy meeting for this case identified that both mother and father had recently moved between local authority areas, noting *"it can be hard when families move across police and health borders to track information"*. Despite recognising this challenge, information gathering from organisations outside the Durham area could have been improved in this case.

At the time of booking her pregnancy with the midwife, mother self-reported that her three other children had been removed from her care (by two different local authorities) and care proceedings were ongoing for her two oldest children. This information was included in the safeguarding referral made four months before the formal Pre-Birth Strategy meeting. However, information from these neighbouring authorities was not available at the Strategy meeting. Minutes of the Durham Local Authority PLO meeting held the week before the Pre-Birth Strategy meeting suggest there were some challenges obtaining this information from at least one authority.[3] Information from this authority was available by the time of the Initial Child Protection Conference (ICPC) but information had not been received from the other local authority.

The gaps in information from outside Durham are not restricted to children's social care. For example, Police in other areas had significant and protracted concerns about the family but this information was not followed up.

It was also recognised at the Pre-Birth Strategy meeting that the health information available may not be complete as parents had recently moved to the area.

At the Learning Event for this review, there was a strong view that agencies from other areas who have recently been involved with children or their families should be invited to key multi-agency meetings, i.e. Strategy Meetings, ICPCs, etc. This was felt to be important to ensure all agencies have a full understanding of key information and history rather than just receiving written information. Durham's child safeguarding procedures have a supplementary protocol for multi-agency engagement in Strategies and Section 47 enquiries. This does not currently include engagement of out of area professionals and does not specifically mention cross-boundary working.

[3] The minutes record an action for one of the Durham Local Authority solicitors to request information from one of the neighbouring authorities *"as when previous Social Worker has requested information, they have not been forthcoming."*

4.1.2 Sharing information obtained from agencies outside Durham

Accessing information from other areas is only of value if it is used effectively. In this case it is concerning that large parts of the information obtained from neighbouring authorities about concerns regarding mother's other children was not shared with all professionals working on the case.

At the ICPC, the allocated Social Worker confirmed that he had the legal bundle for the care proceedings in relation to mother's two eldest children. However, the information discussed at the meeting appears to be largely the same as the information discussed at the Pre-Birth Strategy meeting held three weeks' previously when the legal papers from the neighbouring authority had not been available.

The minutes of subsequent multi-agency meetings also give no indication that the contents of the legal bundle were shared with other agencies. As far as it is possible to ascertain, the only professional in Durham who had detailed knowledge of the information from other areas (including the court papers) was the allocated Social Worker – although there is evidence that he summarised the contents verbally to managers within children's social care.

A knowledge of the safeguarding concerns around the older siblings may have led to more professional challenge and a different perception of mother. For example, the midwife stated she was not aware until the Learning Event for this review that mother was not allowed unsupervised contact with her other children.[4] Had she known this, the midwife said she wouldn't have felt comfortable with some of the decisions made at Core Group meetings which she attended.

The Pre-Birth Strategy meeting noted information from neighbouring authorities would be *"needed to identify the previous concerns and inform any assessment outcomes".* Without detailed knowledge of the contents of the legal bundle and any other documentation shared by neighbouring authorities, it is not possible to determine the extent to which information from previous local authorities was taken into consideration or how their assessments informed future risk assessments and planning in relation to baby C. What is clear is that the lack of understanding of the issues raised about mother in other areas limited the opportunities for professionals in Durham to challenge the social work assessment and decision-making.

There was one noticeable example of a challenge from a professional who had read the full documents related to mother's history in a neighbouring area. The judge in the formal care proceedings for mother's older children (held around the time of baby C's birth), expressed surprise at Durham's decision to allow baby C to remain in mother's care and took the unusual step of requesting confirmation that Durham had full sight of the court papers from these care proceedings. In response to this, Durham submitted a formal statement from the allocated Social Worker confirming that he had received and reviewed the Court bundle and the information in it had been given due consideration when making plans for baby C.

This request from the judge was discussed as part of the Local Authority PLO process but not shared with other agencies. Had this request from the judge been more widely known, it is possible professionals from other agencies may have been prompted to make more enquiries into the circumstances and concerns around mother's older children.

[4] The worries listed in multi-agency minutes do mention that mother had supervised contact with her third child. The midwife's comments suggest that these worries were not reviewed in detail at meetings.

4.1.3 Cross Boundary Information: Learning

This case highlights the importance of obtaining relevant information and analysis from out of area agencies who have had recent or ongoing involvement with the subject child or family. This could include requesting attendance at key meetings at significant points.

This case also underlines the importance of sharing this information with all professionals working with the child and family to enable full participation in multi-agency discussions and to ensure opportunities for professional challenge are not lost.

4.2 Accuracy of Information

There are examples in this case of a failure to verify basic facts or to identify contradictions in the information presented at multi-agency meetings. This meant that inaccurate information was carried through in the notes of meetings and used to inform decision making.

The starkest example of this is the statement about mother's transient lifestyle. The minutes of the Pre-Birth Strategy meeting state mother *"has been at her current address since July 2019"*, implying a stability that balanced her previous transient lifestyle. This statement is included in all subsequent records of multi-agency meetings and is incorrect. Two incidents recorded in the minutes of multi-agency meetings suggest mother was still living a transient lifestyle well after this date. In January 2021 mother shared she'd been a victim of a 'recent' sexual attack while sofa surfing. At the Team Around the Family meeting in April, less than three months before baby C was born, mother is reported to be living with a friend. Checks with the Health Visitor's records for this review found that mother had ten addresses in 2019 and six in the first half of 2020.

The Rapid Review of this case also identified a flag on Health Visiting records that mother had an Education Health and Care Plan (which would suggest that mother has some form of learning needs). This was not noticed at the time and is a potentially significant omission.

Professionals working with mother were aware she is dyslexic but felt confident of her ability to engage and understand advice. It is concerning that the flag on mother's records – and any potential learning needs[5] – was not investigated at the time.

4.2.1 Accuracy of Information: Learning

Information should not be accepted at face value and should be questioned and challenged. This case highlights the importance of all agencies checking facts against the information available to them and sharing this to ensure discussions, and decision-making, are based on an accurate understanding of the family circumstances.

4.3 Exploring Risk Factors

Both parents of baby C had a complex history with numerous safeguarding risks evident. These included[6]:

- Mother had been a victim of domestic abuse from a previous partner

[5] It has subsequently been confirmed that mother was on 'School Action Plus'.

[6] Mother may also have learning needs related to the fact that she had been on 'School Action Plus' (see section 4.2 regarding the flag on her Health Visiting records). This wasn't identified at the time. This has, therefore, been excluded from this list of known risk factors at the time.

- Mother and father both had a history of mental ill-health (anxiety and depression) with both making numerous suicide attempts in the past
- Mother had a history of drug misuse, self-reporting past use of cannabis and amphetamines
- Mother and father had both been looked after children
- Mother had experienced significant childhood trauma
- Mother had a history of homelessness, living a transient lifestyle
- Parents split while mother was pregnant, leading to some acrimony between them
- Mother had previously had small babies and C was born four weeks early.

Many of these risk factors were self-reported by parents and mentioned at meetings, creating a perception that practitioners were aware of potential risk factors. However, information was not collected in a consistent way from all partners and collated. For example, although the Health Visitor attended the ICPC and verbally shared information from antenatal telephone contact, a formal written submission was not made. Harrogate and District NHS Foundation Trust stated they would expect a Health Visitor to access mother's records and complete a cumulative risk assessment when they first become involved with a family and would expect them to share this at safeguarding meetings. The Trust have taken action to ensure this is consistent practice.

There is also no evidence of risk factors being fully explored in a multi-agency setting. For example, mother's prior experience of domestic abuse was reported to the Pre-Birth Strategy meeting along with the fact that she had been referred to Durham Harbour Recovery Service for support. Mother's vulnerability was noted but there was no further enquiry and several practitioners working with mother were unaware of this aspect of her history until the Learning Event for this review.

This lack of analysis of historic risks meant some practitioners working with the family were unaware of key pieces of background and history. It also led to decisions that were largely based on the 'here and now' without consideration of the context.

A case study of mother's substance misuse is included below as an illustration of this. It should, however, be noted that the limitations in the way historical information was shared and explored on a multi-agency basis applies equally to other risk factors identified around both parents.

4.3.1 Substance Misuse

Substance misuse was identified as one of the reasons for the safeguarding referral made by the midwife. However, there is very little evidence of mother's historic and recent substance misuse being explored during the time that agencies worked with the family. This significant gap in the understanding of risks around mother is highlighted by the fact that, at the Learning Event for this review, several practitioners who worked with mother (including some members of the Core Group) said they were unaware of substance misuse being an issue for mother.

It is worth considering what was known about mother's substance misuse at the time and how this information was used to consider any potential risks to baby C.

Mother self-reported a history of using cannabis and amphetamines. At the time of booking with the midwife, mother also disclosed a recent sexual attack from a neighbour under the influence of crack cocaine (indicating that she was mixing with people who were taking drugs).

At the Local Authority PLO meeting the week before the formal Pre-Birth Strategy meeting, mother's solicitor reported that mother's last drug test showed positive for passive exposure

to cocaine and negative for amphetamines and cannabis. The minutes do not record when this drug test took place. There is no evidence of this information being shared in multi-agency meetings (although some attendees at the Pre-Birth Strategy meeting would have been aware of this information as they were also at the PLO meeting).

At her first antenatal appointment with the Health Visitor, mother was asked about alcohol use but there is no record of her being asked about other substances.

The extent to which mother's substance misuse was identified as an issue in the safeguarding of her other children is not known. As considered in the previous section, information from neighbouring authorities and the court bundle for care proceedings for the two oldest children were provided to the allocated Social Worker but the detailed content was not shared in a multi-agency arena.

At the Learning Event for this review, the GP shared information from the child protection meetings related to mother's third child (on mother's GP records) which revealed mother's hair strand tests in January 2020 (approximately one year before baby C's birth) were positive for cocaine. There was, however, no mention of mother's past cocaine use in any of the multi-agency meetings related to baby C.

Instead, at the time of the Pre-Birth Strategy meeting, it was shared that mother had *"a history of drug use, but there is no evidence of that now."*

Although information about mother's historic drug use was limited, and the issue of the people she was mixing with was not identified, professionals at the Pre-Birth Strategy meeting did highlight potential concerns that needed further exploration.

The Police representative and safeguarding midwife from County Durham and Darlington NHS Foundation Trust both stated that they would like confirmation that mother was abstaining from drugs. The Health Visitor also noted that, given mother had started smoking again, there could be a risk of starting drugs again.

Despite the questions raised, the minutes of the Strategy meeting record 'no evidence' of drug use. It is not possible to establish how this came to be recorded in this manner. No tests had been taken at this point. It is possible this was a judgement based on observations of mother and optimism based on the perception that she had openly disclosed her past history.

This assertion, documented in the Pre-Birth Strategy minutes, that drugs were no longer an issue for mother appears to have become the accepted wisdom in this case. The questions raised by professionals about substance misuse at the Strategy meeting remained largely unexplored in a multi-agency setting and the concerns that led to the request for toxicology were rapidly lost (see discussion below).

At the Initial Child Protection Conference three weeks after the Strategy meeting, mother's previous substance misuse was acknowledged and the potential for relapse noted. However, substance misuse issues were deemed *"not a significant worry"* (despite toxicology still not being completed) and the danger statements did not mention substance misuse. The Child Protection Plan did not mention substance misuse and the request for a urine sample for screening was placed against a non-specific worry that mother may take risks that would affect baby's health, growth or development. The focus of this concern appears to be on the fact mother had previously had small babies.

There is no evidence of issues around mother's substance misuse being discussed by the Core Group. The only mention of drugs is at a Review Conference at which father expressed concerns that mother was taking baby to see maternal grandmother who was known to smoke

cannabis. The minutes record that mother was aware that unsupervised contact with grandmother should not be allowed.

By the time of the RCPC that made the decision to de-list, the mention of urine toxicology in the original Child Protection Plan had been removed. Indeed, the minutes of the meeting that made the decision to de-list do not mention substance misuse.

The extent of mother's drug use or risks, therefore, remained largely unexplored. No questions appear to have been asked about whether substance misuse services were ever involved with mother and whether she had received support. Although highlighted by some practitioners as a potential risk, no consideration was given by the multi-agency group to relapse and prevention planning.

4.3.2 Drug Testing

Professionals at the Pre-Birth Strategy meeting asked whether toxicology tests had been completed. The community midwife reported that she hadn't asked mother to bring a sample and would normally do this at the appointment. However, at her appointment mother had just been to the toilet before being called so had not been able to provide a sample.

At the ICPC three weeks' later, mother confirmed that a urine test was being done at her next midwife appointment the following week. This was not completed then and was only obtained on a fourth attempt (when it was found to be negative for all substances).

It is not possible to rule out disguised compliance around the issue of the urine test. Indeed, the one instance when mother's claim to have Covid couldn't be verified by positive swabs on her GP record relates to a failure to attend for a urine test.

The delays completing toxicology was not questioned at the time. It is possible that this lack of professional curiosity was influenced by the way the results were reported to the multi-agency group. The minutes of the Review Child Protection Conference state *"urine screening completed and all fine toxicology wise."* No reference appears to have been made to the fact this had taken four attempts. By this point, substance misuse was not being considered as a potential issue for mother and no reference appears to have been made to the reasons (raised in the Pre-Birth Strategy meeting) for wishing to specifically consider the results of the urine tests.

Questions were asked at both the Rapid Review and the Learning Event why urine toxicology was relied upon and why hair strand testing was not used. County Durham and Darlington Foundation Trust's policy is to use only urine samples for toxicology and any other methods of obtaining toxicology have to be requested by the Local Authority. Children's social care did not feel this was proportionate in this case as they did not identify any signs of drug use. There is no evidence of any challenges at the time to obtaining urine samples and no evidence of suggestions that alternative samples for toxicology should be considered in order to understand mother's current level of drug use and the impact and risks of this on the unborn child.

4.3.3 Good Practice

Professionals at the Pre-Birth Strategy meeting identified the need for evidence of mother's abstinence from drugs and the need to consider the risk of relapse. Unfortunately, these considerations and the reasons behind them, were not carried forward to subsequent multi-agency meetings.

4.3.4 Exploring Risk Factors: Learning

There is a need to improve the follow up and use of historical information and to fully explore any previous risk factors. This information needs to be shared with all professionals working with a child/family. In this case it was apparent that many professionals working with mother did not have sufficient knowledge of background information or concerns.

For all substance misuse – including cannabis – there needs to be quality and timely assessment of the impact on the child and on mother / father's parenting. Relapse prevention work should be undertaken.

These gaps in the information shared around mother's past, and the risks associated with her vulnerabilities, may also have limited opportunities for professional challenge. This is discussed later in this report.

4.4 Cumulative Harm

Although not fully explored, multi-agency meetings were aware that both parents had multiple vulnerabilities that presented potential safeguarding risks (see bullet point list in section 4.3). This included a recent history of the 'toxic trio' of domestic abuse, mental ill-health and substance misuse which has been linked with increased risks of abuse and neglect of children and young people.

Despite the long list of risks and vulnerabilities of both parents, particularly mother, consideration was not given to cumulative harm. Instead, focus was firmly on mother's current presentation and – as noted earlier – professional perceptions seemed to be clouded by her apparent success.

This was at least partially due to the fact that many professionals involved in the case only had a limited understanding of these risks. Information from agencies in other areas wasn't widely shared and there were gaps in both single and multi-agency handovers (see section 4.5 below).

4.4.1 Cumulative Harm: Learning

The Durham Safeguarding Children Partnership have already identified cumulative harm as an area for learning for the Partnership and have developed dedicated tools around this issue. This case highlights the importance of ensuring this learning is embraced by professionals across the system.

4.5 Single and Multi-agency Handover

There were occasions where information from individual agency records was shared with children's social care but not then fully handed over within that agency to all professionals involved with the family. For example, between the booking midwife who made the initial referral and allocated midwife working with mother.

Similarly, the Supported Housing Provider were not made aware of much of the background and family history when they started working with mother after her discharge from hospital. When joining the Core Group, they felt it would have been helpful to have access to minutes of the Strategy Meeting, ICPC and previous Core Group meetings.

4.5.1 Good Practice

When there was a change of IRO, the new IRO observed the Review Child Protection Conference (RCPC) before taking over case responsibility and chairing the subsequent RCPC.

4.5.2 Single and Multi-agency Handover: Learning

There needs to be a more robust handover process to ensure that previous information is shared and there is continuity of understanding. Effective handovers are essential to empower professionals to contribute to, and challenge, conversations and decision making. This includes when a worker is leaving or absent, when a new agency joins an existing multi-agency process, or when a child moves to another area.

5. Assessing Home Conditions

5.1 Assessing Home Conditions

The joint Police and Health examination of the scene following C's death found home conditions to be poor with a set of weighing scales that could indicate drug misuse. This was inconsistent with the previous reports of professionals involved in the case, none of whom raised any concerns about the home environment following home visits.

This inconsistency is concerning given home conditions were a focus area of multi-agency work with mother. The Child Protection Plan for baby C noted that *"home conditions were a significant concern when her [mother's] previous children were taken into care"* and included an action for mother to maintain positive home conditions. The Plan stated that this would be assessed via home visits by the Social Worker and Family Support Worker and would be regularly reviewed in Core Group meetings.

Durham Safeguarding Children Partnership have for many years provided a Home Environment Assessment Tool (HEAT) to help practitioners identify those families where there may be early signs of neglect so that swift action can be taken to address and support families to improve home conditions for their children.[7]

Midwives visited the home during the antenatal and postnatal periods and no concerns were highlighted regarding the home environment within the health records. However there is no evidence of completion of the HEAT tool. The first Health Visitor contact antenatally was completed via telephone and did not, therefore, include a HEAT.

A HEAT tool was completed three times by two different Health Visitors. (Twice while baby C and mother were living in supported accommodation and once approximately one month after they moved to the private tenancy.) On all three occasions the Health Visitors observed C's sleeping environment and assessed upstairs and no concerns were identified.

[7] The Home Environment Assessment Tool, HEAT analysis and action plan, and accompanying guidance is available to download from the 'Toolkits and guidance for practitioners' page on the Partnership website: https://durham-scp.org.uk/professionals/early-help-and-neglect/toolkits-and-guidance-for-practitioners-single-assessments-and-early-help/

It is, however, worth noting that the last visit by a Health Visitor was eight weeks before baby C's death. A Health Visitor did attempt to visit (to share the report for the RCPC) the month before baby C's death but was prevented by mother reporting that she was self-isolating due to Covid.[8]

In light of the failed attempt to visit, the Health Visitor invited mother to contact her if she would like to discuss the RCPC report. Mother did not take up this offer. It would have been good practice for the visit to be rearranged and this would have provided a further opportunity to observe home conditions. (Although it should be noted that no concerns had been identified about the state of the home).

In line with their policy, all Health Visitor appointments were announced so mother would have had the opportunity to clean and prepare for the visit.

Unannounced visits are important to provide a realistic account of the home environment. As part of the child protection process, statutory visits were undertaken by children's social care every ten days. Some of these would have been unannounced but casefiles do not record which.

No concerns about home conditions were noted by either the Social Worker or Family Support Worker. However, there is no evidence of scrutiny of the home environment and no record of the HEAT tool being used. Where home conditions were described, there is no indication in the records of what part of the home had been viewed. This is significant given the history of neglect and the formal action in the Child Protection Plan.

The last statutory home visit undertaken by children's social care was two weeks before baby C's death. No concerns were recorded regarding home conditions other than mother complaining about the number of cat hairs she was trying to clean in advance of the worker's visit. This comment indicates that this was a pre-arranged visit and mother had the opportunity to clean and prepare for the visit. However, further exploration revealed that mother had received only a few hours' notice of this visit. This review was advised that the living room and bedroom was observed on this occasion.

A further home visit was undertaken by the allocated Social Worker one week before baby C's death. No concerns were noted about home conditions. However, records suggest that the Social Worker viewed the living room only.

Following the ending of the Child Protection Plan, monthly visits were agreed. Unfortunately baby C died before the first visit under the Child In Need Plan had been scheduled.

The Child Protection Plan stated home visits would be reviewed at Core Group meetings. Minutes of these meetings are limited but there is no evidence of home conditions being pro-actively discussed. The only mention is a statement that is carried through the minutes stating *"no concerns with home conditions"*.

There appears to have been a rapid deterioration in the home environment in which baby C was living in the week before his tragic death. At the Learning Event for this review, professionals who had witnessed, or seen photographs, of the home conditions from the time of baby's death found it difficult to believe that home conditions had changed so markedly in such a short space of time. This led to questions whether different professionals have differing

[8] This review explored whether the refusal to allow the Health Visitor to enter in mid-January could have been a deliberate attempt to prevent the Health Visitor viewing the property. This does not appear to be the case as mother's assertion that she had tested positive for Covid was confirmed by records of swabs in her GP records.

views on what is good enough in terms of home conditions and whether all professionals know what to look for in terms of drugs paraphernalia.

5.1.2 Assessing Home Conditions: Learning

Regularly monitoring the home environment in which the child lives is crucial to effective safeguarding and it is important to see all areas.

The Home Environment Assessment Tool (HEAT) tool was not used by all practitioners involved in this case, reducing the potential to identify issues and deterioration. The absence of a HEAT tool makes it difficult to determine the rigour of any examination of the home environment and to determine what areas have been seen.

There may be benefits in multi-agency training on how to complete a HEAT assessment, including standards of what should be considered 'good enough' in terms of home conditions.

The only unannounced visits were undertaken by children's social care and the case file does not record which visits were announced or unannounced. Recording of home visits in case files – particularly whether announced or unannounced – could be improved.

6. Multi-agency Working

6.1 Adherence to multi-agency procedures

This case provides an example of good practice with the midwife identifying risks and making an appropriate referral.

The Pre-Birth Strategy meeting, Initial Child Protection Conference, and Review Conferences were held within the expected timescales. The Independent Reviewing Officer (IRO) challenged what appeared to be a lack of regular Core Groups during the period that baby C and mother lived in supported accommodation. The IRO was assured meetings had taken place but, due to workload issues, had not been recorded in the child's files.

Both parents regularly attended multi-agency meetings, including Conferences and Core Group meetings. It is good practice that their views are recorded.

There was a delay in completing and sharing of the social care assessment. This was not completed until the Conference that made the decision to transfer baby C from a Child Protection Plan to a Child in Need Plan. This was a missed opportunity to proactively analyse and understand the information within the assessment on a multi-agency basis.

6.1.1 Good Practice

The IRO Service challenged the timescale regarding the completion of the assessment and the apparent lack of Core Group meetings.

The views of both mother and father are clearly recorded in minutes of multi-agency meetings.

6.2 Membership of the Core Group

The Core Group included the Social Worker and Family Support Worker along with representatives from midwifery and health visiting. The Supported Housing Provider joined when mother and baby C were discharged from hospital.

Despite mother's identified vulnerabilities, the only attempt to widen the membership was an invite to the agency providing support for mother's mental health. An action to invite a representative from mental health to future meetings was included in the Child Protection Plan. They declined as mother had been discharged and was no longer receiving services. No challenge was made to this, despite the fact that professionals with knowledge of mother's mental health may have helped multi-agency planning around her needs and informed decisions around her ability to care for baby C.

Other potentially key agencies – such as substance misuse, domestic violence or housing services – were not invited to join the Core Group. This appears to be because mother was not engaged with these services during the period agencies were involved and (as discussed previously) her historic vulnerabilities and the risks these posed to baby C had not been fully explored.

6.2.1 Membership of the Core Group: Learning

All agencies with relevant knowledge of, or involvement with, a child and their family need to be invited to multi-agency meetings. The Core Group needs to have a good understanding of the child and their family's vulnerabilities to ensure effective multi-agency planning. Similarly, parent(s) engagement and progress can only be accurately reported if all the agencies involved are present at meetings.

6.3 Professional Challenge and Scrutiny

Minutes of the Core Group, where available, show little evidence of professional challenge. The Health Visitor who was part of this group explained that meetings tended to be brief, focusing on the positive progress since the previous meeting with little reflection of mother's wider vulnerabilities. The gaps in the information shared around mother's past, and the risks associated with her vulnerabilities (see section 4.3), are likely to have limited opportunities for professional challenge.

Minutes of some Core Group meetings were never written up and shared. This was challenged by the IRO but there is no evidence of other agencies raising questions or asking about the missing minutes.

Several key decisions related to this case appear to have been taken outside of formal multi-agency safeguarding meetings (see section 6.4 below). The rationale for these decisions does not appear to have been understood by all professionals working with mother and baby C but there is no evidence of clarification being sought or any challenge at the time to these decisions.

Some participants at the Learning Event questioned whether mother's presence at key multi-agency meetings discouraged professionals from challenging other agencies or raising concerns about mother. Whilst there do not appear to be any multi-agency meetings after the Strategy meeting that mother was not present at, in this case it is more likely that the limited professional challenge was due to the lack of understanding across agencies of the historic risks and mother's complex vulnerabilities.

Questions were also asked at the Learning Event regarding the Local Authority's decision not to progress care proceedings for baby C, pointing out that Interim Care Orders or Supervision Orders do not automatically mean the removal of children. However, no such challenges were made to local authority decision making at the time from professionals within Durham.[9]

In order for practitioners and managers to make consistent protective child-centered decisions based on an evaluation of historical factors as well as current and dynamic risk factors, multi-agency supervision needs to be robust and effective with evidence of strong reflective practice.

6.3.1 Good Practice

Given the absence of Core Group minutes, the IRO challenged whether these had taken place and received assurances that meetings had been held.

6.3.2 Professional Challenge and Scrutiny: Learning

While gaps in the information shared around mother's vulnerabilities potentially limited opportunities for professional challenge around these risks, it is surprising that more questions were not asked in order to understand the rationale for decisions made outside of multi-agency meetings. Professional challenge and scrutiny within and between agencies could be strengthened in order to better safeguard children. This could be done through greater use of reflective supervision.

6.4 Decision Making

The initial decision making at the Pre-Birth Strategy meeting appears to have been robust, identifying outstanding lines of enquiry that required further exploration (such as the need to understand mother's historical and current drug use and the risks of relapse). Unfortunately, as noted in section 4.3, this follow up did not happen.

As the case progressed, some key decisions were simply reported to multi-agency meetings rather than being discussed by professionals. This includes the decision to discharge mother and baby C from hospital to supported living accommodation. The timeline for this review indicates that this decision was made by senior managers within children's social care following a Legal Planning meeting and liaison with the allocated Social Worker. It was then reported to a multi-agency discharge planning meeting which appears to have focused on the detail of when agencies would visit mother.[10] Similarly, mother's decision to move to her own tenancy four months later was not discussed in advance in a multi-agency meeting. Few questions appear to have been asked by members of the Core Group for the rationale behind these decisions.

The decision to step down from the Child Protection Plan was, however, discussed in a multi-agency setting. It is worth considering this in some detail.

6.4.1 Decision to step-down from Child Protection Plan

The decision to step baby C down from a Child Protection Plan to a Child in Need Plan was made only one week before his tragic death.

[9] As noted in section 4.1.2, the only challenge to this decision was from the Judge responsible for the care proceedings of mother's older children in the neighbouring local authority area.
[10] Notes of this meeting are not available in baby C's social care records and reports from agencies to this review suggest some confusion on the rationale for the decision.

The Review Child Protection Conference (RCPC) was attended by the IRO, allocated Social Worker, Family Support Worker, Health Visitor and a representative from the Supported Housing Provider where mother and baby C had lived previously as well as by mother and father. All professionals at the meeting talked positively and all but one scaled 9 out of 10, stating to get a 10 they would like evidence of positive parenting being sustained for a longer period. The Health Visitor score was 7 (from a Health Visitor who sent apologies to the meeting). There was unanimous agreement that the threshold was no longer met for a Child Protection Plan.

Records from the Health Visiting team state that one of the reasons to remove baby C from the child protection register was that there had been no concerns regarding mother's substance misuse. However, as noted earlier in this report, mother's substance misuse was never fully explored. The minutes of the RCPC meeting making the decision to remove baby C from the child protection register do not include any discussion of substance misuse.[11]

The first Team Around the Family meeting following this decision was scheduled to take place exactly one month after the RCPC.

It is expected practice that discussions regarding the removal of a child from the child protection register, and the formulation of a proposed step-down plan, take place at a Core Group meeting: the proposed step-down plan agreed at this Core Group should be presented at the RCPC or shortly after the conference. Parents should be clear of the expectations of working with professionals on a Child In Need basis and the professionals involved should have a shared understanding of the work needed to be done and the aims and objectives of this work.

In this case, however, the Core Group did not discuss the step-down plan and there is no evidence on any agency's files regarding what the step-down plan would look like and what it would aim to achieve.

At the time of the decision to remove baby C from the child protection register, baby and mother had been living independently for just two months. It was questioned during this review whether this was sufficient time to determine whether mother was able to sustain change. While this relatively short period is acknowledged, the consensus of the Review Team was that the reasoning and planning behind decision-making is more important that the timeframe. It is essential that there is a clear rationale supported by a safety plan. This was not present in this case. This is the most significant concern for practice in Durham.

6.4.2 Decision Making: Learning

It is important that there is a clear step-down plan when decisions are made to transfer a child from a Child Protection Plan to a Child in Need Plan. Professionals working with the child and family should have the opportunity to discuss this in advance of the Review Conference to ensure a shared understanding of the actions, aims and objectives of this work. Parents should be clear of the expectations of the new Plan.

[11] There is one mention of substance misuse in this document. In the section on child's view that has been carried forward from previous meetings it states: C "*is a young baby so he can't communicate his views but [name of social worked] thinks what he would want is to be in a home where he is loved and cared for, have contact with mam and dad, be happy and settled and not witness any domestic abuse, mental health or substance misuse.*"

6.5 Case Recording

Case recording was not always as good as it could be.

For example, an initial Team Around the Family meeting was convened the month after the pre-birth referral but there is no further information on the case file so it is unclear who attended or the nature of the discussion. Similarly there are no minutes available of the multi-agency pre-discharge planning meeting.

There were times during the child protection process when minutes of Core Group meetings were not completed and shared.

Social care case files do not record whether visits were announced or unannounced. The nature or extent of any home checks completing during these visits is also not recorded.

There was also no evidence in the GP records that they were invited to participate in the child protection process. Further enquires established that the GP Practice was invited to key meetings and did submit a report to the Initial Child Protection Conference.

The Child Protection Plan flag on mother's health records was not transferred to baby's records and this error was not noticed by professionals. This meant there was no safeguarding alert on baby C's record when care was transferred to a new GP. (Relevant documents had been uploaded to baby C's record by Harrogate and District Foundation Trust. These would have been visible to primary care practitioners but they would be unaware unless alerted to look.) Fortunately the GP identified this missing alert at baby C's 6-8 week check and raised with the Practice to ensure an alert was added.

Similarly, at the time of baby C's death, the child protection alert on the Police system had an outdated address (from when mother and baby C had been living in supported accommodation). This meant that the police officers who attended the tragic incident were unaware that baby C was known to children's social care. As a priority call, this did not make a difference in this case. However, it could be important risk management information for another child.

6.5.1 Good Practice

The GP identified this missing alert at baby C's 6-8 week check and raised with the Practice to ensure an alert was added.

6.5.2 Case Recording: Learning

Recognising the context of workload pressures, minimum standards for case reporting need to be adhered to. It is important to record when meetings took place, who was in attendance, what was discussed and the rationale for the decisions / actions agreed including who is responsible for these.

It is important that child protection alerts are correct and up to date, and that vital information – such as the address at which a child resides – is shared with all relevant agencies.

7. Other Learning

7.1 Impact of Covid-19

When mother became pregnant with baby C, many agencies were still following guidance related to the Covid-19 pandemic including virtual and telephone meetings.

The majority of mother's antenatal contacts took place face to face but virtual contacts were completed for her initial antenatal booking appointment with the midwife, obstetric consultant initial appointment and 16-week gestation. The antenatal Health Visitor appointment was via the telephone but all other Health Visitor appointments were face to face.

It is possible that virtual contacts may have reduced opportunities for professionals to explore mother's history and limited professional curiosity. However, there is no evidence whether or not virtual appointments made a difference.

All multi-agency meetings were also held via Microsoft Teams. This did appear to limit father's ability to engage (see below) but there is no evidence that these virtual meetings had a detrimental effect on the quality of discussions and decision-making amongst professionals. However, many practitioners at the Learning Event felt that consideration should be given to re-establishing face to face meetings for key meetings (such as the Initial Child Protection Conferences and Review Child Protection Conference where it is likely that a child will be removed from the child protection register).

7.2 Unseen Men

Numerous safeguarding reviews have found that men are frequently 'unseen' by services involved with children.[12]

Father was involved in this case. He was invited to participate in multi-agency meetings and the IRO spoke to both him and mother before the formal Child Protection Conferences. Children's social care also commenced a parenting assessment when father initially said he wanted to be considered as the primary carer for baby C.

Despite this involvement, the information about father available to agencies and at multi-agency meetings was limited.

While father remained keen to continue to be part of baby C's life, he appeared to struggle to engage with online meetings. His phone died during one meeting and another meeting was scheduled for a time when he was returning home from contact with baby C.

On at least one occasion father expressed concerns about mother taking baby C to visit people he did not consider to be suitable (grandmother who was known to smoke cannabis) and stated that he was unhappy with the assurances he had been given. In turn, mother made accusations about father's care of baby C when he had contact.

Many professionals at the Learning Event felt not enough effort was made to engage with father and to understand how he could support baby C.

[12] NSPCC Learning *'Unseen men: learning from case reviews'* (September 2022)

7.2.1 Unseen Men: Learning

> Although father was involved, and an assessment of his potential to care for baby C was commenced, the information about father available to agencies and at multi-agency meetings was limited. Meaningful engagement with fathers is important to successful safeguarding. It is crucial fathers, and any other men in the child's life, are considered in both the assessment and safety plan.

Although father was involved, and an assessment of this potential to care for baby C was commenced, the information about father available to agencies and at multi-agency meetings was limited. Meaningful engagement with fathers is important to successful safeguarding.

8. Conclusion and Recommendations

8.1 Cross-Boundary Information

This case demonstrates the challenges of safeguarding children when families move across local authority boundaries. It highlights the importance of obtaining information from out of area agencies and ensuring this is used effectively in local multi-agency safeguarding processes.

Effective cross-boundary working cannot be achieved by Safeguarding Partners in Durham alone. The Review Team, therefore, recommended that the learning from this review is shared with regional colleagues and joint work is undertaken to improve this important area of practice.

Options suggested include developing a pro-forma to simplify initial enquiries where out of area involvement is known or suspected. However, the Review Team noted that the exchange of written information should not be an automatic substitute for qualitative input from practitioners who have worked closely with the family in other local authority areas. The Review Team would like to recommend to regional colleagues that consideration be given to formalising reciprocal arrangements to allow key professionals to attend multi-agency meetings at significant points, such as the Initial Child Protection Conference. This would be a valuable, and practical, way of sharing information and understanding across boundaries to ensure professionals from all agencies have a better understanding of the child's circumstances and any associated risk and protective factors. Virtual meeting technology (such as Microsoft Teams) could be used to prevent the need for out of area practitioners to travel to meetings.

8.1.1 Recommendation 1

The Durham Safeguarding Partners initiate a conversation with regional colleagues to explore ways of improving cross-boundary information sharing.

Durham's protocol for multi-agency engagement in Strategies and Section 47 enquiries will then need to be updated to explicitly cover cross-boundary working and the processes that should be followed to ensure appropriate engagement of out of area professionals. (Cross boundary working is not mentioned in the current protocol.)

Knowledge of this revised guidance will need to be cascaded to all relevant practitioners.

8.2 Role and responsibilities of frontline practitioners in multi-agency safeguarding

The learning identified by this review suggests that, while frontline practitioners have a good understanding of how to identify need and safeguard children, they do not as consistently understand their roles in multi-agency processes.

Many of the practice issues identified as learning in this review are already covered in formal multi-agency safeguarding guidance – both locally and in the national *Working Together to Safeguard Children 2018.* However, these principles are not always consistently applied in practice.

While the importance of information sharing is understood, there is less confidence in interrogating and challenging information in a multi-agency setting. This includes verifying the accuracy of information presented in multi-agency meetings and exploring inconsistencies in the information presented in these meetings.

The shared responsibility for contributing to assessments and collectively exploring risk factors also appears to be inconsistent. Quality assessments are reliant on all practitioners sharing both their knowledge and professional judgement. Important issues such as cumulative harm can only be identified if there is a robust examination of all relevant background history and current risks.

The findings of this review would suggest that frontline practitioners need to be encouraged and empowered to ask more questions of their peers. This could include identifying agencies who are missing from meetings or who haven't been invited to join the Core Group. It could include encouraging practitioners from all agencies to request the rationale for decisions that they were not part of. It could include them challenging the quality of case recording, or asking whether other family members – especially unseen fathers – should be making a bigger contribution.

There is an individual responsibility for effective internal handover within organisations and a collective responsibility to explain the background and issues to practitioners joining the process. This includes when a new organisation joins multi-agency meetings. For example, when the Supporting Housing provider joined the Core Group in this case.

8.2.1 Recommendation 2

All members of the Durham Safeguarding Children Partnership contribute to a concerted campaign to ensure that frontline practitioners have a practical understanding of both their individual and collective role in multi-agency work to safeguard children.

This should build on and develop further the existing work being delivered by the Durham Safeguarding Children Partnership.

As part of this work, every agency should:

- **ensure standards for reflective discussions are embedded, and health agencies should review their safeguarding supervision policies to ensure there is sufficient oversight and support.**
- **review their existing handover processes when practitioners leave, or when a different members of staff joins a multi-agency process, to ensure that previous information is shared and there is a continuity of understanding.**

- **provide assurance to the Safeguarding Children Partnership that processes are in place to share vital information – such as the fact that a child is on a child protection plan or the addresses at which they reside – with all relevant agencies.**

8.3 Assessment Tools

This review highlighted the importance of regularly monitoring the home environment in which the child lives and the role of the Home Environment Assessment (HEAT) tool. This HEAT tool is currently being adapted and refreshed to make it simpler to use and to bring it in line with the Graded Care Profile 2.

Once the HEAT tool refresh is completed, it will be important that all agencies ensure that it is used consistently by their practitioners. However, it is equally important that this isn't used as a single agency tool and completed HEAT assessments need to be shared with other professionals working with a child and their family.

The Review Team noted that other family engagement tools are currently being developed and welcomed these as a practical support to recommendation 2 (above).

8.3.1 Recommendation 3

The refreshed Home Environment Assessment (HEAT) tool and related family engagement tools should be rolled out alongside the campaign to empower individual frontline practitioners to be more pro-active in multi-agency safeguarding meetings.

All agencies to audit the use of these tools and to ensure they are consistently recorded in case files.