Lincolnshire Safeguarding Children Partnership

SCR H

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Final report

Contents

Executive Summary

Initiation of the Serious Case Review

This review was initiated by Lincoln Safeguarding Children Board (now Lincoln Safeguarding Children Partnership (LSCP) as a result of the tragic death of Ellis. Professionals attending to Ellis at the time of his death expressed concerns regarding the neglectful state of the home. The children in the family were subject to Child Protection plans. The pathologist who completed the post-mortem concluded that the medical cause of Ellis's death was unascertained. The pathologist recognised that a co-sleeping environment could increase risk but could not conclude that it was a contributory factor in this case.

The children

There were three children in this family. Practitioners observed that they had good relationships with each other and with their mother. Ethan was aged 9 and Maya aged 1 when Ellis died aged 39 days. Mother indicated she had fallen asleep with all three children in her bed. Ellis was described as a small, relaxed baby who was always appropriately dressed. Ethan was attending mainstream school and Maya nursery. Practitioners described Ethan as loving with a big beaming smile and Maya as a beautiful child.

Summary of Case

The period covered by this serious case review is six months from Mother being referred to the Perinatal Mental Health Team in April 2018, during her pregnancy with Ellis, until Ellis's death in October 2018. During this period there were concerns regarding Mothers mental health, Father's violent and offending behaviours, Father and Grandmother misusing substances and the risks of neglect to the children. Grandmother lived in the family home and Father was in prison for part of the review period, subsequently living separately.

Summary of Learning Points

The death of Ellis was in the view of the author unexpected and could not have been predicted by the professionals who had been working with the family. There is no certainty that any of the learning points identified below would have made any difference to the outcome in this case. At the time of Ellis's death, the professionals involved did not know factors that may have contributed to Ellis's death

1. Understanding the cause, nature and symptoms of a person's mental health issues is essential. Professionals need to consider what factors are likely to exacerbate a person's condition, so they can assess the likely impact of changes of circumstance on the person, and/or their children, and develop meaningful plans.
2. When problematic drug use is suspected professionals must seek advice and assess whether what they are identifying supports their suspicions; interventions to address the presenting issues should feature within CP plans.
3. Whilst not specific to this case, the importance of gaining input from all health disciplines involved with a family is clear. When a decision is made that a strategy meeting is required, thought needs to be given to which health services are working with the family in order to ensure all disciplines are represented. LPFT have agreed to attend initial strategy discussions at the protecting vulnerable persons (PVP) hub.

4. All disciplines and invitees must provide information to conference and be held to account through the existing escalation process if they do not comply.
5. All unborn babies who are to be subject to a child protection plan must have an agreed multi-agency pre-birth plan. If concerns have been raised at the time of birth a discharge planning meeting or core group must be held.
6. Maintaining child focus when a case is complex and parental need is high, is difficult. Conferences and core groups are designed to bring professionals and the family together to share information, make decisions and plan interventions to address the issues. Agency's safeguarding teams have a role to play in co-ordinating and supporting their staff in such circumstances.
7. It is important that the strengths and risks are represented in a balanced and accurate way in order to develop adequate child protection plans. Whilst there is evidence of high support the high challenge that is also part of the Signs of Safety model is not evidenced.
8. When parents are indicating they are being overwhelmed with appointments there is a need for professionals to be clear about what appointments have been made, what the priority should be and whether the parent is exhibiting potentially deceptive behaviour.
9. When parents are not engaging, are deflecting or deceptive, professionals must acknowledge this, challenge it and remain objective so as not to minimise the harm their actions/inactions are causing their children
10. All adults living in a household who are tasked with an action within a CP plan, must be assessed to ensure they have the ability and capacity to contribute to the children's care and decrease the level of risk to the children.
11. Professionals had insufficient clarity on the level of neglect. Use of a neglect assessment tool and the clutter score in this case would have provided professionals with greater clarity regarding the level and impact of neglect in this family.
12. Where families have repeatedly reverted to unsafe sleeping practices, safe sleeping should feature as a risk within plans.

Recommendations

Each single agency has identified learning and actions taken within their narrative reports. The recommendations below are in addition and are designed to target areas where further improvements are considered to be required. Actions have already taken place to address some of the recommendations. Please see the LSCP response.

1. Mental Health to provide awareness training regarding mental health diagnoses which may affect parents parenting abilities, either through fluctuation of mental health or physical ability, and consider how information can be effectively shared with partner agencies.
2. LSCP and its partners to ensure its employees are sighted on neglect by:
    - introducing a recognised neglect tool and provide training to key professionals in its use

- ensuring neglect tools are being consistently used across all services in Lincolnshire by professionals trained in their use
- prompting professionals to use descriptive language that conveys what they are seeing and what they are meaning in understandable terms
- introduce the use of the clutter scale for all services who are entering households where neglectful conditions are found

3. LSCP to introduce training regarding deception and disguised compliance that equips professionals with the tools and the questions to ask parents to help them recognise their own behaviours.
4. The LSCP to hold partners to account when they do not fully contribute to safeguarding processes.
5. The LSCP and its partners to develop a culture where high challenge to the family becomes normal practice, to run alongside the existing culture of high support.

What will the LSCP do in response to this?

Actions have already taken place to address some of the recommendations. Where action has been taken the LSCP is requested to seek assurance that the actions taken have elicited the required change.

- Working with Parents with Mental Health Problems guidance has been agreed and will be in the March procedures manual update.
- A Business Case for a Neglect Tool, recommending the roll-out of GCP2, was agreed at the December 2019 Strategic Management Group. The roll-out of GCP2 is in planning phase.
- A course entitled 'Recognising the Power of Language' has been devised and is being offered through LSCP training.
- A course entitled 'Recognise Disguised Compliance' has been developed and is being offered through LSCP training.
- Where agencies do not attend or send a report to CP conferences this is escalated to the Senior Liaison Officer for that agency.

1 INTRODUCTION

1.1 This Serious Case Review (SCR) concerns three children:

- Ethan
- Maya
- Ellis

There were two additional children aged 3 and 6 (maternal cousins) who spent significant time in the household but are not part of this review.

1.2 Ellis was 39 days old when he died. Mother indicated she had fallen asleep with Ellis, Maya (aged 1) and Ethan (aged 9) in her bed. Professionals attending to Ellis at the time of his death expressed concerns regarding the neglectful state of the home. All three children were subject to Child Protection plans. The pathologist who completed the post-mortem concluded that the medical cause of Ellis's death was unascertained. The pathologist recognised that a co-sleeping environment could increase risk but could not conclude that it was a contributory factor in this case.

1.3 The family were well known to multiple agencies and services and were known to Lincolnshire Children's Services (CS) from December 2014. There were concerns regarding home conditions, poor school attendance, maternal mental health, financial difficulties, cannabis and alcohol use, and domestic violence. Ethan and Maya had been open to a child in need (CIN) plan from January 2017.

1.4 Following review of the facts of the case it was agreed there was evidence that this case met the criteria for an SCR in accordance with Working Together (2015)[1] as:

- Abuse or neglect of a child is known or suspected and
- Either a child has died; or the child has been seriously harmed and there is cause for concerns as to the way in which the authority, the board partners or other relevant persons have worked together to safeguard the child

1.5 This case was commissioned under Working Together to Safeguard Children 2015. Although Working Together to Safeguard Children 2018 had been published, the decision that this case met the criteria for a SCR was made prior to publication of the new arrangements in Lincolnshire.

1.6 The LSCB appointed Nicki Walker-Hall, an experienced SCR author from a health background, as independent overview report author for this review. Nicki, formerly a Designated Nurse Child Protection has an MA in Child Welfare and Protection and an MSc in Forensic Psychology.

1.7 The purpose of the SCR is to:

- identify improvements which are needed and to consolidate good practice.
- translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

[1] Working Together to Safeguard Children, 2015 Chapter 4

Timeframe

1.8 The decision was made that the review would focus on the period from 16 April 2018 until 17 October 2018. In order to add context, this timeframe covers a period two months prior to a strategy meeting until the date of the death of Ellis. The strategy meeting was convened because of:

- increased concerns about home conditions
- lack of sustained change
- concerns regarding the impact of the unborn baby
- risks to the children in relation to physical and emotional harm, and neglect

1.9 The LSCB identified nine key themes, each will be analysed in section 3:

1. Parental mental health and impact of prescribed medication
2. Impact of problematic drug use on parenting capacity and ability
3. Professional engagement
4. Parental engagement
5. Maternal Grandmothers' role in household and involvement in parenting
6. Information sharing between agencies, and between agencies and the family
7. Issues of long term neglect
8. Issue of safe sleeping
9. Domestic abuse within the family

Methodology

1.10 All agencies to whom one or more of the children were known, have participated in the review. Those agencies with direct involvement with the family submitted a chronology of involvement and an agency narrative report covering the period under review (see appendix 1 for a full list of involved agencies). Each agency has identified relevant actions taken as a result of examining this case; the action plans can be found at Appendix 2.

1.11 Ellis's parents have been written to and informed of the SCR. The review panel considered whether they could participate and contribute to the review at each panel meeting. Mother met the reviewer and LSCP business manager providing her perspective of the services she and her family received. The reviewer is grateful for her input.

1.12 A practitioners' event was held. The practitioners learning event was organised in line with Welsh Government guidance.[2]

1.13 Following the practitioners event, the Reviewer collated and analysed the learning and developed a draft report including recommendations to address the learning points. The draft report was provided to the panel in advance of panel meetings in November and December 2019. The panel meetings provided an opportunity for organisations to conduct further analysis.

[2] Child Practice Reviews: Organising and Facilitating Learning Events, December 2012

Parallel processes

1.14 The SCR process was cognisant of parallel processes.

The Family

Term Used	Relationship to subject	Age in October 2018
Ellis	Subject	39 days
Maya	Sister	1 year
Ethan	Brother	9 years
Mother	Mother	
Father 1	Ethan's father	
Father 2	Maya and Ellis's father	
Grandmother	Maternal Grandmother	

1.15 During the review period, there were three generations of the family living together; Maternal Grandmother, Mother and the three children. Mother and the children were of mixed heritage (African Caribbean/White). Mother did not celebrate or follow any specific cultural events relating to her heritage. Ethan's father (Father 1) was of white heritage. Father 1 lived in close proximity to the family but was not involved with his son. Both Maya and Ellis were the children of Father 2 who was of white heritage.

1.16 Mother experienced childhood trauma and was known to CS as a child due to issues of parental drug misuse. Issues of neglect, homelessness and domestic abuse led to Mother being made subject to a child protection plan as a young child. At the practitioners' event Mother was described by professionals as articulate and presented as high functioning. Mother, was reported to have short friendships. Mother made differing reports of anxiety, sometimes depression and/or psychosis to different professionals, and at times would indicate she felt she was being treated unfairly by professionals because of her mental illness. Mother would appear to listen and take on board advice but then did not always independently follow the advice through.

1.17 Father 2 also experienced childhood trauma and was known to CS as a result of parental drug misuse. As an adult Father 2 was the perpetrator, of domestic abuse, and was known to use illicit substances. Father 2 had convictions for violent offences.

1.18 Grandmother moved in with Mother, following the birth of Ethan when Mother was 16. Mother reports she had to have Grandmother's signature in order to secure housing because of her age. Grandmother was a cannabis user. Grandmother had accepted a caring role for two of the children's cousins; they regularly (5-6 nights a week) stayed at the house following school until late at night (10pm). This arrangement caused added financial strain for Mother and the entire household, increased caring responsibilities for both Mother and Grandmother, over-crowding and a rather chaotic situation at bedtime.

1.19 Ellis, the subject of this review, was described by practitioners as being small, his birth weight was below average. Ellis was described as relaxed in nature. Ellis was

always dressed appropriately and Mother was noted by the Health Visitor (HV) to be handling him appropriately.

1.20 Mother was estranged from Father 2 early in Ellis's pregnancy and had made an active choice to keep Ellis. Ellis was born before arrival of a healthcare professional; a home birth was neither planned or expected. Mother had previously had very quick deliveries with both Ethan and Maya, and Maya was born at home before the arrival of a healthcare professional.

1.21 At the practitioners' event Ethan was described as loving with a big beaming smile. Practitioners reported Ethan loved being out and about in summer and going to the park. Ethan was reported to have tantrums; practitioners believed he had become aware that his peers were excelling ahead of him and he displayed his frustrations in stubborn behaviour. Ethan enjoyed becoming independent, walking to school on his own and being a big brother; he was said to be protective of his mum. Ethan was identified as having self-esteem issues. To practitioners Ethan appeared accepting of his life and had developed some resilience. In school Ethan has intense, short-lived friendships but not friends. Ethan had been on a healthy weight 'My Healthy Choices' programme. Whilst on the programme Ethan loved sampling vegetables, cooking and sharing his achievements. During the review period Ethan was sometimes very tired in school and would sometimes present as 'unkempt'.

1.22 During the review period Maya was always presented nicely dressed. Maya attended two funded sessions at nursery a week and was thriving. Practitioners described Maya as a beautiful child and Mother was said by practitioners to love the attention this brought. Maya had been more demanding as a baby than Ellis.-Maya likes to sing and dance and loves an audience. Maya loved and adored Ellis. Mother was said by practitioners to dote on Maya and love the 0-3-year-old child stage.

2 BRIEF OUTLINE OF THE CIRCUMSTANCES RESULTING IN THE REVIEW

Prior to the review period

2.1.1 In 2013 Mother was referred to improving access to psychological therapies (IAPT) (now known as Steps2Change) for anxiety. Mother received cognitive behavioural therapy (CBT) to support her to feel more confident in engaging in the community, and reduce her anxiety. Mother's anxiety was assessed as likely to be linked to past experiences of not feeling safe. Mother did not have a mental disorder. During therapy Mother spoke at every session about Grandmother and the impact that she was having at that time. For example, how her mood was negatively impacted upon when they had arguments, when Grandmother took on a childlike role and Mother often felt responsible for managing Grandmother's mood. Mother also described anxiety about leaving the house, thought likely to link back to her childhood traumatic experience. Mother did not, during this period, make reference to hearing voices or other psychotic phenomena. Mother attended all but her final appointment for CBT reporting a marked increase in her confidence and functioning.

2.1.2 Prior to the review period there had been a number of referrals to CS. In 2014 Ethan appeared tired in school, indicating he was sleeping in the hall stating "mummy said

she was drunk". Mother was in financial difficulties borrowing money from her then partner. The case was closed in April 2015.

2.1.3 There was a continuous fluctuating picture of neglect with Team Around the Child (TAC) involvement including Early Help. On an annual basis further concerns were raised including poor school attendance, Mother struggling with depression, isolation, not getting up, dressed and staying at home, which lead to further interventions. Ethan's behaviour had been affected by witnessing domestic abuse (a previous partner of Mothers), there were concerns about the people living in the family home and numerous people were dropping Ethan off and picking him up from school.

2.1.4 In both June and October 2016 Mother was seen by a psychiatrist following referral from her GP due to symptoms of anxiety. Mother reported to the reviewer that she was told by the psychiatrist that she had psychosis.

2.1.5 In December 2016 school raised concerns that Mother had collected Ethan late from school and smelt of alcohol. Mother had identified to school she had mental health issues stemming back to childhood but refused to discuss them; she was thought by school to be unable to prioritise Ethan's needs. The Police made a child protection check and visited the family home the same evening, it was established that Mother was sober and able to care for Ethan. It does not appear the fact that Mother had mental health issues had been shared with the Police however they made a referral to CS despite this. As a result of the referral CS commenced an assessment in December 2016.

2.1.6 Following this assessment, a decision was made that the threshold was met for CIN and the children were made subject to CIN plans in January 2017.

2.1.7 In April 2017 Mother was referred to the perinatal mental health team (PMHT) by the consultant in obstetrics and gynaecology. The perinatal service declined the referral as Mother was neither diagnosed with a serious mental illness nor was she experiencing acute symptoms of the same, as per the perinatal service's criteria. This decision was challenged by the consultant in obstetrics and gynaecology and following a discussion between Mother's psychiatrist and the perinatal service it was decided that the psychiatrist would refer mother if it was felt appropriate.

2.1.8 In July 2017, when Mother was 28 weeks pregnant with Maya, there was a domestic abuse incident between Mother and Father 2. A restraining order was issued until March 2018.

2.1.9 In August 2017, Mother was seen for a routine appointment with her psychiatrist. A referral was made to the perinatal service by the psychiatrist as, although well, Mother raised concerns about her mental health. Mother did not respond to the perinatal service and they attempted to liaise with the children's social worker (SW).

2.1.10 The same month cannabis plants were seized from the family's back garden; the police were unable to prove who was growing them.

2.1.11 In October 2017, Mother did not attend the psychiatrist's outpatient appointment and was discharged back to her GP.

2.1.12 In January 2018, Father 2 failed to comply with post sentence supervision and an arrest warrant was executed. The GP referred Mother back to the outpatient psychiatry service. The GP highlighted that Mother had given birth to Maya in October 2017 and they had started her back on Quetiapine as it had reportedly benefitted her in the past. In January 2018 Mother did not attend the psychiatrists appointment.

2.1.13 In February 2018, it became known to Police Mother was pregnant with Father 2's baby. Police contacted CS who accepted the information.

During the Review period

April-June

2.1.14 In April 2018, during an antenatal appointment, Mother informed the consultant in obstetrics and gynaecology that she had psychosis, anxiety and depression and had a named psychiatrist. Mother was referred to the PMHT because she had a named psychiatrist. The SW informed the PMHT that Mother's two children were open to CIN due to concerns regarding neglect.

2.1.15 As the result of concerns regarding domestic abuse and Father 2's propensity to violence, the case was assessed to be high risk and referred to Multi-Agency Risk Assessment Conference (MARAC)[3] where it was discussed and analysed. Father 2 was, at that time, incarcerated due to an assault on a police officer for which he was given a 16 weeks and 5 day sentence. The midwifery recording of the MARAC meeting records that it was discussed that Mother had indicated she was frightened of Father 2 and his drug using associates. This was reportedly challenged within the meeting and a note was made that Mother was deemed to not be a protective factor for the children as she had previously breached a restraining order, resuming a relationship with Father 2, during which time she became pregnant. Mother indicated she was seeking a further restraining order. Safety planning was completed.

2.1.16 During SW supervision it was decided the case needed to be discussed at a strategy meeting, and progressed to an initial child protection conference (ICPC), as there had been no significant improvements made over the previous year whilst the case was in CIN.

2.1.17 A referral was made to CS by midwifery informing of Mother's pregnancy with Ellis. A plan was made to discuss the pregnancy at the strategy meeting.

2.1.18 At the strategy meeting a decision was made that the threshold was met for a single agency Section 47 and to proceed to ICPC regarding concerns of neglect. A Section 47 assessment was completed.

July – September pre Ellis's birth

2.1.19 The ICPC took place with a decision to place all the children on child protection (CP) plans under the category of neglect, there were additional concerns relating to

[3] A MARAC is a multi-agency meeting to which domestic abuse victims who have been identified as at high risk of serious harm or homicide are referred to. The MARAC then creates a multi-agency action plan to address the identified risks and increase the safety and wellbeing of all those at risk

physical and emotional harm.[4] The CP plan followed the Signs of Safety framework and included danger statements regarding domestic violence and Father 2's imminent release from prison, finances and Mother's mental health.

2.1.20 Following the ICPC Mother attended two PMHT appointments where Mother discussed her mental health, diagnosis, early life experiences including domestic abuse, drugs, alcohol and violence, family life, co-dependency with her mother, her ambitions for the future and her relationship with professionals. Mothers' diagnosis was anxiety and depression. Mother missed all hospital ante-natal clinic appointments from 20 weeks into the pregnancy, however the community midwife strived to maintain contact and follow up on the non-attendances. Mother did not attend the next two PMHT appointments.

2.1.21 Father 2 was released from prison in August and advised not to attend his ex-partners address; he was to contact the SW if he wanted to have contact with his daughter. Following an assault on his sister 2 days after release, and a further assault to a police officer in attendance, he was again imprisoned.

Ellis's birth until his death

2.1.22 Ellis was born at home before an ambulance crew arrived. The ambulance crew raised concerns regarding the housing conditions and hoarding, indicating a clutter image rating scale of 6 (scale 1-9)[5] indicating a household that requires help. Conditions were described in the referral as dirty, unhygienic, unruly pets, unhealthy and not suitable for children. Ethan was described as unkempt.

2.1.23 Ellis was taken to hospital because he had an unstable temperature. As a precaution Ellis received treatment for sepsis and was discharged 3 days later. A core group meeting was cancelled as Ellis was in hospital and there was no discharge planning meeting as a request by hospital staff was declined by the SW. The SW conducted a home visit on the day of discharge, saw Mother and all three children, and determined home conditions had improved.

2.1.24 In the weeks following Ellis's birth the SW visited frequently, home conditions and safe sleeping featured as part of the discussions as well as Mother's mental health; the case was discussed in supervision.

2.1.25 The HV when conducting the primary visit, was aware of the EMAS referral, and used this opportunity to discuss with Mother the state of the house on the day of Ellis's birth. The HV described the kitchen as untidy. The midwife remained involved as she had experienced three no access visits.

2.1.26 A review child protection conference (RCPC) was held 18 days after Ellis's birth with positive progress being noted in terms of home conditions, better engagement,

[4] Signs of Safety is an innovative, strengths-based, solutions-focused approach to working with families. The Signs of Safety risk assessment process integrates professional knowledge with local family and cultural knowledge, and balances a rigorous exploration of danger/harm alongside indicators of strengths and safety.

[5] The Clutter Image Rating Scale (CIR) was developed to help individuals and professionals determine where to draw the line. In general, rooms or homes that reach the level of 4 or higher reflect a level of impact on every day life that might qualify for a hoarding diagnosis and will benefit from seeking help. https://hoardingdisordersuk.org/wp-content/uploads/2014/01/clutter-image-ratings.pdf

Ethan being healthier and the children meeting developmental milestones. Remaining concerns related to people visiting the house, finances, and Mother's mental health. There was recognition of the need to add a further danger statement to the safety plan regarding unknown/inappropriate people visiting.

2.1.27 Ellis was seen at home by the HV at 4 weeks of age. He was feeding well and gaining weight. The HV attended a link HV liaison meeting with the GP where the family were discussed.

2.1.28 School started monitoring Ethan's appearance on a daily basis as they had a number of concerns. Ethan was noted to have a dirty shirt and to be tired in school, indicating his sister was keeping him awake and that they were sharing a bedroom. Ethan was behind in reading, writing and numeracy. Ethan's attitude to work was good when it was something he could do, but he could be challenging if, due to missing being taught, he was unable to do the work. Ethan chose not to take school reading books home as the first one went missing and Mother did not engage in learning at home. Ethan never completed his homework.

2.1.29 The day prior to Ellis's death, the PMHT sent a letter to Mother as she had disengaged and did not respond to telephone calls, to try to engage her back in services. The SW had supervision that day and spoke of positive changes around the home, better engagement, good interactions with, and the basic needs of the children being met.

2.1.30 On the day Ellis died all three children were said to have been co-sleeping with Mother. Mother was awoken by Maya at approximately 0800, Ellis was blue and unresponsive.

3 PRACTICE AND ORGANISATIONAL LEARNING

3.1 Introduction

3.1.1 This section will provide analysis to address each of the key focus points identified in section 1.7. The review also suggested the following factors should be considered:

- Management oversight and accountability
- Policy and procedures
- The role and involvement of the fathers
- Voice of the child
- Strategy Meeting 13 June 2018
- Initial Child Protection Conference
- Discharge Planning Meeting
- Review Conference
- Effectiveness, delivery and progression of child protection plan

3.2 Parental mental health and the impact of prescribed medication

3.2.1 Mother had an established diagnosis of depression and anxiety for which she was prescribed appropriate medications to treat both. Low level depression/anxiety should be treated by the psychological wellbeing service. There was confusion

regarding Mother's diagnosis with some professionals believing she had psychosis. This confusion was caused in part by Mother's own report that she experienced psychosis. Mother reported she had been informed she had psychosis by her psychiatrist. As a result of Mother's self-report, Midwifery believed she was psychotic. This belief was compounded by Mother indicating she was hearing voices, as well as being prescribed anti-psychotic medication. This medication had been prescribed to manage her anxiety and intrusive thoughts, not as treatment for psychosis.

3.2.2 As a result of this confusion, and because of previous referral to the perinatal mental health team, when Mother presented during Ellis's pregnancy, midwifery referred Mother back to the PMHT. The team accepted the referral as Mother had previously been known to the service and was under a psychiatrist's care however, Mother did not meet the services criteria as she did not have a complex or severe perinatal mental illness. If policy and NICE guidelines had been followed when Mother was originally referred during Maya's pregnancy, Mother should have received care through IAPT and the GP. The acceptance of the referral caused misunderstanding of the nature and severity of Mother's mental health for partner agencies, and was a causal factor in over concentration on Mother's mental health throughout the review period.

3.2.3 There was lack of clarity as to what medication Mother was taking throughout the review period. Indications were that Mother stopped taking all medication during Ellis's pregnancy. The impact of doing so on Mother's mental health and on her parenting capacity was not sufficiently explored. Of note, if Mother had been taking her medication at the dose prescribed, this was not sufficient to have negatively impacted on Ellis or on Mother's ability to respond to the needs of the children.

3.2.4 There was confusion amongst practitioners regarding the severity of Mother's mental condition. This confusion was well founded as practitioners were being told Mother had mental health problems and she was under a psychiatrist, but her behaviour was not consistent with her having a severe problem. Meetings and conferences provided an opportunity for the psychiatrist to provide partner agencies and Mother with clarity. A lack of attendance and submission of a report meant that whilst Mother's mood, mental health and medication were regularly discussed, clarity around diagnosis, treatment and the impact of both on Mother and the children were not. The opinion of mental health professionals is that Mother should not have been open to a psychiatrist.

Learning point: Understanding the cause, nature and symptoms of a person's mental health issues is essential. Professionals need to consider what factors are likely to exacerbate a person's condition, so they can assess the likely impact of changes of circumstance on the person, and/or their children, and develop meaningful plans.

3.3 Impact of problematic drug use on parenting capacity and ability

3.3.1 Mother's use of cannabis was not declared by her until after the death of Ellis. Mother sometimes smelt of cannabis and was challenged by professionals. Mother

always denied personal use of cannabis to professionals and because she associated with, and lived with, others who were known to use cannabis, professionals, although sceptical, had no evidence of actual use. The issue for professionals is what to do when problematic drug use is suspected. There was no exploration into whether use of drugs was problematic and no advice was sought from safeguarding specialists or specialist drug services. The value of doing so would have been to gain a greater understanding of indicators of drug use, and clarity on whether mother had accessed the service. Even if Mother was not using cannabis what was known was Mother did not exclude individuals from her home who were known to misuse substances. Mother was not actively protecting the children from the impact of problematic drug use.

3.3.2 Father 2 was known to misuse drugs; this was recognised to cause an escalation in his violence and unpredictability; this was a clearly identified risk factor within assessments and plans. Father 2's relationship with other known problematic drug users was also well recognised and clear plans were made to reduce the risk to the children and keep them safe from these individuals. Practitioners reported the area the family lived had an issue with problematic drug users and dealers; Mother had reported concerns about drug dealing in a nearby house. Whilst plans were clear regarding Father 2 there was no clarity regarding the impact of grandmother's use of cannabis. There was no exploration as to whether her use was perpetuating the issue of drug users coming to the home.

3.3.3 Grandmother, as a permanent resident within the family home, with an active role in the child protection plan, should have been considered within assessments and plans. Grandmother's problematic drug use was not specifically assessed and as a co-carer for the children this was a missed opportunity. Discussing concerns within safeguarding supervision and making use of the expertise of specialists from local drug misuse services would likely have aided professionals.

3.3.4 Whilst Mother did not admit drug use within pregnancy research has shown parental problematic drug use can have a negative impact on children at each stage of their development[6]. Women who misuse substances during pregnancy may put their babies at risk of impaired brain development, congenital malformations, premature delivery, low birth weight and withdrawal symptoms after birth.

3.3.5 Parents and carers who are problematic drug users are often unable to respond to their children's needs adequately and as a result, this can have negative impact on the children. In later stages, impacts to children can be:

- physical and emotional abuse or neglect as a result of inadequate supervision, poor role models and inappropriate parenting
- behavioural, emotional or cognitive problems and relationship difficulties
- taking on the role of carer for parents and siblings
- preoccupation with, or blaming themselves for, their parents' substance misuse
- infrequent attendance at school and poor educational attainment
- experiencing poverty and inadequate and unsafe accommodation

[6] NSPCC study (Altobelli & Payne, 2014; Cleaver et al, 2011; Cornwallis, 2013; Home Office, 2003; Templeton, 2014)

- exposure to toxic substances and criminal activities
- separation from parents due to intervention from children's services, imprisonment or hospitalisation
- increased risk of developing drug or alcohol problems or offending behaviour themselves.

3.3.6 Many of these impacts can be seen in this case.

Learning point: When problematic drug use is suspected, professionals must seek advice and assess whether what they are identifying supports their suspicions; interventions to address the presenting issues should feature within CP plans.

3.4 Professional engagement, including information sharing, the strategy meeting and the Conferences.

3.4.1 Lincolnshire has adopted the Signs of Safety approach to safeguarding. This is a strengths-based, safety-organised approach to child protection casework. There are three core principles to the model[7]:

1. Working relationships – Establishing constructive working relationships and partnerships between professionals and family members, and between professionals.

2. Munro's maxim: Thinking critically, Fostering a Stance of Inquiry.

3. Landing grand aspirations in everyday practice – delivering on the ground good practice in the face of complex and challenging cases.

3.4.2 There is evidence, on paper and within the practitioners' event of constructive working relationship between the frontline professionals and of extensive multi-agency working and information sharing across agencies. All frontline workers made significant efforts to develop working relationships with Mother and encourage her engagement with their services.

Information sharing

3.4.3 There was substantial information sharing and attendance at key meetings. There were some notable exceptions. The GP received information from health services however, there is no evidence that they shared information they held about non-attendance for immunisations and psychiatric appointments with partner agencies. Nor did they share information regarding their attempts to discuss non-attendance with Mother. Where attendance at meetings proved problematic for the police, alternate arrangements were made to consult and include information in plans.

3.4.4 It is clear that the timing and accuracy of information sharing is crucial. There were occasions when professionals waited until a multi-agency meeting to share information or where the information known was not shared accurately. Generalised statements, rather than stating exactly what the professional had observed, served to dilute the understanding of the receiving professional. An added issue was a delay

[7] https://knowledgebank.signsofsafety.net/resources/introduction-to-signs-of-safety/signs-of-safety-comprehensive-briefing-paper/signs-of-safety-comprehensive-briefing-paper-en/signs-of-safety-comprehensive-briefing-paper

in information being relayed internally within CS to the assigned worker. This is significant as when the case was discussed in CS supervision the advice given was not always based on the most up to date information e.g. the SW was unaware of recent missed appointments.

Strategy meeting

3.4.5 The strategy meeting was well attended by all invited agencies except the Police. The Police met with the SW separately to mitigate this gap however it does not appear offending relating to other members of the family was ever discussed. The decision to hold a meeting rather than have telephone discussion was good practice. Whilst health was well represented, the Psychiatrist overseeing Mother's mental health was not present. As Mother's mental health was a key area of concern, information from the Psychiatrist at this point might have helped partners to gain a clear understanding of Mother's mental health diagnosis and the potential impact upon her parenting capacity. Whilst there was a Midwife in attendance to represent the unborn (Ellis), other practitioners should also have been representing the unborn. As it had been established that Mother had quick deliveries, there should have been consideration as to whether this presented a risk, and what measures needed to be taken to mitigate the risk.

Learning point: Whilst not specific to this case, the importance of gaining input from all health disciplines involved with a family is clear. When a decision is made that a strategy meeting is required, thought needs to be given to which health services are working with the family in order to ensure all disciplines are represented. LPFT have agreed to attend initial strategy discussions at the protecting vulnerable persons (PVP) hub.

3.4.6 All services described a fluctuating picture of neglect with a pattern of non-engagement from Mother and her not taking responsibility. Mother had been offered a large package of support that had yielded little positive impact on the children's health and wellbeing. Concerns were raised regarding the home environment being unclean and in disrepair, concerns were expressed for Maya's development in the future. Ethan was frequently absent from or late for school, he was rapidly gaining weight, his clothes were too small, he was unclean with evident odour. It was acknowledged that Mother had been on a CP plan when she was a child due to neglect. It was acknowledged that Grandmother was not a protective factor and to a degree had a negative impact on Mother but those present felt Ethan would be at greater risk if she was not there as she was, at least, taking and collecting Ethan from school.

3.4.7 The focus of the meeting was largely on the adults in the household. Whilst concerns were identified and discussed, translating that to the impact they were having on the children was less visible. For example, loss of benefits due to the inactions of both adults was not related to what this meant for the children, were they hungry, without light or heat?

3.4.8 All the complicating factors identified during the meeting related to the issues with the adults in the household. All the strengths related to professionals plans and

actions; suggesting that despite extensive long term support while the children were subject to CIN, there remained no identified strengths within the family. The tasks to be completed largely relate to addressing adult issues, and although seeing the children was included what was missing was working with the children to understand their daily lived experience. In relation to the unborn (Ellis) there were no tasks other than linking him on the IT systems to the rest of the family. Putting a pre-birth plan in place that ensures safe delivery was not tasked.

Initial Child Protection Conference

3.4.9 The ICPC was well attended with the exception of the following invitees:

- GP,
- the Psychiatrist and
- the Community Midwife who was unavoidably called to a home birth; Midwifery was represented by the Safeguarding Midwife.

It is expected that a Psychiatrist attends the conference and that they would provide a report. The GP, Psychiatrist and the Community Midwife did not provide a report for conference. The Midwife did provide a verbal update to the SW and the Safeguarding Midwife verbally relayed information during the meeting; a report from Midwifery was received after the conference. It was good practice for Father 2's probation worker to attend the conference. There is a process for escalation if reports are not provided.

Learning point: All disciplines and invitees must provide information to conference and be held to account through the existing escalation process if they do not comply.

3.4.10 Lack of attendance and reports from key disciplines means significant information relating to diagnosis, treatment, engagement, and historical information was not fully shared. Review of the minutes of the meeting and discussions at the practitioners' event indicate extensive discussions were had regarding the presenting issues as identified by Mother and the professionals present. Mother was portrayed as someone who was loving to the children and who often helped others; she was thought to be doing her best with no challenge to this. The SW made an astute observation within her S47 assessment querying whether Mother had the ability to sustain meaningful change as many of the presenting issues were the same as those identified in CS assessments in 2011.This was a key observation but was not part of the discussions. Sharing this observation could have elicited a frank discussion regarding what would make a difference when the children were on a CP plan and establish the bottom lines.

3.4.11 Whilst there was discussion about the impact of:

- Father 2 and others,
- Mother's mental health,
- Grandmother's care of the cousins on Ethan,
- finances,
- Mother smelling of cannabis

there was little discussion regarding the impact of long term neglect on the children's health and wellbeing. The adult issues appear to have taken the focus away from the children.

3.4.12 Opportunities to challenge Mother had been missed. There was:

- no challenge regarding what a £4000 grant had been spent on,
- lack of exploration of Ethan's disclosure that he was being bullied and no consideration as to whether the bullying related to neglect,
- no full exploration of why Ethan was falling behind in key subjects
- no discussion regarding Mother attending school under the influence of alcohol

3.4.13 There were three danger statements. The first related to Father 2 and concerns if Mother resumed the relationship with Father 2 and allowed him to visit the home. Professionals were very worried about Father 2's chaotic drug use and increase in violence. The second related to Mother's mental health, which those present thought a decline could result in Mother disengaging with professionals and avoiding issues that she was struggling to cope with. The long -term implications for Mother and the children and being at risk of losing the family home. The third related to Mother struggling to manage her money and experiencing increasing debt. Professionals felt it was important that Mother was able to provide a warm home, be able to prepare feeds and meals for the children and to keep them clean.

3.4.14 There was no specific danger statement relating to neglect or a contingency plan for if the situation deteriorated, stayed the same or didn't improve sufficiently for the children to be deemed no longer at risk of harm.

3.4.15 It was the intention for the conference to include discussion around the unborn baby however, whilst it was acknowledged that Mother had quick deliveries with both Ethan and Maya, and that Maya had been born before the arrival of a health care professional (BBA) at home, no danger statement was suggested as being necessary to promote the safe arrival of Ellis. The risk of having a further unplanned BBA home birth increases when mothers have had multiple births or have had a previously swift birth as in this case. BBA can result when mothers are trying to conceal births or are struggling to come to terms with a pregnancy; concealed pregnancy was not a factor in Ellis's pregnancy. The reasons for Maya's BBA were not established; this would have been relevant to know for safety planning during Ellis's pregnancy. Research has shown increased risks of death both to mother and child when babies are BBA. [8]

3.4.16 The lack of a multi-agency plan for Ellis later led to confusion at point of discharge. Hospital staff's Midwifery Plan stated a need for a discharge planning meeting however this was challenged by the SW. This difference of opinion was not escalated or challenged by Midwifery. Best practice would have been to hold the discharge-planning meeting. A core group-meeting due at this time was cancelled because of Ellis's birth. In view of the concerns raised by the ambulance staff who attended the

[8] Loughney A, Collis R, Dastgir S. Birth before arrival at delivery suite: Associations and consequences. Br J Midwifery. 2006;14(4):204–8.

family home, the reviewer suggests a discharge meeting/core group should have been held prior to Ellis's discharge home to ensure all professionals were satisfied home conditions were not posing a risk to Ellis.

Learning point: All unborn babies who are to be subject to a child protection plan must have an agreed multi-agency pre-birth plan. If concerns have been raised at the time of birth a discharge planning meeting or core group must be held.

3.4.17 It appears that there was an imbalance in professionals' focus. Whilst it is important to develop constructive working relationships and partnerships with family members there is a need to stay child focused. The discussions were overly focussed on the adults and the here and now, with a lack of focus on neglect and the impact of long term neglect. Plans were not sufficiently focussed on promoting the safety, health and wellbeing of all three children. LPFT have recently introduced a process whereby all CP conference invitations are managed by their safeguarding team.

Learning point: Maintaining child focus when a case is complex and parental need is high, is difficult. Conferences and core groups are designed to bring professionals and the family together to share information, make decisions and plan interventions to address the issues. Agency's safeguarding teams have a role to play in co-ordinating and supporting their staff in such circumstances.

Review Child Protection Conference (RCPC)

3.4.18 The review conference was less well attended. Apologies were received from psychiatry, perinatal mental health and five others who had been present at the initial conference despite the fact the date of the review conference would have been agreed at the end of the ICPC. Although midwifery was no longer involved, having discharged Mother a week before the RCPC, there would have been an expectation that they provide a report to update the conference regarding their most recent involvement, however there is no evidence this occurred. The GP was neither invited nor represented. All those who did not attend also did not provide a written report, to inform those in attendance, of Mothers engagement and attendance with their services; this is contrary to LSCB policies and procedures. The SW had gained some information verbally from housing, and the Police had provided some written information which was shared.

3.4.19 There is evidence discussions focused on Father 2's offending, Mother and Grandmother's mental health, known drug users coming to the house and finances. The fluctuating picture of neglect was not well represented within this meeting. Whilst the ambulance service referral citing the conditions in the home following Ellis's birth was discussed, there was no challenge to Mother as to why the deterioration had occurred and how she would prevent this happening in the future. When the home conditions then improved this was seen overly positively. Whilst improvement should be acknowledged when it has only been maintained for short periods, professionals must be mindful that they don't appear overly optimistic that they will be maintained. Considering whether there was an improving or deteriorating picture when all agencies or disciplines are not present is difficult. At this conference, the lack of information from some key services about non-attendance and non-engagement seemingly left attendees with an overly positive view of the progress made and a lack of recognition regarding chronic neglect.

3.4.20 Both the initial and review conference pro formas have a section to include bottom line or contingency plans. These were not completed at either conference. The reviewer is not clear whether this practice is case specific or routine practice but it is essential for families and professionals working with long-term neglect to understand what the bottom lines are, and for contingency plans to be made.

3.4.21 There is evidence of extensive effort and work by professionals to both understand and bring about changes to improve the children's lives. The two major changes identified for Ethan were improved school attendance, he was now walking himself to school, and weight loss, achieved by an increase in activity and learning about health food choices. Maya was said to be developing well and since carpets had been obtained was now walking. Ellis was settled and gaining weight. Whilst these are all positive and were rightly acknowledged, there was no discussion about the impact of Ethan not taking school books home and not submitting any homework, Maya's immunisations not being up to date nor Mother delaying seeking medical attention when she went into labour, all of which present/presented risk to each child. Whilst having your child immunised is not compulsory it becomes significant when considered as part of the bigger picture of neglect; there is no evidence that this was discussed with Mother or that it was an active choice on Mother's part.

3.4.22 It is challenging for professionals to achieve the appropriate balance between acknowledging the positives and identifying the concerns in a case, whilst also considering the rights of children and the rights of parents. It can be a struggle to achieve successful engagement with parents and make appropriate assessments of the impact their actions are having on the safety and wellbeing of the child.

3.4.23 As Professor Ward and Rebecca Brown at Loughborough University pointed out, neglect is a "chronic, corrosive condition which may deteriorate over a long period without reaching a specific crisis, such as a baby being locked up alone overnight or abandoned in a shop, that might prompt specific action". Research by the University into infants suffering harm over time also identified the difficulties faced by professionals in balancing support for the family unit and protecting the children, concluding that: Almost all professionals did everything they could to keep families together. Parents were given repeated opportunities to prove they could look after a child [...] However, in the drive to ensure that parents' rights were properly respected, children's needs could be overlooked[9].

3.4.24 The lack of detail regarding the neglect issues within the CP plan suggests the children's needs were being overlooked; it would also hamper attendees when assessing whether progress had been made.

Learning Point: It is important that the strengths and risks are represented in a balanced and accurate way in order to develop adequate child protection plans. Whilst there is evidence of high support the high challenge that is also part of the Signs of Safety model is not evidenced.

[9] Loughborough (2010), *Infants suffering, or likely to suffer, significant harm: a longitudinal study,* p.4

3.5 Parental Engagement

3.5.1 Father 1 was not involved with Ethan and as such, none of the professionals involved with the family had any contact with him during the review period. Professionals had very limited direct contact with Father 2 during the review period. Father 2 was in prison much of the time and when he was not in prison, he was only required to engage with probation. Father 2's violence towards Mother and the restrictions placed on his contact with Mother and the children acted as a barrier to engaging him in plans. It was good practice for an independent SW to carry out an assessment of Father 2 whilst he was incarcerated.

3.5.2 Mother's engagement with professionals fluctuated. Mother was articulate and intelligent and would seemingly allow practitioners to take control. Mother informed the reviewer that it was easier for professionals to get her appointments as they got a quicker response; she struggled to get GP appointments. Practitioners indicated that whilst Mother might attend her appointments, she 'did not listen' or 'did not do'. Mother indicated to a mental health worker that she had a tendency to say what she thought other people wanted to hear, which made professionals think she was manipulative. Mother informed the reviewer that as a result of her anxiety her brain did not function well and she needed people to reinforce messages as they didn't stick. Mother also shared with a mental health worker that because she found it difficult to connect with people in general, she would put on a front which said 'don't mess with me'. Knowing these behaviours would have been helpful to professionals both in planning interventions and in challenging non-compliance. A parenting assessment whilst the children were deemed CIN, would have assisted professionals understand and assess Mother's capabilities.

3.5.2 Mother frequently did not attend her appointments leading services to consider case closure. Following prompting, Mother would attend thus keeping her open to services. Practitioners did not distinguish between Mother attending of her own accord or because she was being prompted to attend. Mother would often cite her mental health issues as a reason for non-attendance at appointments. At the practitioners' event, those present felt Mother used her mental health as an excuse to 'get professionals to back off'. Mother indicated she had so many appointments she wasn't able to attend them all. It appears this was accepted with little challenge. The reviewer learned from Mother that interactions were weekly.

3.5.3 In this case, Mother was directed to prioritise her mental health appointments, this decision was made because non-mental health professionals believed she had a serious mental illness and this was the priority. This needed further clarification with mental health services; had this occurred the reviewer believes appointments for the children would have been prioritised. The unintended consequence of this decision was a greater acceptance when Mother didn't attend Midwifery and GP appointments.

Learning point: When parents are indicating they are being overwhelmed with appointments there is a need for professionals to be clear about what appointments have been made, what the priority should be and whether the parent is exhibiting potentially deceptive behaviour.

3.5.4 At the practitioners' event, those present indicated they felt there was a degree of deceit and deflection on Mother's part. Deflection is defined as 'the act of preventing something being directed at you' and can be a useful tactic to remove attention from your own actions or inactions. For example, Mother would bring Maya to conferences and meetings, despite there being nursery provision available; professionals thought this was to deflect professionals' attention.

3.5.5 In research based on previous Serious Case Reviews, Fox[10] found social and health care professionals were aware of parental deception but would draw a line between malicious and benign deception by parents. Mother in this case was viewed as someone who ultimately loved her children and was seen in a positive light; her deception fitted into the benign category.

3.5.6 Fox indicated that professionals that consider the deception to be benign believed the parents lied not to conceal abuse of their children but because of their distrust of professionals and their reluctance to be intruded upon in their private lives. Mother, having experienced social work intervention as a child, may have been distrustful of professionals. Mother reported to the reviewer she was worried about being judged. Deception is accepted as almost permissible and not motivated by the intent of parents to cause harm to children, this largely ignores the possibility that these parents could be seeking privacy in order to cover abuse.

3.5.7 This research found that even when professionals recognised the signs of deceit, if they attributed them to benign deception the risk to the child was minimised. This view is underpinned by a shared conviction amongst professionals that the vast majority of parents do not wish to hurt their children. There is a need for professionals to maintain objectivity, view deception dispassionately and accept it for what it is - a deliberate act by parents to hide the truth about the harm they are causing their children.

3.5.8 There are other reasons Mother might appear to be deflecting or deceiving professionals. Mother identified to the reviewer that Grandmother would often undermine the advice given by professionals by telling her she "did not need to do" what the professionals had asked. In addition, the Lead mental health professional completed a stress vulnerability grid with Mother within which Mother identified a number of personal protectors she used. One of these was to distract herself with her children, this was shared verbally with the core group and a paper copy given to the social worker although this does not appear to have influenced non-health professionals thinking.

Learning point: When parents are not engaging, are deflecting or deceptive, professionals must acknowledge this, challenge it and remain objective so as not to minimise the harm their actions/inactions are causing their children

[10] Fox. L (2019) The paralysis of practice in child safeguarding: Understanding and responding to deceptive practices by parents and carers in the child safeguarding context. University of Portsmouth

3.6 Maternal Grandmothers role in household and involvement in parenting

3.6.1 Maternal Grandmother's role in the household was largely assumed. It was widely known amongst professionals, the difficulties Mother had experienced as a child and the concerns about neglect and chaotic parenting that had led to CS involvement. What doesn't seem to have been fully considered is that Grandmother was the person who had neglected Mother. Grandmother's use of cannabis was also known. Despite this Grandmother was seen to be offering practical support to get Ethan to school and taking part in child-care and cleaning the house. Grandmother was seen by professionals to be parenting the children and it was noted she had a good relationship with them. The fact that the house was noted by a number of professionals to be below an acceptable standard of hygiene, and Ethan's school attendance was not at an acceptable level until he was able to take himself, suggests the positive impact of Grandmother presence was at best limited.

3.6.2 There was no assessment of Grandmother in her own right. With the benefit of hindsight, it is clear that any benefits to having Grandmother in the household were outweighed by the difficulties this created. There were difficulties in Mother and Grandmother's relationship with Mother clearly stating they had an unhealthy co-dependency. Grandmother impacted negatively on the household finances as she did not attend appointments in order to gain her benefits. Grandmother's caring responsibilities for the children's cousins created disruption to routines and sleeping arrangements for Ethan, reduced the level of attention the children received and added additional financial strain. Mother reported to the reviewer that she was the one cooking and looking after all the children.

3.6.4 The impact of Grandmother's cannabis use on her abilities to care for the children and her association with individuals who posed a risk was never fully assessed or addressed. Mother informed the reviewer that Grandmother would undermine the messages she was receiving from professionals saying, "you don't have to do that", "you don't have to listen to them" leaving Mother feeling like "piggy in the middle".

3.6.5 Mother was clear in her discussion with a mental health worker that her Mother was coercive and controlling however this did not lead to discussion or assessment of Mother being a victim of domestic abuse from her Mother; this was an omission.

3.6.6 The presence of Grandmother in the home also made it difficult to assess whether Mother could parent her children effectively on her own. The lack of parenting assessments of both Mother and Grandmother led to a situation where professionals, able to see some benefits to Grandmother being in the home, felt her presence was largely a positive.

Learning point: All adults living in a household who are tasked with an action within a CP plan, must be assessed to ensure they have the ability and capacity to contribute to the children's care and decrease the level of risk to the children.

3.7 Issues of long term neglect

3.7.1 The severity of neglect in this family fluctuated but never reached a level where there were no concerns. Practitioners visiting the family home did not always record

the conditions in the home and generalised statements such as 'unkempt' were open to individual interpretation. Workers involved day to day appear to have been more accepting of a lower standard of hygiene as opposed to those entering the family home for the first time. When Ellis was born the ambulance service raised concerns regarding the home conditions. A SW visit a week later indicated the home was tidier. It is difficult to demonstrate whether this was tidier than when the ambulance service had attended because no grading system was used. No other involved professional who visited the home expressed concerns about the home conditions until the day of Ellis's death.

3.7.2 There are many families who live in neglectful circumstances, which are less than ideal, and at the practitioners event those present suggested in the area the family were living, this family did not stand out. Professionals can become desensitized to what they are seeing and accepting of sub-optimal conditions especially when those conditions fluctuate, as in this case. It is difficult to assess neglect without using a tool as risk and protective factors need to be analysed and weighted accordingly. A study by the NSPCC[11] found in 2009 9% of 18-24 year-olds and 9.8% of 11-17year-olds when asked, reported they had experienced severe neglect as children. Determining when neglect has reached a threshold where there is a risk of it causing significant harm requires knowledge and skill. When the level of neglect fluctuates, as in this case, this can cause additional complications as cases are stepped up and down between services. It is essential for practitioners to focus on the day-to-day lived experiences of the child and the impact of this e.g. Look at the world through the child's eyes. Stand in the child's shoes. See the world as he or she sees it. Ask the question: 'What is life like for this child in this family?'

3.7.3 Across the locality professionals were not guided to use any single recognised neglect tool. The LSCB had not adopted a recognised tool therefore no neglect tool was used in this case. Such a tool has the potential to direct professionals' focus and produce clarity on when the situation changed and was reaching unacceptable levels. The Ambulance service used the clutter score, a tool, to assess the home conditions. Both tools had they been used by professionals, could have provided greater clarity and assisted the core group in their work. Using the information gleaned through the use of these tools would have increased the effectiveness of the core group and taken away subjectivity whilst giving the family clarity on what was expected of them. Mother reported to the reviewer she was not always clear on what was expected, although the CP plan gave greater clarity.

3.7.4 The multi-agency network was offering significant support to the family. From discussions with the practitioners working in this case this significant support resulted in a "corporate parenting" approach, even though the children were not "Looked After" by the Local Authority. Whilst in some respects this is to be commended, this masked the adults' inabilities to adequately parent the children. What was less evident was work to improve Mother and Grandmothers parenting skills and evidence improvement had been made based on their actions; it therefore could be predicted that any decrease in professional support would lead to increased neglect of the children. Mother appeared to all professionals to be a loving

[11] NSPCC (2018) How Safe are our children? The most comprehensive overview of child protection in the uk.

and caring mother. This appears to have somewhat hindered professionals who were willing Mother to succeed. When asked at the practitioners' event whether Mother was able to prioritise the children's needs above her own the answer was universally "No".

Learning point: Professionals had insufficient clarity on the level of neglect. Use of a neglect assessment tool and the clutter score in this case would have provided professionals with greater clarity regarding the level and impact of neglect in this family.

3.7.5 The lack of parenting assessment of both Mother and Grandmother, left professionals at a disadvantage when deciding the level of harm the children were at risk of, due to parenting. Within safeguarding children forums there has been much discussion regarding what constitutes 'good enough' parenting. Research by Chaote & Engstrom[12] suggested that clinical literature failed to offer workers guidance on the practical application of this terminology and left families with the probability that the standard against which they were judged varied from worker to worker; this can clearly be seen in this case.

3.7.6 Managerial oversight is a necessity when trying to effectively manage long-term neglect cases. In this case, the SW had regular supervision. Discussions regarding neglect within supervision were obscured by Father 2's offending behaviours and Mother's mental health. The neglect issues were not accurately represented and what was presented was said to be an improving picture, this was not challenged. What was not represented, was that most improvements were not down to the actions of Mother but the endeavours of professionals. It is clear, with hindsight, that the improvements were as a result of interventions being carried out by professionals rather than any significant sustained changes made by Mother or Grandmother. The need for supervision within health is well recognised, however following a change in the structure and leadership model of the Children's Health service at that time, 1:1 supervision was reduced. HV's were provided with group supervision and staff were able to request further support. The HV's did not seek individual case supervision. The change in delivery of supervision at that time was said by frontline workers to have impacted; they indicated that this was a case they would normally have sought supervision on. Whilst managers indicated supervision arrangements were in place, front line workers reported this was not clear to them. Managerial oversight was provided to the Midwife and the Mental Health worker also accessed supervision.

3.8 Issues of safe sleeping

3.8.1 Prior to the review period the SW advised the HV of suspicions that Mother was not following safe sleeping advice with Maya and had not done so with Ethan. In addition and despite advice to the contrary, Ethan indicated in December 2017 that he was sharing a bed with Mother and Maya.

3.8.2 During the review period safe sleeping was discussed with Mother by a number of health and social care professionals, although this was not always recorded.

[12] Peter W. Choate & Sandra Engstrom (2014) The "Good Enough" Parent: Implications for Child Protection, Child Care in Practice, 20:4, 368-382, DOI: 10.1080/13575279.2014.915794

Midwifery has clear records following the birth of both Maya and Ellis that this was discussed with evidence Mother acknowledged this to be the case.

3.8.3 Following Ellis's birth professionals had no indication that Mother was currently co-sleeping with the children. Ellis was observed to be sleeping feet to foot, as per advice, in a Moses basket

3.8.4 There is clear evidence that the dangers of co-sleeping were continually revisited. Whilst the practice is not unlawful, the dangers are well evidenced and as such should have remained on the CP plan as a risk. Professionals needed to both establish whether Mother intended to follow the advice given and evaluate the impact of Mother's refusal to accept advice.

3.8.5 Following the death of Ellis, whilst Maya was in hospital, Mother continued to co-sleep with Maya despite the risks and having lost a child. Some Professionals continued to be optimistic indicating this suggested a lack of understanding of the risks; ward staff were not of the same opinion. The alternative to lack of understanding is that Mother was ignoring, refusing to, or incapable of following advice.

Learning point: Where families have repeatedly reverted to unsafe sleeping practices, safe sleeping should feature as a risk within plans.

3.9 Domestic abuse within the family

3.9.1 Mother had experienced domestic abuse between her parents within childhood. Research has shown that the single best predictor of children becoming either perpetrators or victims of domestic abuse later in life is whether they grow up in a home where there is domestic abuse. Studies from various countries support the finding that rates of abuse are higher among women whose husbands were abused as children or who saw their mothers being abused.[13] Mother's exposure to domestic abuse distorted her perception of the behaviours she was experiencing. Mother reported she didn't feel right taking on "the title" as she witnessed the same behaviours in other households and didn't think it was that bad; she wasn't experiencing "intended violence".

3.9.2 Mother was correctly identified as a high-risk victim of domestic abuse from Father 2 and a MARAC was held. At the meeting it was reported that Mother said she was scared of Father 2 being released from prison, scoring a 20 on the Domestic Abuse, Stalking and Honour Based Violence (DASH) assessment. Mother was offered the support of an Independent Domestic Violence Advisor (IDVA) and support to obtain restraining and non-molestation orders. Mother did not engage with the IDVA and once obtained both Father 2 and Mother breached the restraining order. Mother later indicated said she was forced to apply for a non-molestation order (NMO) and didn't see Father 2 as a concern. When the SW completed a parenting assessment, Mother said she was forced to say she was scared of Father 2.

3.9.3 During a consultation with her mental health worker, Mother identified she was being coerced and controlled by Grandmother and others. This disclosure was not referred to or discussed within multi-agency forums as domestic abuse.

[13] https://www.unicef.org/media/files/BehindClosedDoors.pdf

Grandmother was not seen as a protective factor but was viewed as a helpful one. Had professionals considered Grandmother's behaviours as abusive this should have prompted professionals to remove Grandmother from any plan of care rather than giving her responsibility.

3.9.4 Biennial reviews of SCRs found the combination of mental health, substance abuse and domestic abuse produced a toxic caregiving environment for the child and increased risk of harm Brandon, Bailey et al. [14] Within this family all three factors were known to exist. This should have heightened professionals concerns about the level of risk posed to the children but there is no evidence to support this consideration.

3.10 Voice of the Child

3.10.1 All the professionals with direct involvement knew the children well, and were aware of the issues and the children's needs. The reviewer acknowledges the difficulties in obtaining the voice of the child in particularly young children. There is clear evidence that Ethan had been spoken to by professionals in the past about some aspects of his lived experiences. Ethan appeared to engage and had expressed his concerns and experiences to both school staff and the SW.

3.10.2 During the review period, Ethan was positive when he spoke about his Mother and Grandmother. Ethan wanted to protect Mother from Father 2 suggesting he was aware of Father 2's violence. There is evidence that Ethan engaged in direct work with the SW but no evidence that any specific tools designed to elicit a holistic view of Ethan's life were used. Ethan was more guarded when talking about his home life; the reasons for this warranted further exploration.

3.10.3 When working with chaotic families it can be easy for children's voices to get lost. In this case, Ethan's voice was visible however it could have been more strongly represented within plans if assessment tools such as Three Houses, Wizards and Fairies, Safety House and Words and Pictures had been used. There is no evidence that the voice of the child was considered in relation to Maya or Ellis.

4 CONCLUSIONS

4.1 Ellis's death is a tragedy. The pathologist who completed the post-mortem concluded that the medical cause of Ellis's death was unascertained. What is known is that the living conditions at the time of death were in a neglected state and Ellis had been co-sleeping with Mother and his siblings. Mother had been smoking cannabis the previous evening. The pathologist recognised that a co-sleeping environment could increase risk but could not conclude that it was a contributory factor in this case.

4.2 All the professionals working in this case worked tirelessly to try and improve the outcomes for the children; indeed, they indicated to the reviewer that at times they were acting as corporate parents, purchasing school uniforms, sourcing beds, and providing high levels of support to the children. Whilst the CP plan was lengthy and

[14] Brandon, M., S. Bailey, P. Belderson, R. Gardner, P. Sidebotham, J. Dodsworth, C. Warren and J. Black (2009). Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07. London, DCSF

incorporated much of what was required, the evidence of the difference it was making for the children is less clear. Professionals were taking on all of the tasks, and in doing so, they unwittingly enabled Mother to not take actions or responsibility. This effectively stopped professionals from obtaining evidence that Mother was not complying with the plan. The level of support was such that it masked any potential evidence that Mother was making or sustaining change.

4.3 There remained confusion amongst non-mental health professionals about the severity and impact of Mother's mental illness. Mental health professionals needed to provide clarity to their non-mental health colleagues about what the mental health issue was, what that meant for Mother and how that might impact on her parenting capacity. They also needed to challenge when the decision was made to prioritise Mother's mental health as this was not necessary and averted focus from the children's needs to Mother.

4.3 The fact that Mother was not following safe sleeping advice following Ellis's birth was unknown. What was known was that there had been issues regarding safe sleeping in the past with Mother co-sleeping with both Ethan and Maya against professional advice. That said, all the indications prior to Ellis's death, were that Mother was placing Ellis in his Moses basket to sleep. It appears that Mother was not open about this and deceiving professionals about many other aspects of her parenting; Mother always denied cannabis use but it now transpires she had been using it all the children's lives.

4.4 It is a fundamental role of professionals to establish constructive relationships and maintain objectivity however this can be a challenge. The result of not being able to maintain objectivity is that professionals can become overly optimistic that parents can or have changed and are able to sustain acceptable level of care to the children. Professionals need to voice scepticism when what they are being told does not match what they are observing and, as well as offering high support there needs to be high challenge; this was lacking in this case.

4.3 In order to maintain objectivity professionals need to be provided with the tools to make accurate assessments, and with supervision and managerial oversight that challenges and analyses their assessments and views of the current presentation.

5 RECOMMENDATIONS

5.1 Each single agency has identified learning and actions taken within their narrative reports. The recommendations below are in addition and are designed to target areas where further improvements are considered to be required. Actions have already taken place to address some of the recommendations these can be seen in blue. Where action has been taken the LSCB is requested to seek assurance that the actions taken have elicited the required change.

1. Mental Health to provide awareness training regarding mental health diagnoses which may affect parents parenting abilities, either through fluctuation of mental health or physical ability, and consider how information can be effectively shared with partner agencies.

   Working with Parents with Mental Health Problems guidance has been agreed and will be in the March 2021 procedures manual update.

2. LSCP and its partners to ensure its employees are sighted on neglect by:

- introducing a recognised neglect tool and provide training to key professionals in its use
- ensuring neglect tools are being consistently used across all services in Lincolnshire by professionals trained in their use
- prompting professionals to use descriptive language that conveys what they are seeing and what they are meaning in understandable terms
- introduce the use of the clutter scale for all services who are entering households where neglectful conditions are found

A Business Case for a Neglect Tool, recommending the roll-out of GCP2, was agreed at the December 2019 Strategic Management Group. The roll-out of GCP2 is in planning phase.
A course entitled 'Recognising the Power of Language' has been devised and is being offered through LSCP training.

3. LSCP to introduce deception and disguised compliance training. This will equip professionals with the necessary tools and questions to ask parents to help them recognise their own behaviours.

A course entitled 'Recognise Disguised Compliance' has been developed and is being offered through LSCP training.

4. The LSCP to hold partners who do not fully contribute to safeguarding processes to account.

Where agencies do not attend or send a report to CP conferences this is escalated to the Senior Liaison Officer for that agency.

5. The LSCP and its partners to develop a culture in which high challenge to the family becomes normal practice, which runs alongside the existing culture of high support.

Appendix 1

List of involved agencies

- Lincolnshire County Council Children's Services
- Lincolnshire Police
- Clinical Commissioning Group (GP)
- Lincolnshire Community Health Services NHS Trust (LCHS)
- United Lincolnshire Hospital Trusts (ULHT)
- Lincolnshire Partnership Foundation Trust
- Lincolnshire County Council Children's Health
- National Probation Service (NPS)
- School
- Addaction