Local Child Safeguarding Practice Review:
Baby JS

Independent Lead Reviewer: Dr Zoë Cookson

May 2023

Contents

1. Introduction and Background

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 Context

Baby JS (aged four months) was found unresponsive in bed with mother, an ambulance was called and paramedics administered CPR. Baby JS was subsequently pronounced dead in the hospital Emergency Department. The cause of death has been recorded as unascertained by the Home Office Pathologist.

Father and mother had recently been through an acrimonious separation that took place shortly after baby JS's birth. At the time of baby's death, father had moved out and mother was the primary care giver. Mother was also the primary care giver of JS's older siblings – aged six and two.

2. Methodology and Process

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

2.2 An independent Lead Reviewer (Dr Zoë Cookson) was appointed to manage the review process, chair all relevant meetings, facilitate the Practitioner Learning Event and author the final report. She was supported by a Review Team made up of local safeguarding professionals from key agencies.

2.3 The following Key Lines of Enquiry were developed as part of the Rapid Review and refined by the Review Team:

- The impact of the processes followed at the front door in terms of screening (including timeliness), effective information sharing and decision making.
- The effectiveness of the Early Help Assessment and subsequent plans to ensure a co-ordinated multi-agency response to the family's individual needs.
- The potential for unconscious bias around female perpetrators of domestic abuse and how this affects actions and decision making.
- The impact of alcohol use on parenting capacity when no evidence of drug or alcohol dependency.
- The extent to which the cumulative risks from alcohol use, mental health needs and domestic abuse, when present in combination, impacted on outcomes in this case.
- Whether indicators of neglect were appropriately logged and reported and whether the voice of the child was always considered.
- The extent to which domestic abuse, including coercion and control, affected parenting capability in this case.

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

2.4 The Review Team agreed the focus of the review should be the date of mother's engagement with services around her pregnancy to the date of baby JS's death. It was agreed that information prior to these dates would be considered where relevant.

In practice, however, no concerns came to the attention of agencies until the month of JS's birth so the focus of this review has been on a narrower time period – from the month of baby JS's birth to the date of JS's tragic death. The review does not go beyond the date of baby's death.

2.5 The review drew on the initial scoping information submitted by agencies to the Rapid Review alongside individual agency analysis of learning related to the agreed Key Lines of Enquiry, and a multi-agency chronology of events.

2.6 A reflective Practitioner Learning Event was held with frontline practitioners. This sought to obtain first-hand experience from those working with the family, and to also understand the context that practitioners were working within.

2.7 Both mother and father were invited to contribute to the review and asked whether they wished their parents to be invited to participate.

Mother initially replied to say that she would like to be involved and would like to be interviewed as a family group with the maternal grandparents. It was noted that the timing of this involvement would depend on the police investigation. Mother and the maternal grandparents were contacted in February 2023 to set a date to meet the Lead Reviewer and they requested that the interview be delayed until April 2023. Despite several attempts, the Lead Reviewer was not able to make contact with mother or the maternal grandparents in April 2023 and an interview did not, therefore, take place.

Father was interviewed via Microsoft Teams in May 2023.

3. Analysis and Identification of Learning

3.1 Introduction

The cause of baby JS's death has been recorded as unascertained by the Home Office Pathologist. However, the potential risk factors that may have impacted on baby's death – and on adherence to safe sleep advice – were examined as part of this review. Unfortunately, there is insufficient evidence to make a judgement regarding the existence or impact of many of these risk factors, largely because the knowledge agencies had of the family in this case was limited during the time period being examined.

This review has, however, identified important wider learning about safeguarding practice in Solihull that has the potential to improve the safeguarding of other children in the area.

The detailed examination of this case identified learning about the processes followed at the children's social care front door at the time of the referral.

While the incident that led to baby JS's death did not relate to domestic abuse, this case identifies learning around how agencies view, and respond to, domestic abuse.

Similarly, while the detailed examination of the case found the family's needs were inappropriately filtered as early help and should have followed a safeguarding route, the case does highlight learning about how agencies work together to support families

requiring early help. In particular, it reveals a tendency to rely on children's social care to co-ordinate multi-agency early help work.

4. Considering the Risk Factors

4.1 National Research

In July 2020, the national Child Safeguarding Practice Review Panel (the Panel) published a review into sudden unexpected death in infancy (SUDI) in families where the children are considered to be at risk of significant harm.[2]

The report noted that infants dying suddenly and unexpectedly represented one of the largest groups of cases notified to the Panel. Almost all of the tragic incidents involved parents co-sleeping in unsafe sleep environments with infants, often when the parents had consumed alcohol or drugs. In addition, there were wider safeguarding concerns – often involving cumulative neglect, domestic violence, parental mental health concerns and substance misuse.

These predisposing risks were often combined with out-of-routine incidents or 'situational risks', where unexpected changes in family circumstances meant an infant was placed in an unsafe sleep environment.[3]

4.2 Predisposing risk factors in this case

Several professionals were aware that mother had **mental health problems**, largely because mother shared this information with them. Mother was receiving support from the perinatal mental health service and their observations found mother to be meeting the needs of her children.

Domestic abuse was a feature of the parent's relationship. However, this was not explored by professionals at the time and the extent and nature is unknown (see section 6 of this report).

There was insufficient evidence to make a judgement regarding the presence of other predisposing risk factors in this case (see section 4.2.1 – 4.2.3 below).

4.2.1 Alcohol Use

Alcohol use, even if there is no dependency, can have a negative impact on parenting capacity. When under the influence of alcohol, parents may make decisions they would not usually make and there is a risk that these decisions can place children in danger.

Where an adult is struggling, agencies should discuss the strategies they are using to cope including the use of alcohol and other substances.

Mother was asked about alcohol use as part of routine enquiries by multiple agencies.[4] This did not identify any concerns about the use or alcohol or any other substances

[2] The Child Safeguarding Practice Review Panel, *Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm* (July 2020).
[3] These 'situational risks' include moving to different accommodation; a family party; the arrival of a new partner; the baby being unwell; alcohol or drug use on the night in question.
[4] Lifestyle issues, including alcohol, were explored during mother's antenatal assessment by the midwife and no concerns were identified. Alcohol and substance misuse was included in the screening process undertaken by children's social care following the safeguarding referral, and also in her

and there were no indicators of alcohol use in any of mother's interactions with professionals.[5] Mother is, however, known to have consumed alcohol on the night before JS's death.

The family support worker reported that, in a parental conflict session a few days before baby JS's death, father mentioned concerns about mother going out drinking with friends while she was responsible for the children. However, the family support worker reported that his concerns appeared to be around who mother was leaving the children with rather than concerns about mother's alcohol consumption. In light of events, the family support worker reflected that she could've gone back and explored the mention of alcohol in more detail but at the time she felt the focus of father's concerns were on mother's friendship group. Indeed, she explained that one of the outcomes of the session was an agreement regarding which individuals both parents were happy for the children to be around.

In his interview with the Lead Reviewer, father strongly disputed this account of the issues he raised at the parental conflict session. He reported raising serious concerns regarding mother's alcohol consumption. These concerns were based on his knowledge of people taking bottles of alcohol into the house and mother's past behaviour when drinking alcohol. Father reported also raising concerns about the people who mother was mixing with, particularly as some were known to be involved in drug use. Father feels his concerns about the safety of the children in this environment were not taken seriously. Indeed, as with the issue of domestic abuse (see section 6), he feels that there was a gender bias in favour of mother.

4.2.2 Cumulative Harm

No investigations were made around cumulative harm by any agency. The combined presence of key risk factors was not identified by any professional and there was no multi-agency working to share information.

As outlined above, alcohol use was not considered an issue for mother by professionals. There was also no exploration of drug use. At the Learning Event, one agency shared that they were aware mother had taken drugs in her past but that had been before any of her children were born and they had no concerns.

Mother's mental health needs were known to some agencies working with mother but others were unaware: neither the midwifery service nor the primary school attended by the oldest sibling[6] knew of any mental health difficulties.

Several of the professionals working with family were unaware that domestic abuse may be a feature of the parents' relationship. Indeed, as noted in section 6.4, the nature of domestic abuse within the family was not explored or understood by professionals and, therefore, remains largely unknown.

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assessment by the perinatal mental health service mother. Mother stated that she used to be a social drinker before having children but did not drink now. In the health visiting screening at both the New Birth and six to eight week contact, mother reported that she was not drinking alcohol.

[5] There was a historical alcohol related police incident (just over 3 years before baby JS's birth). There was, however, no information at that time to suggest that alcohol was an issue for either parent beyond overindulgence at a party.

[6] When he met with them the month before baby JS's death, father informed the school that mother is bipolar but this was not verified by any formal information and is not correct.

This limited exploration of risk factors at the time makes it impossible to determine retrospectively the impact of cumulative risks.

4.2.3 Neglect

Responses to this review from all agencies who were engaged with the family stated that no indicators of neglect were identified within the household.[7]

The only concern noted was by the health visitor during the six-week review. The health visitor noted the floor was cluttered and dirty crockery was within easy reach of children. This had the potential to result in a physical injury to JS's two-year old sibling and create a trip hazard for parents whilst carrying baby. Home safety advice was given, additional visits were offered and mother reported she had support from the perinatal mental health team. The home environment had improved by the next visit and the health visitor recorded that both baby JS and two-year old sibling appeared well cared for and were dressed in clean appropriate clothes.

Father did raise concerns about JS's oldest sibling with her school, expressing a concern that she hadn't been given breakfast on one occasion and on another noting her hair had been matted. School staff responded that they had no concerns.[8] JS's oldest sibling was closely monitored by school staff and they saw no evidence of neglect either prior to or during the review period.

4.3 Safe Sleeping

Health visiting standards state that a safe sleep assessment should be completed at the New Birth and six-to-eight-week visits. This should include an observation of the baby's sleeping area.

A safe sleep assessment is clearly documented in baby JS's health records and is extensive. The health visitor documented that the family was adhering to safe sleep advice, had been advised not to co-sleep and parents had been signposted to the Lullaby Trust for further information. Sudden Infant Death Syndrome (SIDS) was also discussed. Baby JS's sleeping environment was observed and recorded to be in a Moses Basket.

This is consistent with the National Panel's review of sudden unexpected deaths in infancy which found that in all cases safe sleep advice, including information leaflets, had been given to parents and documented, frequently on more than one occasion. However, the Panel found that this advice is not always clearly received or acted on by some of the families most at risk.[9]

To engage effectively with these families, the national review concluded that local areas need to move beyond a framework that sees SUDI risk reduction in isolation from other risks and as solely the responsibility of a narrow range of health professionals. The review recommended that practitioners in all agencies who are working with families with children at risk need to develop a clear evidence-informed

[7] This included the midwifery service, the family support worker from children's social care, the perinatal mental health service, the school of the oldest sibling, and the police officers who attended the home address and conducted enquires in response to the serious incident.
[8] As noted elsewhere in this report, the school had been offering this oldest sibling support around her relationships with other children for some time.
[9] Mother did not participate in this case review and it is not possible to determine why safe sleeping advice was not followed on the night of baby JS's death.

understanding of parental decision-making in relation to the sleep environment and how this might be changed.

In light of this, the Panel encouraged local safeguarding partners to adopt a 'prevent and protect' practice model. As a matter of good practice, safeguarding partners in Solihull should ensure that this model has been reviewed and action taken to implement this, as appropriate, across the area.

4.4 Good Practice

The health visitor appropriately challenged the home conditions at the six-week review and provided advice on home safety. These issues were addressed by mother.

While no concerns were identified with screening processes, following JS's death Solihull Integrated Addictions Service were invited to provide refresher training to the health visiting team in Solihull on alcohol screening to support best practice with families.

Learning

While the cause of baby JS's death has been recorded as unascertained by the Home Office Pathologist, the circumstances would suggest that alcohol consumption may have played a part. No agency identified alcohol use as an issue for mother.

The case identifies the importance of reinforcing messages around the potential risks to a child's safety of alcohol use by parents, even where there is no dependency.

The Solihull Safeguarding Children Partnership recognised this during the Rapid Review of baby JS's death and developed a one-page briefing. This is accessible on the internet at this link. The briefing was circulated to all strategic leads across the Partnership with a request that they take action to embed the learning within their organisation's operating processes. The Safeguarding Children Partnership are monitoring and collating feedback to ensure this action is completed.

5. The Front Door

5.1 Referral

Mother was in receipt of universal services until referred to the perinatal mental health team in December 2021, and then to children's social care in January 2022.

Mother phoned the duty number for the perinatal mental health team on 4th January 2022 reporting that, during an argument, she had "slapped / clipped" father while he was holding their two-year-old. She was distressed and expressed concern about how close she had come to hitting her son.

Mother reported she had also phoned children's social care for support. The perinatal mental health service called to verify this with social care. Mother did not appear to be known to social care so the perinatal mental health team called mother back and obtained consent to make a referral. The referral was then made.

5.2 Social care screening

5.2.1 The screening process followed

A children's social care manager identified that the screening should be completed by a Level 4 social worker within the MASH (multi-agency safeguarding hub).

Although received on 5th January, this screening was not undertaken until 13th January.

The social worker spoke to the perinatal mental health service, although there are conflicting accounts of whether this was as part of the formal screening or in a call to ascertain mother's phone number. The perinatal mental health service provided a summary of their recent assessment of mother.

The social worker phoned both mother and father. Mother reported that father had never been physically violent towards her, but she had been physical towards him.

Father disclosed physical abuse from mother over a number of years. Father stated he had no concerns about the needs and safety of the children.

A DASH Risk Assessment was completed on mother on 13th January but not on father.

No information from other agencies was requested.

The social worker undertaking the enquiries made a recommendation to step the family down to early help and this was approved by an early help manager who was not social work qualified.

No further action was taken until 27th January when mother was informed by letter that a family support worker would be allocated.

5.2.2 Analysis of the screening

On reviewing the screening process that was followed, managers within children's social care identified significant concerns.

The screening itself was inadequate as phoning parents and the referrer does not enrich information sufficiently to allow a threshold decision to be made. Lateral checks should have been completed and the absence of these resulted in missed opportunities for information about the family to be brought together (see section 7.3.2).

The focus was on the parents rather than the children.

Despite this focus on the parents, the emotional aspect of domestic abuse and coercive control was not recognised in the screening process. The situational impact of a new baby, depression, isolation, domestic abuse and admittedly struggling to cope with three young children was not considered in enough detail and the risks that can emerge from this were not identified.

There appears to have been a presumption that early help would be the outcome of the screening conversations. Consent for an early help assessment was obtained from mother in the screening conversation before the phone call to father had been made. Consent for an early help assessment was also sought from father at the start of the phone call, before he was asked any questions about the family's circumstances and situation. Father disclosed physical abuse during the subsequent conversation but this did not lead to a revision of the recommendation to continue to early help.

The decision was not quality assured by a social work qualified team manager, allowing the case to leave the MASH and move to support at level 3.

There was a delay before the decision was shared with mother. The agency who made the referral was not informed of the outcome of their referral and, despite participating in screening conversations, father was also not informed of the outcome.

Social care managers examining this screening process agree that this should have been assessed and managed as a Level 4 safeguarding case and it was not appropriate to transfer this to early help.

5.2.3 Action that has been taken to address the issues in MASH screening

This case is illustrative of a wider problem with MASH screening at that time and action has been taken to address the concerns identified.

Social workers are now allocated to all children referred to the MASH and these social workers are responsible for leading all enquiries.

At least two core checks with agencies are required for all enquiries in addition to conversations with the referrer, parents and – if appropriate – the child(ren). This ensures adequate information is gathered for enquiries to be meaningful and for a threshold decision to be reached.

A qualified social work manager quality assures and signs off all cases before they leave the MASH into any other service.

Feedback to the referrer and those participating in the screening is expected.

The referral form has been revised. This includes the removal of the requirement for the referring organisation to specify the 'level' of the case. At the Learning Event for this review, practitioners particularly welcomed the removal of the previous choice between family support and social worker assessment as they do not feel equipped to make these judgements.

5.3 Timeliness of response

There was timely screening and response from the perinatal mental health service. They received the referral on 16th December and completed their screening on the following day, making a formal appointment for home visit on 31st January 22 and providing contact details should mother need immediate support.

The perinatal mental health service were also responsive when mother contacted them in distress on 4th January. They provided telephone support, initiated the safeguarding referral and brought forward the first home visit with mother from 31st to 11th January.

In contrast, there were significant delays in taking action on the safeguarding referral to children's social care with a two and half month gap between the referral and support being provided.

The referral was received on the 5th January, screening conversations were held on 13th January, and mother was informed of the decision to allocate a family support worker on 27th January. Social care have confirmed that screenings should be completed within one or two days of receipt of the referral.

There was a further delay allocating a family support worker due to capacity pressures but mother was given contact details for the team in case of urgent change. Children's

social care were aware that a worker from the perinatal mental health team would be visiting and supporting the family whilst they waited for a family support worker. However, this worker from the perinatal mental health team was not informed of any social care decision making or plans.

A family support worker was allocated on 17th February but, due to an oversight and annual leave, the case was not picked up by the family support worker until 7th March. The family support worker phoned mother on the 8th March, visited her on the 9th March and initiated contact with other agencies on 15th March. The family support worker commenced work on the early help assessment.

Changes have since been made to how the "unallocated" list of those waiting for early help family support is managed. Both the referral and the child and family's circumstances are now reviewed by a duty team manager who contacts those professionals who are already involved with the child or family. Support is then allocated on the basis of the level of need.

Children's social care are also in the process of recruiting additional staff to enable them to better manage this waiting list. This includes two extra social workers, one qualified social work manager and three additional family support workers.

5.4 Good Practice

The perinatal mental health service demonstrated good practice by verifying mother's assertion that she had already contacted children's social care following the incident on 4th January. As mother did not appear to be known to social care, it was good practice that the perinatal mental health service obtained consent and made the referral.

Learning

This case demonstrates significant weaknesses in the social care response.

The initial screening was inadequate and there appears to have been a presumption that it would result in a transfer to early help. The screening did not draw on information from other agencies and did not consider the changes in potential risk revealed through screening conversations. For example, father's disclosure of a history of physical abuse by mother.

Given the presenting issues, the referral should have been assessed and managed as a Level 4 safeguarding case and should have resulted in a Strategy discussion. This would have been an opportunity to explore whether the three children were at risk due to domestic abuse (see section 6 below).

There were also significant delays at every stage of the process, from screening to the allocation of support, as well as noticeable gaps in the feedback on the outcome of the referral.

Having recognised these weaknesses, it is important to note that changes have been made to the way that MASH screenings operate in Solihull. These should address the issues highlighted in this review.

Changes have been made to how the 'unallocated list' is managed for those waiting for family support. Early Help services more broadly are also currently being redeveloped with additional funding to ensure a comprehensive service is in place in Solihull which is able to meet demand.

6. Exploring issues of domestic abuse

6.1 Definition of domestic abuse

The Domestic Abuse Act 2021 defines domestic abuse as behaviour between two people aged 16 or over who are personally connected to each other that involves any of the following: physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse[10]; psychological, emotional or other abuse. It does not matter whether the behaviour consists of a single incident or is a pattern of behaviour.

The Domestic Abuse Act 2021 also states that children are victims of domestic abuse that is perpetrated against their parent or carer.

6.2 Evidence of domestic abuse

6.2.1 Screenings for domestic abuse

University Hospitals Birmingham NHS Foundation Trust, who deliver midwifery services, have a policy that domestic abuse screening should be completed at least three times during the antenatal period. Mother was asked five time and no concerns were identified.

Covid-19 restrictions were in place during the period that mother engaged with midwifery services and she was, therefore, seen without father. This meant that the midwifery service had no contact with father. This would, however, have provided mother with an opportunity to disclose domestic abuse if she was the victim.

South Warwickshire University NHS Foundation Trust, who deliver the health visiting service, also have comprehensive policies around domestic abuse screenings. A routine enquiry was made at the new birth visit and mother denied any domestic abuse. When asked the routine enquiry at the six week visit, mother disclosed that she had hit father in the face during an argument. In response to this, the health visitor discussed the negative impact on children of witnessing physical abuse with mother. The health visitor also followed up and verified mother's assertion that a referral had already been made to children's social care.

6.2.2 Incidents of domestic abuse

In the relatively short timescale covered by this review, there were two key incidents that shaped both the actions and perceptions of professionals. Both relate to domestic abuse. In the first (the incident that led to the social care referral), mother was the perpetrator of physical violence while, in the second incident just over two months later, father was accused of coercive and controlling behaviour.

Agency responses to these incidents reveal unconscious bias about female perpetrators of domestic abuse and also demonstrates a failure to fully explore the nature of the relationship between the parents.

It is worth noting that there was one other incident indicating potential domestic abuse that fell outside of the formal review period. In October 2018, father reported an assault

[10] This is any behaviour that has a substantial adverse effect on the victim's ability to acquire, use or maintain money or other property, or obtain goods or services.

by mother to the Police following a night out drinking. He retracted this the following day.

6.3 Unconscious bias around female perpetrators of domestic abuse

There is evidence of unconscious bias around female perpetrators of domestic violence.

At the Learning Event, practitioners noted that routine domestic abuse screenings of pregnant women and new mothers are focused on mother as the potential victim and suggested that questions could be reframed to avoid this unconscious bias. For example, in this case, the health visitor recalled asking mother a question along the lines of 'has there been any domestic abuse in your relationship?' (framed this way because she was aware a toddler was in room) and this led mother to disclose the January incident where she had been the perpetrator.

The initial social care screening was in response to the referral report of mother's "slap / clip" to father. As part of this screening mother admitted to being physical towards father in the past. Father also disclosed physical violence by mother to him over a number of years. Despite this, the DASH assessment looking at the risks associated with domestic abuse was completed on mother not father.

No follow up action was taken in response to father's disclosure of domestic abuse, even though this abuse was substantiated by mother during the screening conversation. Father was not offered any support and he reported feeling *"like I don't matter"* and "*no-one cared what I said."*

Father was the victim of domestic abuse and consideration should have been given to the risk towards him from mother's behaviour. Instead, the recommendation from the screening was the allocation of a family support worker to support mother with no reference being made to father.

It is possible that this unconscious bias around female perpetrators of domestic abuse may have influenced how the risks to baby JS and JS's siblings were perceived. The two-year old sibling could have been injured by mother should her "slap" to father have struck the child instead. However, the referral did not prompt a Strategy discussion to consider whether the three children were at risk due to domestic abuse. It is possible that this was because father was not seen as a victim of domestic abuse (despite clear disclosures by both father and mother during the screening conversations).

Other agencies have also reflected that they did not fully explore mother's actions as a perpetrator of domestic abuse. The perinatal mental health service, for example, reflected that there was an over reliance on self-reporting by mother and an acceptance of her word that she hadn't perpetrated any further domestic abuse. Had multi-agency conversations been held, it would have been possible to triangulate this and additional information – such as the 2018 incident recorded in Police files – may have led to more exploration of mother's role as a perpetrator. Instead, mother's future engagement with the perinatal mental health service was focused on the stresses she reported father was placing on her and support was provided to mother to help her deal with this.

6.4 Failure to explore the nature of the relationship between parents

Mother described coercive behaviour by father towards her. From these descriptions, and their interactions with mother, several practitioners had a strong perception that father was controlling towards mother.

This, however, remains an unverified perception: the focus of most professionals was on mother and they had no engagement with father. The exceptions to this were the family support worker and the school of the oldest sibling.

The family support worker was aware of the incident in January in which mother hit father but described this as being a one-off event as a result of ongoing parental conflict rather than domestic abuse. Both parents described heated arguments which included a lot of screaming and shouting.

In contrast to other practitioners, the family support worker did not have the impression that father was controlling or using coercive behaviours. Mother told the family support worker that father was a good father and mother said she wanted him to be more involved with the children and to see them more. Similarly, in his conversations with the family support worker, father said that he thought mother was a good mother.

Both parents agreed to attend a parental conflict session with the family support worker. This was held on 30th March and the family support worker felt this meeting was very positive.[11] The family support worker reported that mother and father both expressed their concerns openly and agreed actions moving forward. Indeed, when she left, the family support worker felt mother and father were both calm and described how they both chose to stay behind to have a coffee together.

In recognition of mother's mental health difficulties, the family support worker checked that mother knew how to access support from the perinatal mental health service and confirmed that a visit from the service was scheduled.

The only other agency who had any engagement with father was the primary school of the oldest sibling. School staff saw father on a regular basis but they were unaware of any potential issues related to domestic abuse (as either a victim or potential perpetrator). Had the school known, they may have taken action to ensure that other agencies were aware of the support they were offering to this sibling.

The primary school had been providing specialist Play Therapy support to the oldest sibling with her relationships in school since her Reception Year. Social care also have a record of a call from the oldest sibling's childminder in 2019 reporting concerns about her behaviour and making false allegations that someone had hit her. It is possible that this unusual behaviour could be a result of this child witnessing domestic abuse within the family. However, her behaviour could equally be due to other factors.

The absence of multi-agency working (see section 7 below) means these issues weren't explored during the period that professionals engaged with the family. The true dynamics of the parents' relationship and the potential effects on their children, therefore, remained unknown at the time of baby JS's death.

[11] Father had a different view of this meeting: this is covered in section 4.2.1

6.5 Impact of domestic abuse

While there are domestic abuse indicators, these do not appear to have directly influenced the tragic events of baby JS's death.

Key professionals were aware of mother's physical assault of father in January 2022 but remained confident of her ability to safely parent her three children. Similarly, professionals who believed mother to be subjected to controlling behaviour from father did not feel this negatively affected her parenting capability. At the Learning Event, and in reflective feedback, practitioners described how they had observed good bonding between mother and her children as well as responsive and safe caring.

However, witnessing domestic abuse within the family is likely to have had a detrimental impact on the children's emotional wellbeing. The extent of any domestic abuse was not explored at the time and is, therefore, unknown.

6.6 Good Practice

Routine enquiries around domestic abuse were completed by both the midwifery and health visiting service. This prompted mother to disclose to the health visitor in January 2022 that she had hit father.

The health visitor demonstrated good practice by verifying the referral with children's social care when mother stated that she had self-referred to social care.

While there was no multi-agency working to examine issues of domestic abuse, there are examples of good practice on a single agency level. For example, the health visitor discussed the negative impact of children witnessing physical abuse.

Following the parental conflict session, the family support worker checked that mother knew how to access support from the perinatal mental health service and confirmed that a visit from the service was scheduled.

Learning

While the incident that led to baby JS's death was not related to domestic abuse, this case does identify learning around this issue that has the potential to improve the safeguarding of other children in the Solihull area.

Routine domestic abuse screenings of pregnant women and new mothers need to allow for disclosure of domestic abuse by female perpetrators. It is, therefore, important that screenings do not focus exclusively on mother as the potential victim. Agencies who undertake these screenings should review the questions used and, if necessary, reframe questions to avoid this unconscious bias. Guidance should be included to encourage the father's voice to be considered as part of routine screenings, wherever practical.

Fathers who are victims of domestic abuse should be considered in the same way as mothers in regard to support and intervention.

There is a need to ensure that all professionals explore and identify the dynamics of situations involving domestic abuse. This includes establishing who is using abusive behaviours and who is the victim. It also requires a recognition that a victim of domestic abuse could also be a perpetrator.

Risks to children need to be thoroughly understood in all referrals related to domestic abuse and consideration must be given to the direct harm of domestic abuse on children.

7. Co-ordinating a multi-agency early help response

7.1 Early Help

The analysis in section 5 of this report explains that the needs of this family were inappropriately filtered as early help and should have followed a formal safeguarding route to allow the exploration of potential domestic abuse and the impact on the three children.

This does not, however, prevent this case from being used to identify learning about how agencies in Solihull work together to support families requiring early help. The circumstances of this family's experience in the relatively short review period suggests a tendency for agencies to work in isolation, a lack of inter-agency information sharing, and a reliance on children's social care to co-ordinate early help work.

7.2 Definition of Early Help

The Early Help Guidance (2019) issued by Solihull Local Safeguarding Children Partnership defines early help as:

"the support that is delivered to any child at Level 1 to Level 3 of Solihull's Threshold guidance. It includes universal interventions that are offered to an entire population to prevent problems developing and targeted support to particular children and families with additional needs.

The purpose of Early Help is to support the well-being of children and families by tackling emerging needs at the earliest opportunity and prevent them from getting worse. This means working with children and families to engage and include them as equal partners and to support them to access additional services that can promote positive outcomes."

Solihull's Early Help Procedure also makes it clear that:

"any universal or specialist service can offer early help, including community and voluntary sector organisations"

and this support should be offered:

"as soon as an unmet need is identified for a child / young person".

7.2.1 Reliance on children's social care to lead early help

Several agencies have reflected there was a missed opportunity to offer early help support to the family in December 2021 before the safeguarding incident in January 2022. There was also a lack of multi-agency co-ordination immediately after the incident.

At the Learning Event for this review, professionals from a range of agencies reflected that multi-agency meetings in Solihull are too often reliant on social care organising them. There was a consensus that multi-agency co-ordination needs to take place as soon as the need for joint working is identified and this should not wait until a threshold for social care involvement is met.

Work did not commence on an early help assessment until the family support worker from children's social care picked up the case two and a half months after the January

incident. The scheduled completion date for the early help assessment was 25th April 2022.

At the time of baby JS's death, therefore, no multi-agency meeting had been held, the circumstances and needs of the family had not been explored, and no plan had been drawn up for a multi-agency response.

The lack of co-ordination meant that agencies continued to work in separate organisational silos. Indeed, mother had multiple visits and phone calls from agencies – often on the same day.

Multi-agency meetings would have helped triangulate information and could have helped return some of the focus to the lived experience of the children rather than centring upon the difficulties in the parents' relationship.

7.3 Information Sharing

Despite several agencies being aware (from either December 2021 or January 2022) that the family may require additional support and that multiple agencies were involved, there was no formal sharing of information.

7.3.1 Over reliance on mother sharing information

Instead, there was a reliance on mother sharing information with professionals. For example, the perinatal mental health team knew about the 2018 incident involving the police as mother disclosed this to them. The health visitor knew about the involvement of the perinatal mental health service and the incident in which mother "slapped" father because mother shared this information.

7.3.2 Absence of information sharing at the time of the referral

Children's social care did not make any lateral checks in response to the referral. Indeed, they appear to have obtained information on the assessment undertaken by the perinatal mental health team largely by accident when they telephoned the service because they hadn't been able to contact mother. No other agency sought formal information from others. This absence of information sharing around the time of the referral led to a missed opportunity for developing a shared understanding of the family's needs. For example, it would have given the police an opportunity to share their information about the incident in October 2018 when father claimed that mother had assaulted him. (Due to an oversight, this had not been shared at the time, possibly because no child was present.)

There was also a missed opportunity at this time to ensure that all relevant agencies were aware the family had additional needs. The school of the oldest sibling knew that the parents had separated but had no knowledge of any concerns until a meeting with father on 2nd March. School then received an alert from the police on 15th March (prompted by mother's complaint about father), which was the same day the family support worker telephoned them. Although they maintained usual levels of vigilance as they would for all children, they were not aware of the potential need to provide additional support between January and March.

7.3.3 No shared understanding of outcome of the referral

Children's social care did not share their decision to allocate a family support worker and undertake an early help assessment with any other agency.

Those agencies who were aware of the referral did not proactively follow up the outcome of the referral when they did not hear from children's social care. Nor did they seek to initiate conversations with other agencies about the family.

7.3.4 Father's views

Father was a victim of domestic abuse and this was not acted on (see section 6.3). Father reported feeling dismissed when he shared concerns about neglect of the oldest sibling with school and was advised to report these concerns to the MASH himself as the school had not identified any signs of neglect. Father's concerns about mother's alcohol use (see section 4.2.1) were not followed up.

7.3.5 Formal notification and sharing of information between agencies

The perinatal mental health team showed good practice sharing information on their work with the GP Practice and in their referral to children's social care but they did not communicate directly with the health visiting service.

The importance of effective communication and joint working between the perinatal mental health service and heath visitors was recognised by the Rapid Review of this child's death. To improve the support to new mothers with significant mental health needs, practice has been reviewed and new guidance has been agreed. Perinatal mental health teams now update health visitors following appointments with clinicians by copying them into GP letters. Care co-ordinators also now contact health visitors when they are allocated to ensure information is shared and communication pathways are set up.

There was a suggestion, in the written feedback to the Practitioner Learning Event, that improvements could be made to how community midwives assess mental health at discharge, ensuring key events are handed over to health visitors.

7.3.6 The need to share information at an early stage

The family support worker did contact other agencies in order to begin to gather information shortly after she picked up the case. Unfortunately, delays meant that this was two and a half months after the referral and only two weeks before JS's tragic death.

Bringing together information at an earlier stage would have allowed practitioners to be more professionally curious and explore need within the family and issues such as potential domestic abuse. For example:

- Mother as a potential perpetrator of domestic violence was unknown to some practitioners working with mother.
- Since Reception, and during Year 1, school had been offering specialist Play Therapy to oldest sibling to support her with her relationships in school. If other concerns were known about potential domestic abuse, it may have led to further exploration of what was happening within the family.
- School staff were seeing mother, father or his new partner daily (often twice a day) and felt that, had they known more, they may have been more alert to watching for potential concerns and may have been able to offer support.
- Multi-agency discussion and co-ordination would have ensured more focus on the lived experience of the children in the family rather than the focus on the parents' relationship.

In the written feedback at the Learning Event for this review, several practitioners reflected it would have been useful to share information and develop a multi-agency chronology as part of partnership working.

7.4 Good Practice

The perinatal mental health team showed good practice sharing information on their work with the GP Practice.

Learning

Multi-agency co-ordination needs to take place as soon as the need for early help is identified and this should not wait until a threshold for social care involvement is met. In line with Solihull's *Early Help guidance and procedures*, all agencies need to be proactive in responding to identified need and should obtain consent from the family to share information with other agencies.

Where formal referrals are either made or known, agencies need to be similarly proactive in following up the outcome of these. The referral should not be viewed as an end itself.

Agencies need to ensure processes are in place to make appropriate notifications about their work and to work with key partners. As noted in section 7.3.5 above, perinatal mental health teams now update health visitors following appointments with clinicians by copying them into GP letters. Care co-ordinators also now contact health visitors when they are allocated to ensure information is shared and communication pathways are set up.

8. Voice and Lived Experience of the Child

8.1 Voice and Lived Experience of the Child

Children, especially babies and infants, are usually seen in the care of their parents and it can be challenging to ascertain their wishes and feelings. Whilst supporting parents to provide appropriate parenting is important, it is crucial that the risks to children, their needs, wishes, feelings and their lived experiences are also examined.

Records of several agencies report positive observations of baby JS. The health visitor recorded good interactions between mother and baby, while the midwifery service reported that JS was gaining weight, was being breast fed and appeared to be well cared for.

The perinatal mental health service noted that mother at times reported feeling overwhelmed but observations showed her to be meeting the needs of her children and interacting positively with them. However, the service has reflected that the focus on supporting mother with her mental health and the conflict within her relationship with father meant that the lived experience of the children was not always proactively considered.

A large part of the work by the family support worker was also focused on the parents' relationship but time was spent considering the children's needs. In the short time the family support worker engaged with the family, the children were seen three times in their home environment. The family support worker took proactive action to secure funding for the middle sibling to attend nursery, made a referral for an Autism consultation for this child and contacted the health visitor about his two-year-old check.

The family support worker also provided advice on behaviour management and healthy sleep regarding this middle child and on feeding for baby JS. At the family support worker's request, direct work was undertaken with JS's oldest sibling by the school Designated Safeguarding Lead in the form of the 'three houses' tool. (The family support worker felt the oldest sibling would respond better to an adult she knew well).

GP files record mother reporting that JS's middle sibling, aged two, was suffering from night terrors. Accounts of the period when these had been a problem and their frequency changed between the telephone consultation with the GP in mid-March and the face-to-face consultation one week later. This inconsistency does not appear to have been explored at the time. There is also no evidence of questions being asked about any other changes within the family that may have impacted on the child.

8.2 Good Practice

In the short time the family support worker engaged with the family, she proactively arranged support for the children. For example, securing funding for a nursery placement and Autism assessment for the middle sibling and initiating direct work in the form of the 'three houses' tool with the oldest child.

Learning

This case demonstrates how easy it is for the voice of the child to be overshadowed by the needs of parents. More could be done to ensure that the lived experience of the child remains central to practitioners' work.

9. Conclusion and Recommendations

This review has identified significant learning around screening at the social care front door as well as issues around the timeliness of the response.

While the incident that led to baby JS's death was not related to domestic abuse, this case also identifies learning around domestic abuse that has the potential to improve the safeguarding of other children in the Solihull area.

Similarly, while the family was inappropriately filtered as early help, the examination of the response to this case illustrates where improvements could be made to multi-agency working around early help in Solihull.

Finally, this review draws on the learning from the National Panel's review into sudden unexpected death in infancy and highlights the importance of ensuring that the recommendations from that review have been acted upon.

The learning points at the end of each section of this report have been used to inform the recommendations below. It is anticipated that these will be used by the Solihull Safeguarding Children Partnership to create detailed SMART action plans capable of delivering real change.

9.1 Recommendation 1: Acting on the learning from the National Review into SUDI in families where children are considered at risk of significant harm

Safeguarding partners should review the learning from all national reviews and ensure it is fully implemented in their area. Almost three years on from the publication of the National Panel's review into SUDI where children are considered at risk of significant

harm, it would be timely for the Solihull Safeguarding Children Partnership to request evidence and assurance from all relevant partners that appropriate action has been taken. An action plan should be developed if this identifies any concerns.

9.2 Recommendation 2: Assurance of the impact of changes to the front door

Changes have been made to the way referrals are managed in Solihull's MASH (multi-agency safeguarding hub). These should address the issues identified in the screening of this case. However, given the significance of the issues, it is crucial that ongoing monitoring takes place beyond initial assurance checks.

Evidence of this monitoring, and of the impact of the overall changes to the social care front door, should be provided by Solihull MASH to the Safeguarding Children Partnership to provide assurance that the changes introduced are making a real difference and all cases are now being appropriately screened.

9.3 Recommendation 3: Responding to and following up referrals

This case demonstrated weaknesses in the feedback when a referral is made to children's social care and also in the follow up of referrals by other agencies. It is, therefore, recommended that:

- Assurance is provided by the Solihull MASH to the Safeguarding Children Partnership that practitioners in the MASH are providing feedback to all referrers in a timely way. This feedback should include any key actions for the referring agency as well as the formal outcome of the referral.
- Relevant partner agencies review their internal systems and guidance around making and following up referrals. All agencies should commit to ensuring that frontline practitioners are aware of their responsibility to proactively chase the outcome of a referral if they have not been informed. Guidance must be clear that referrals cannot be seen as an outcome in their own right.

9.4 Recommendation 4: Screenings for domestic abuse

Routine domestic abuse screenings of pregnant women and new mothers need to allow for disclosure of domestic abuse by female perpetrators. Agencies who undertake these screenings should review the screening questions they use and, if necessary, reframe questions to avoid any unconscious bias. Guidance should be included to encourage the father's voice to be considered as part of routine screenings, wherever practical.

Relevant agencies should provide assurance to the Solihull Safeguarding Children Partnership that a review has been completed, with evidence of any learning and changes that may be necessary.

9.5 Recommendation 5: Recognising and responding to domestic abuse

The Domestic Abuse Partnership Board and Safeguarding Children Partnership should work together to co-ordinate an audit of the understanding of domestic abuse amongst relevant staff in Solihull and take action to ensure that all practitioners:

- are able to recognise domestic abuse;
- know how to respond to incidents of domestic abuse;
- are confident to explore situations involving domestic abuse, including establishing who is using abusive behaviours and who is the victim;

- have an understanding of coercive and controlling behaviour;
- are mindful of the **importance of avoiding unconscious bias**, including around female perpetrators;
- fully understand the impact of domestic abuse on children, including the fact that children are victims of domestic abuse perpetrated against their parents or carers.

In doing this, it is recommended that local tools developed to support practitioners to recognise and respond to domestic abuse are pro-actively promoted to all relevant practitioners. For example, Solihull Local Safeguarding Children Partnership have recently produced guidance on parental conflict which includes a series of question to support staff to identify and distinguish between parental conflict and domestic abuse.

9.6 Recommendation 6: Multi-agency co-ordination of early help

Multi-agency co-ordination needs to take place as soon as the need for early help is identified and should be delivered by existing professionals using a collaborative approach rather than waiting until a threshold for social care involvement is met.

All agencies should review their service operating procedures to ensure:

- all practitioners understand the need to follow the Early Help procedures to ensure a co-ordinated approach to working with the family;
- robust information sharing takes place before a case progresses to statutory services.

9.7 Recommendation 7: Raising awareness of the risks of alcohol and drug use by parents

This case identifies the importance of reinforcing messages around the potential risks to a child's safety of alcohol use by parents, even where there is no dependency.

Solihull Safeguarding Children Partnership have already taken action to raise awareness amongst professionals of the risks to a child's safety of alcohol use by parents. The Partnership is collating feedback in order to monitor how agencies are promoting these messages to staff. More could, however, be done to share this message directly with families.

Solihull Safeguarding Children Partnership should review how they communicate the risks associated with alcohol and drugs use with parents and carers and how this could be strengthened.

Birmingham have been doing this through their 'Who's in Charge?' campaign (see box below) and Solihull may wish to consider adopting this or something similar.

Birmingham's 'Who's in Charge?' campaign

In the four year period ending in March 2020, 35 babies in the West Midlands region died while sharing beds or sofas with adults who had consumed more than two units of alcohol or used illegal drugs.

In response to this, the Birmingham Community Healthcare NHS Trust and Birmingham Safeguarding Children Partnership launched the 'Who's in Charge' campaign in November 2020.

The campaign uses a series of short hard-hitting films, urging parents, and those with responsibility for children, to be aware of the risks and potentially dangerous consequences of drinking alcohol while caring for children and to always know ‘Who’s in Charge?’

The videos depict some of the most worrying trends identified locally and nationally, particularly baby deaths connected with sleeping on a sofa or co-sleeping in a bed with an adult who is under the influence of alcohol.