Suffolk Safeguarding Partnership

Thematic Review for

L, M and N

Report

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Contents

Introduction and scope of the thematic review

This report focusses on three children who were born to three families in Suffolk in 2021 and the children are named for the purpose of this report as L, M and N. The timeline for this review includes the life of the babies to their date of death or injury.

L, a baby girl, died at 12 weeks old on 18th December 2021 and N, a baby boy, died at 11 weeks old on 28th November 2021; both died in their respective parent's care. Baby M sustained a fractured arm at 6 weeks old on 9th December 2021 whilst also in the care of his parents and is now in Local Authority (LA) foster care.

All three babies were subject to Pre-Birth Assessments and had been open to Social Care under Child in Need processes. At the time of death, baby Ls case had recently closed to Social Care, baby M and N were open cases with plans for closure.

In line with the National Safeguarding Panel procedures, the Suffolk Safeguarding Partnership notified the National Panel. Following completion of rapid reviews for all three children it was agreed that the children's cases required a Partnership Review and therefore L, M, and N were joined as a thematic review using the key lines of enquiry set out below.

Agreed areas of exploration.

- A pen picture of the three babies concerned and a summary of their lives in order that we can understand their lived experiences.
- An analysis of the common and individual factors in their lives including the impact of domestic abuse, mental health issues, and alcohol and substance misuse on parenting capacities.
- Systems findings in relation to the local child safeguarding system regarding the three babies which includes missed opportunities by agencies and the impact of non-engagement, and the work undertaken by Public Health and others regarding overlay and co-sleeping.
- An analysis of the pre and post birth assessments undertaken for all three babies. Was the application of the Pre-Birth Assessments applied? What assessments took place and consideration for assessments and what advice was given professionally in supervisions/reflections?
- Exploration of the care leaver status of Baby L and Baby N's parents and how this affected how they were perceived as parents by professionals. Did this detract from the need to ensure there was a clear focus on the needs of the child? How did their experiences as care leavers affect their parenting capacity?
- What effective help and support were parents given for their parenting capacity to improve?
- A literature review of babies and children under one who have died because of sudden infant death, looking at the National Panel research, local reviews, and any other relevant research. How are these issues considered as standard as part of Pre-Birth Assessments stages?

Methodology

Professionals took part in one-to-one virtual meetings with the reviewer, with the option of a colleague to support them if required. In total, 31 meetings took place involving Social Care, Health, Youth Justice, the Safeguarding and Reviewing Service, and Norfolk Social Care Services. Consultation took place with Suffolk Police.

Parents were invited to take part and offered face to face or telephone meetings. For baby L and N, the home visits were supported by the linked Child Death Nurses working with each family. For baby M, an office visit was undertaken alongside the Suffolk Safeguarding Partnership Acting Board Manager.

The reviewer had full access to the rapid review documents compiled by the involved agencies, Social Care electronic records and reports, as well as support from Health professionals who accessed the relevant electronic records for the families.

Lived experience of the children and their families

A pen picture of the three babies concerned, and a summary of their lives in order that we can understand their lived experiences.

Baby L was born in Bury St Edmunds in September 2021 and was a full-term healthy baby girl with lots of hair and blue eyes. She was the second child born to her parents Miss W and Mr B and had an older sister, R, who was 12 months at the time of L being born. After birth L was discharged with her mother to the family home in Bury St Edmunds, which was a new property and provided Miss W with her own home with her two children. Prior to this Miss W and R had been living at Coupals Court, a supported mother and baby accommodation in Haverhill, for about a year and they moved when the new property became available before L was born.

Ls parents had been in an unsettled relationship during their time together. They met in 2019 when Miss W was living in the YMCA in Bury St Edmunds having been placed there by the Local Authority when she returned to Suffolk from Northampton after a reported incident of sexual violence towards her by a boyfriend at the time. Consequently, she no longer felt safe and returned to Suffolk. Following this, there were several different addresses where Miss W lived a somewhat transient lifestyle until being supported by the Local Authority to move to Coupals Court after it became known she was pregnant with R.

Mr B was living with a friend of Miss Ws locally in Bury St Edmunds when they met. This is understood to have been Miss W first serious relationship and she was believed to have been influenced by what Mr B said during this time. A ‘Claires Law’ disclosure was completed with Miss W in 2020 in relation to the concerns regarding domestic abuse pertaining to Mr. B. However, Miss W believed Mr B when he stated the information was untrue and then continued the relationship. Mr B is understood to have physically assaulted Miss W which led her to end the relationship stating she now believed the information that had been disclosed.

They were not living together or a couple when L was born. Mr B was serving a prison sentence at the time of his daughter’s death for an unrelated matter and was told of the death by the prison chaplain which he described as an experience no one wants to have in prison.

Miss W had reported that although both pregnancies were a surprise to her, welcomed them and wanted to give her children the best she could. Miss W had experienced a difficult and at times painful childhood and did not want this for her children. She said she wanted it to be different.

Miss W had entered Local Authority care in Suffolk under s20 in 2012 aged 12 following a disclosure of physical abuse from her father. Section 47 enquiries determined the concerns were substantiated for her and her siblings. Social Care undertook work with the family, but Miss W's mother wished for her husband (the children's father) to return home and asked for her children to be taken into LA care so that they could live as a couple.

Miss W's father died in 2017 in a road accident, and she found it difficult to come to terms with his sudden death and experienced depression. Her own mother had remarried, her current husband had children of his own and they lived as one family. This has been a significant event in Miss Ws life who felt this as a further rejection.

Miss W's siblings also experienced difficult childhoods in the care of their parents. Miss W brother now an adult, continues to have Local Authority involvement through the Leaving Care service in Suffolk and has difficulties resulting in a chaotic lifestyle, including homelessness, drug, and alcohol misuse. Miss W half sibling has Local Authority involvement in respect of her own children in Norfolk.

Miss W has a diagnosis of ADHD from 2008 which is not medicated and had a statement of educational needs when at school due to her diagnosis of dyslexia. Miss W reported that she used to self-harm, including scratching and cutting herself. As a teenager in care, she experienced periods of low mood and was known to mental health services. Her last known overdose was December 2019 and took place when living in Bury St Edmunds where Miss W advised another resident was sharing drugs and she took some but did not mean to overdose (a previous overdose took place in Northampton in 2019). Miss W used cannabis and alcohol regularly but stated during assessment this had ceased when she knew she was pregnant with R.

Miss W attributes these difficulties to being a child in care and feels that since becoming a mother she has put these behind her. Professionals overall agreed that Miss W had made positive strides and was caring well for both children with the home conditions at times being noted as outstanding.

Mr B is not known to have had any Social Care involvement as a child growing up and with his father in the Army moved several times as a family. He reports that his home life was positive, and he cannot recall any anger or violence at home. He feels that he has taken the path he has due to his own actions and not because of anything that he experienced. Mr B has a history with the Police and Courts and served prison sentences, the most recent one for driving offences.

Mr B acknowledges he was not involved in Ls care but was with R, being present at her birth and spending time with her and Miss W in the first four months of Rs life. He reports things changed when the Social Worker met him at Coupals court and after that time, he felt Miss W did what Social Care said regarding the relationship as she was afraid of what might happen. He understood her history and involvement with services and expressed that she would be frightened in a way he would not. He now believes the relationship between Miss W and himself was immature.

On 18th December 2021 Miss W and her children were staying at maternal grandmother and step grandfathers' home in Norfolk having been collected from their own home in Bury St Edmunds the day before. It is believed that the sleeping arrangements for that weekend was for Miss W to sleep upstairs in the bedroom with L in a car seat and R in a travel cot in the same bedroom. The family consumed alcohol that evening and went to bed late. It is understood that Miss W wanted to go home with the children but due to the time of day around 5am, grandmother interjected. It is not known why Miss W wanted to leave at that time. During the early hours of the morning Miss W fed L but did not return her to the car seat and remained in bed with her. In the morning maternal grandmother entered the bedroom and found L lifeless with Miss W asleep partially on top of her. Despite attempted

resuscitation, first by grandmother and then paramedics attending the address and then at the hospital, it became clear that L had died some hours before whilst sleeping with her mother.

Miss W was initially arrested and bailed, pending further enquiries, for child cruelty overlay offences as it was suspected she had laid on L whilst under the influence of alcohol and a blood sample was taken whilst in custody. The bail conditions ended after safe arrangements had been made by the Local Authority for R, Ls older sister. Miss W was then released under investigation. Currently it is understood that the full toxicology report has now been received which has evidenced both alcohol and cannabis in Miss Ws system at the time of Ls death. Police are now considering this added information as part of their enquiries. The parents and family are waiting for the inquest to provide a formal cause of death.

As L died so young it is hard to talk about her developing personality, her likes and dislikes and what made her unique. Her sister R at that time was seen to be curious and happy in the visits undertaken by professionals who saw her and that she was physically well cared for. Equally the hospital noted L appeared to be a well-cared for baby and Miss W advised L was starting to try to roll over and was becoming more aware of her surroundings.

Baby M was born in Ipswich in October 2021 and was a full-term healthy boy and a first child for his mother, Miss F, who was then aged 19. Her partner and father to M, Mr D, was aged 26. The couple had connected the previous year on the website Tinder and met up after messaging for around a month. After around two months of seeing one another, Miss F became pregnant, and both appeared happy with this.

Miss F and Mr D acknowledged they argued but did not feel it was anything more serious than other couples. Miss F had advised her previous relationship had been controlling and violent and she believed this had led to a miscarriage. During conversation with the reviewer Miss F advised this had been Mr D.

Miss F was not known to Social Care Services in Suffolk growing up. Miss F was diagnosed with depression and anxiety at 16 but was not medicated at the time of pregnancy but advised she takes prescribed medication to help her sleep at night. Due to this she felt it helpful that Mr D would be present to help with M at night.

It was known that Mr D had a period of child in care in Norfolk following difficulties at home as a teenager. Information from Norfolk Social Care details a troubled homelife with Mr D becoming increasingly angry leading to leaving the family home. Mr D was known to have a daughter in Norfolk with whom he did not have any involvement and was within care proceedings at the time of Ms birth. Concerns centred on the mother's capacity to safely care for her. As part of the care proceedings Mr D was contacted by Norfolk and then put himself forward to care for the little girl. Assessments completed in 2021, including a parenting capacity and a psychological assessment, did not recommend Mr D as a carer for her.

M was discharged from hospital into his mother's care to her home in Ipswich which was a flat near the town centre. It was understood that Miss F's parents who lived locally would be the main support that most new parents need, and the family plan was for M and Miss F to reside at their home until they moved to Norfolk to reside as a family with Mr D who already lived there. Until this happened it was expected that Mr D would stay with maternal grandparents also. Mr D was understood to have insomnia and had felt this meant he would be able to undertake Ms night feeds.

However, M was living in Miss Fs accommodation with Mr D. It is understood the property was at times less than clean and smelled unpleasantly during some professional's visits.

On 9th December 2021 M was brought into Ipswich hospital by parents after M was noted to have a floppy left arm and to be in pain. The hospital was advised by parents that the incident had taken

place at around 4 am at maternal grandparents' home, where they were staying at the time, and there had been an accident caused by father dropping M into the cot. Concerns were raised about a potential non accidental injury to M and the medical opinion formed was that this type of fracture is very unusual and did not match the account of the incident as recounted by Mr D. Joint s47 enquiries resulted in M being placed in Local Authority care under an Interim Care Order on 15th December 2021 where he remains at the time of writing.

M has made a full recovery and is developing well and continues to live with the same foster carers with which he was originally placed. He has supervised family time with his mother three times a week and Miss F has been consistent in keeping to this and written reports indicate she is attentive and in tune to Ms needs. Contact between M and his father has been organised by the Local Authority for once a week, but this has not been kept to consistently. Mr D still resides in Norwich and the supervised family time is in Ipswich at a contact centre.

Baby N was born in Ipswich on 8th September 2021 and was the first child born to his parents Miss S and Mr K. N was born full term with no complications and was a healthy baby with his parents said, a chubby face. Both parents although young, with mother being 18 and father 17, were excited to become parents, particularly as the pregnancy progressed. Parents said N was a happy baby and very alert to everything going on around him and was beginning to move around more.

Miss S when growing up did not have significant Suffolk Social Care involvement. The records indicate a period of CIN involvement in 2012 after Miss S parents had separated and this was a challenging time for parents and the children. Concerns were raised about mother's care, including neglect and physical chastisement resulting in a period of Child in Need support. In 2018/19 Miss S's relationship with her own mother became difficult and she moved to the YMCA in Ipswich.

Mr K has had significant long-term involvement with Social Care services growing up with domestic violence in the household leading to Care Proceedings in 2007 when he was removed from the family home, then residing with his grandmother under Special Guardianship for several years. The most recent episodes have focussed on his involvement and vulnerability to exploitation, gangs, and associated criminality. Mr K was subject to a Child Protection plan for emotional harm from 2020 until 2021 which then became Child in Need until case closure in September 2021.

The couple advised they were using cannabis and smoked cigarettes and reported to professionals to be cutting down whilst expecting N but still using. It is believed that Mr Ks family had a culture of cannabis use, and this is documented in Child Protection reports. Both Miss S and Mr K attended Suffolk Wellbeing services to help with these issues and wanted to do this for the wellbeing of their baby.

It is recorded that Miss S and Mr K had argued before the baby was born and there had been verbal incidents where in addition Miss S had pushed him.

Mr K has a diagnosis of ADHD and ASD, and this made school difficult for him before his diagnosis. He has struggled with controlling his emotions and his anxieties and knowing that he has a condition has helped him and professionals and family to support him. On occasions Mr K can experience difficulties with expressing his emotions and he felt he could rely on Miss S to support him when needed.

N was developing normally and gaining weight and observations from professionals was that N was a well-cared for baby. N had had bronchitis but had recovered from this and there were no concerns.

Miss S had her own privately rented studio accommodation in Ipswich which she felt was not suitable for a baby. Professionals agreed that the flat, which was damp and had mould in the bedroom, was not habitable and therefore the parents planned to temporarily live at their respective parents' homes

until suitable accommodation could be found. This meant that N did not have a settled home with his parents during his short life and experienced a lot of movement between properties at a time when establishing routines is important. Both parents were worried about this.

On 27th November the family were staying at Miss S's own family home and had been out for the day with N. Parents did the usual bath and bed routine after Miss S returned with her cousin at around teatime. Parents slept when at the property on an L shaped sofa, with N near to them in a next to me crib. On the morning of the 28th of November 2021, Mr K woke Miss S up as he had noticed N was not moving. Miss S had fallen asleep whilst holding N following a night-time feed and not returned him to the next to me crib N had been sleeping in. N had been pressed against the soft sofa cushion and consequently unable to breathe.

Police who attended the address did not suspect either parent as being under the influence of alcohol or substances and therefore did not ask consent for a blood sample from them at that point. The home was in good order and did not smell of smoke. The following day when Police visited the home of paternal grandparents where Miss S was staying with Mr K, when asked then about providing a blood sample, she readily consented to this. No concerns were raised following this and there are no further Police enquiries. Parents and family await the inquest for a recorded reason for their baby's death.

Analysis of agencies involvement and actions

The key questions posed for this review are detailed on p4 of this report and will be addressed here and any themes drawn together.

There is no suggestion that L and N's deaths could have been prevented by any agency and it is known that both children died due to being unable to breathe because of unsafe sleeping practices with a parent. It is understood there is no criminal prosecution resulting from either tragedy and both families await the formal decision regarding the cause of death from the inquest hearing.

For M, it is known the spinal fracture was caused at grandparents' home in the care of his parents, specifically Mr D at the time although he disputes how the injury occurred. There is no criminal prosecution at this time but there will be a Fact-Finding Hearing in the family court to determine in law who is responsible for the injury.

All three children were subject to Child in Need (s17) services during and after the Pre-Birth Assessment This means that the information gathered and analysed was not considered to reach the threshold for a strategy discussion and Child Protection (s47) enquiries which may have indicated the need for an Initial Child Protection Conference.

When professionals are trying to make sense of situations, it is important to understand that risk assessment in prebirth work is often challenging and complex with professionals effectively assessing parenting capacity without a child present and to test out safety plans before birth. Parents and families own accounts are important but are one of potentially many and should not be relied upon alone. Therefore, it is imperative that all known information that either lowers or raises concerns is considered and understood, forming part of a balanced risk assessment. Where areas of information are unclear, conversations must take place between professionals involved or with those who have knowledge. These conversations can support good practice and help navigate difficult areas to avoid over optimism.

Pre-Birth Assessments when referred as soon and as early in a pregnancy as possible (given that Social Work Assessment can begin from 12 weeks into pregnancy) are in-depth assessments lasting from the time of Social Work Assessment until birth, often with unfolding and new situations and information emerging as the assessment progresses. Pre-Birth Assessments will assess the most vulnerable and delicate as the children are born and as such need to be given the weight and

seriousness that such an assessment requires whether the hypothesis during the start is for Child in Need planning. As the need for Pre-Birth Assessments has grown over time, they have become part of standard social work practice and as such newly qualified SWs are undertaking these. Pre-Birth Assessments will use the skills Social Workers use every day in practice, but this can be a real opportunity to work with parents for some months and build working relationships whilst assessing. However, what is key to this is experienced supervisors who can understand, unpick and question information with the Social Worker and provide meaningful direction on areas requiring more detail where it is needed.

No plan when children remain at home can remove all risk, it can only try, following careful assessment, to balance the risk of harm and provide opportunity for professionals and the network to support and guide families. Some families will require a period of Child in Need, and some may begin with Child in Need and progress into Child Protection as needs and risk escalate or a culmination of concerns over time may require this. To families, it is likely not important which plan is in place if they feel it is helping. For professionals, the risk is measured against the type of plan in place and therefore may influence how professionals approach work with families and perceive the level of risk. L, M and N were subject to Child in Need plans which meant they were not considered at risk of serious harm by the professionals who were working with them.

However, the Pre-Birth Assessments that led to the Child in Need plans for L, M and N did not explore in depth already known information about the family circumstances and the history. For M, the Pre-Birth Assessment was not completed before he was born and therefore there was level of reliance on the Social Work Assessment and conversations in supervision alone. The pre-birth work was also further weakened by the absence of Mr D, the father, in relation to his own history and the impact that this has had on his own emotional development both growing up and as an adult. For Mr D there were a number of adverse childhood experiences which needed to have been explored with him.

Both Miss W (Ls mother) and Mr K (Ns father) experienced difficult childhoods which impacted on their emotional health and wellbeing, at times significantly. Both had witnessed anger and violence in their homes growing up and this may have shaped their perceptions of how adult relationships are. Therefore, the Pre-Birth Assessments needed to have explored this in depth and analysed the impact of this in relation to their parenting capacity but also in their own right. Apart from Mr D who was 26 when M was born, the other parents were young and quite vulnerable.

This echoes the finding of reviews both at national and local levels across the UK and in fact even wider. For example, the national review of Arthur Labinjo-Hughes and Star Hobson commented that," *the previous and recent closure of the work with Star with no further action, and the fact that previous referrals from family members had been deemed to be malicious, may well have influenced the decision to undertake a single agency assessment.*" For L, M and N the recent positive Pre-Birth Assessments appears to have influenced the direction of planning for the three children and subsequent Social Work Assessments in respect of L. In addition, the review found that supervision was not driving forward practice for the children, and this is particularly pertinent for M.

The review was asked to consider ***whether risks associated to sudden infant death are considered as standard practice as part of Pre-Birth Assessments***. For context, 196 babies and young children die every year of SIDS or SUDIC in the UK. Since parents and carers have been following the risk reduction advice first promoted in the early 1990s, the number of infants dying has fallen significantly.

Positively, information gathered from Midwives and Health Visitors for L, M and N evidenced that for these babies' safe ways for sleeping had been discussed with parents and documented within health recording systems. This appears to be very much embedded into health practice and is seen as standard in Suffolk. In addition to explaining the risks of co sleeping, smoking and other factors that

could be dangerous to babies is covered. Time is also spent discussing how to cope with a crying baby which is helpful and practical.

Suffolk County Council Health and Children's Centres best practice guidance highlights the factors that can increase the changes of sudden infant death syndrome.

- **Unsafe sleep position**
- **Unsafe sleep environment** – co sleeping in the presence of other risk factors – overwrapping (head covered pillows, duvets), soft sleep surfaces (soft or second-hand mattress), alcohol and drugs
- **Tobacco** – pregnancy and environmental exposure
- Alcohol and **drugs** during pregnancy and when co-sleeping
- Poor post-natal care - late booking, poor ante natal attendance
- Low birth weight (under 2.5kg) and preterm (less than 37 weeks gestation)
- **A change in family circumstances affecting routine**

Where risk factors are identified, the health practitioner can use the *risk assessment framework for sudden infant death syndrome* found within the main guidance to clarify the level of risk for the baby. Co sleeping on a sofa or armchair is a high-risk factor and boys statistically are at higher risk than girls from sudden infant death syndrome.

Parents agreed in all three cases that this work had been carried out with them by their Midwife and again with their Health Visitor. In addition, for baby L, Miss W had already received this advice when pregnant with R and so when this was addressed within her second pregnancy Miss W felt she had a good grasp of safety in this respect.

A key factor for baby L and N is that the safe sleeping arrangements which had been discussed and seen were not in place at the time they died. They were not in their own beds and then later during the night and early hours of the morning were co sleeping with their mother which sadly it is believed led to their deaths. For L there is the additional risk factor of her mother having consumed alcohol and used cannabis and then sleeping with her mother in an unsafe way.

Whilst it is positive that the risks are being explained clearly to parents by Health and followed up at times by Social Workers as good practice, this needs to be an agreed multi-agency approach as standard. Given the seriousness of risks in relation to sudden infant death syndrome this needs to be a standard part of Pre-Birth Assessments and crucially to be revisited periodically with the family by Health and Social Care, especially where it is known children are moving between addresses with their parents and as part of the Child in Need (or Child Protection) plan.

The review also posed the question, "***what effective help and support were parents given for their parenting capacity to improve?***

An important point to note is that for L, M and N no parenting concerns had been identified that warranted continued involvement and therefore it could be suggested that the families' needs were perceived as being no greater than any other welcoming a new baby into their lives and that universal services would be present as L, M and N grew.

In addition, as sadly L and N died at 12 weeks and 11 weeks old respectively it is unknown as to what help and support parents may have benefited from if the cases had remained open in the longer term. Professionals at the time noted warm interactions between parents for both children with no health or welfare concerns emerging prior to the events that led to L and Ns deaths that had been highlighted by professionals.

In general, for both Child in Need and Child Protection cases once babies are born following a Pre-Birth Assessments where it has been assessed that there is likely to be some support needs, a Parenting Capacity Assessment is often undertaken which would further inform any support needs

parents may have or highlight where there is emerging risk. In L, M and N cases this was not identified as being necessary within supervision or management oversight as the assessments were overall positive.

During the pregnancy the Family Nurse Partnership was referred to (a midwifery and health visiting service which offers a complete service for up to two years for younger parents) for the then unborn babies L and M, but it is understood this was not put in place due to capacity issues. Both mothers advised they would have welcomed the extra support.

For unborn baby N the Acorn team was put in place and this is a wraparound service for younger, vulnerable mothers providing Midwifery and Health Visiting care combined. The Midwife also wrote a supportive letter in relation to housing needs and the Social Worker contacted the property owner.

A key part of assessment is the exploration and understanding of the family and connected network. Family Network Meetings are held with key family and friends to include them in planning and to find out what support they can provide in the short and longer term. For L, M and N this does not appear to have taken place formally.

Family Network Meetings can also highlight where there may be difficult dynamics and in Ls case where maternal grandmother was suggested as Miss Ws main support and may have well needed to work with Social Care, this may have revealed the difficulties this could bring. For N, an FNM would have brought together both sets of grandparents and included them formally within planning. For M, it would have provided for the first time an opportunity for both sides of the family to come together and for maternal grandparents, who were supporting parents with accommodation, to be part of creating the family plan as part of the Child in Need process. These are missed opportunities and an important part of assessment, where services are planning to step away, it would have been prudent to try to secure a family led plan for those early months where routines are not yet established by new and vulnerable parents.

The review was requested to ***explore the care leaver status of L and Ns parents and if this affected how they were viewed as parents by professionals.*** As highlighted within professionals' perspectives and reflections, the Social Workers involved did not believe that this had influenced their thinking and for L the Social Work Assessments conducted after the Pre-Birth Assessment with the outcomes based on observation and lack of evidence of any concern. For example, professionals could not evidence any concerns regarding Miss W alleged alcohol misuse. For Ns father, Mr K, the Child Protection planning which had moved into Child in Need processes appears to have been a factor in determining what level of plan would be appropriate for the baby rather than considering his history of Child in Care his current vulnerabilities and the impact that the birth of the baby could have on him. At the time of the Birth Assessments and Child in Need planning for M, the information regarding Mr D and his history of Child in Care, family dynamics and other relationships when in Norfolk was not considered as part of the assessment in any depth and therefore no opinion can be formed.

Baby Ls sibling R had been subject to a Pre-Birth Assessment in 2020 due to some concerns regarding mothers' relationships and her own vulnerabilities including a difficult home life leading to child in care procedures, and her young age at the time (nineteen). Overall, the assessment appeared positive and the subsequent child in need planning in 2020 was relatively short term and focused on supporting Miss W as a new parent alongside working with her on her own relationships which could make her and R vulnerable, with a plan for closure knowing that there was continued support at Coupals Court where they were residing. However, during this period Miss W became pregnant with L and the decision was made to continue with Child in Need processes until a Pre- Birth Assessment for the unborn baby could be undertaken and a continuing support plan put in place if required.

The Pre-Birth Assessment for L was completed in March 2021 and the case was closed to Social Care in May 2021 after a short period of Child in Need planning before L was born. This was on the basis that Miss W continued to work with services and had the support of Coupals Court staff and sought support if she needed around her mental health or concerns for Mr B re-emerged. Miss W moved with R and L to her new property in Bury St Edmunds and this took her away from the on-hand support she had experienced at Coupals Court. It also meant a change in Health Visitor and GP surgeries.

A referral was received from Probation in June 2021 with concerns that the father, Mr B, was visiting the mother and baby accommodation and the case was reopened. A SWA was undertaken, and the SW visited the property and spoke with Miss W and saw R and spoke with the housing provider. There was no evidence that Mr B had been visiting and as CCTV was in place, it was felt this was a reliable source. Mr B advised through his probation officer that he had made it up and the case was closed. Health was not contacted as part of the assessment and Mr B was not spoken with directly as part of the Social Work Assessment. Miss Ws Leaving Care worker was not consulted as part of the Social Work Assessment.

Practice point
The presenting issue was understood to be concerns of father visiting the property against the Pre-Birth Assessment advice and the housing provider was spoken with. However, consultation and relevant information sharing needs to take place between all involved agencies if assessment is to be reliable and comprehensive. Leaving Care were worried about Miss W's choice of relationships and the impact of being young and parenting two small children. Liaison with the team could have explored these issues further. Health, if updated during the Social Work Assessment, could have updated their systems and been aware for any future contacts with the family.

In addition, conversation with Mr B was not pursued and his motivation for why he told probation he was visiting Miss W and R and then recanted when this information was passed to Social Care was not explored within the Social Work Assessment.

Miss W moved with R and L to her new property in Bury St Edmunds and this took her away from the on-hand support she had experienced at Coupals Court. It also meant a change in Health Visitor and GP surgeries. The home was seen by professionals involved who agreed that it was (and continues to be) kept to a high standard of cleanliness and suitably safe for children.

Practice point
When recommendation is case closure in Pre-Birth Assessment (and subsequent Social Work Assessment), consideration of potential impact for families who may be moving to another area at a time of change for the whole family. For Miss W this meant changing health visitor, midwife, and surgery, very close to L being born whilst moving away from a supported living environment.

Days after L was born a new referral was received in September 2001 raising concerns about shouting and smacking R and Miss W misusing alcohol. A Social Work Assessment was undertaken, and a Social Worker visited the home, spoke with mother, and saw R and L and found no evidence to support the allegations. Professionals working with mother were consulted who advised they had no concerns for mother's care of the children or had concerns regarding levels of alcohol consumption. Attempts were made to see Mr B but was not successful, however he was spoken with by phone. The Social Work Assessment was closed on the 25th of November with agreement for case closure. L died on 20th December 2021 before closure.

Practice point
Initial professional thinking which becomes accepted in an assessment may be at risk of being replicated in subsequent assessments if information is not sought out that may challenge or question this theory.

Baby M had been subject to Social Work Assessment leading to a Pre-Birth Assessment following a referral from Midwifery with concerns for Miss F's consumption of alcohol, poor periods of mental health with a diagnosis of anxiety, depression alongside ADHD. During the assessment which commenced in June 2021 it became known that the father Mr D had been involved with Norfolk Social Care Services as a young person and as an adult in relation to another child. Mr D reported he had to leave home and became homeless before moving to a shelter in Norfolk. Whilst in this environment it is understood he became involved in confrontations which led to a criminal record.

Practice point
It was known information that Miss F had experienced periods of poor mental health including self-harm, and this was part of the reasoning for the referral from Midwifery. However, there is no evidence of recorded checks with Miss F's GP or follow up with ICENI regarding her reduction work for alcohol and cannabis and therefore the assessment relied on mothers self-reporting that she was feeling stable, and this was in the past. Mr B had advised he had completed assessment with ICENI also for alcohol and cannabis use but had not consumed these since February 2021 and this appears to be based on father's own reporting.

It is of note that the Pre-Birth Assessment was written up 6 weeks after M was born and this is acknowledged within the authorising comments. The decision was that the family required a period of Child in Need support.

Practice point
For M, decisions were made based on the initial Social Work Assessment as well as case discussion as the Pre-Birth Assessment had not been written up or authorised. Key elements in fathers' life had not been explored or understood and therefore was an unknown quantity which is likely to heighten risk. A key aspect of supervision in Pre-Birth Assessment is to help analyse what is known and provide direction where more information is required to make an informed decision about risk.

Norfolk Social Care Services had contacted Suffolk Social Care to share relevant information during the Pre-Birth Assessment period. The Social Worker in Norfolk had advised that Mr D had a child from another relationship who was in care proceedings and that Mr D had been ruled out of assessment. Suffolk did not request further sharing of information or have sight of completed reports which would have been pertinent to the Pre-Birth Assessment and risk management.

Mr D took part in a psychological assessment completed in February 2020 which highlighted his difficulty regulating his emotions since childhood, particularly with difficulties controlling his anger. During the assessment Mr D described a poor experience of being parented, witnessing domestic violence, as well as feeling that he was treated differently from the other children in the family. The report concluded that Mr D is likely to behave impulsively and show significant lack of empathy for others. In his relationships including with a child, there is likely be a degree of emotional ambivalence due to his attachment difficulties and his fear of intimacy and that he is likely to be an emotionally highly inconsistent parent who will often respond to a child impulsively who would not understand this, and this therefore poses a significant risk of emotional harm. The psychologist felt that for a relationship to be successful some physical distance would need to be in place between Mr D and his partner to minimise frustrations and chances of disputes. This would have been helpful when thinking about the plan for once M was born and what kind of emotional environment he would be living in if parents were living together.

Practice point
The omission of information from reports from Norfolk County Council that could have been included in the Pre-Birth Assessment led to a flawed assessment and plan. The information

contained within the psychologist report regarding father would have very likely increased the recognised risk of significant harm to M and would have resulted in a child protection plan before birth. In addition, the knowledge that Mr D had been effectively ruled out by Norfolk County Council as a carer for his older child if included and considered within the Pre-Birth Assessment would have raised additional concerns.

On the 9th December 2021 parents with grandfathers help, took M to Ipswich hospital as Mr D noticed that Ms arm was floppy and he was in pain. Medical assessment determined that M had suffered a spiral fracture to his arm and that the explanation provided by Mr did not fit with the injury. A joint s47 enquiry began and the Local Authority made an application to court, and an Interim Care Order was granted which meant M was placed locally with foster carers where he remains.

Baby N was the subject of a Pre-Birth Assessment following a referral from fathers own Social Worker. The concerns for the then unborn baby focussed on the vulnerabilities of both parents with Mr K being 17 at the time and Miss S being 18. Father had been subject to a Child Protection Plan until 2021 and then Child in Need as it was felt progress had been made in relation to his vulnerabilities to gangs and associated lifestyle decisions. Concerns had been noted about verbal arguments between the couple. During the Pre-Birth Assessment period Mr K's own case was closed as it was felt he had support from the Social Worker and professional network for the then unborn baby.

Practice point
Case closure took place at a crucial point for Mr K - two days before N was born without settled accommodation for N and with Mr K about to become a father. Whilst Social Care remained involved with the family through N, this was not in Mr Ks own right as a vulnerable 17-year-old who experienced anxieties and very recent Child Protection involvement. Mr K had developed a trusting working relationship with his Social Worker, and this could have continued (as she remained case responsible to the siblings) until some measure of stability was in place and there were some months to go before Mr K was 18.

It was known information that Mr K had entered Local Authority care in Suffolk after a difficult home life and was made subject to an Interim Care Order and then Special Guardianship to grandmother. The dynamics of the family network were complex, and Mr K and Miss S had effectively grown up alongside one another when their respective parents became involved with each other in a relationship. Information from the Child Protection Chair could have been included within the Pre-Birth Assessment as a professional who had, alongside the Social Worker for Mr K, had an overview of the family prior to the Pre Birth Assessment period. In addition, the Youth Justice Service (YJS) worker had met the paternal family and Mr K and the work planned was to focus on his use and understanding of cannabis in relation to the law.

Practice point
Although some good practice is evident in liaison between the Social Workers for the then unborn N and Mr K, the Pre-Birth Assessment does not explore in depth the dynamics of paternal family and Mr Ks place in this or utilise other involved professional's insight in any depth.

As assessment continued, improved engagement with Midwifery was noted and parents engaged with the Social Worker and other professionals, and this lowered concerns. It was recognised by all professionals involved with the family that housing was inadequate, and that N, once born, was unlikely to have his own permanent accommodation with his parents. Efforts were made by Health and Social Care to help address this but ultimately N left the hospital without a suitable permanent home address.

Practice point
Babies who are moved between addresses need to be viewed through a situational risk lens and require active plans which recognise this as a risk for families.

It appears that because Mr K's case had become Child in Need, this lowered the concerns in the current assessment and was perhaps viewed in an over optimistic light. An observation is that whilst a Child in Need plan was appropriate for Mr K himself at that point, with Mr K about to become a parent the impact of this event on him was unknown.

Professionals' perspectives and reflections

A strength in the review has been professionals' engagement. Interviews have been opportunities for reflection and discussions about wider practice as well as understanding the facts of each family's situation. For some professionals who had not been involved at the time of L and Ns death, it was the first opportunity to discuss what had happened to the children, how they as professionals felt about this, and the impact on them. One professional stated, "*do I have the right to be upset*?". It is important going forward that when such tragedy occurs professionals who have been involved in the child's life should be sensitively notified and supported. Professionals need to be reassured their emotions are valid and that this is healthy.

Practice point
All professionals who have worked with children recently (not only current allocated workers) to be notified sensitively by their agency and offered an emotional wellbeing session in recognition of the impact this can have on professionals.

Almost all Social Care professionals reflected that looking back over the known information for each family that there were several red flags and there appeared a lot of reliance on what parents had said which was taken at face value. Most felt that a Child Protection Plan that recognised the risk factors would have been appropriate for the three babies.

Heath professionals reflected in discussions that they were unsure of the Child in Need status and if this was the appropriate level for the families. For N, Health advised this was raised at the time and was advised that Child in Need was the correct level as there was family support in place.

Wider issues have emerged regarding Pre Birth Assessments in Child in Need with Health professionals noting a marked difference in process between Child Protection and Child in Need in terms of working together and receiving documents and plans. When reviewing health records, no evidence of the Child in Need plan was found for any of the babies or notes of the meetings. Health Visitors advised that they take their own at the meeting, but when added to the electronic recording system, some will be very brief.

Baby L Interestingly, the professional who took part in this review was not contacted for the purpose of the Pre-Birth Assessments as this is not seen as standard practice. The Independent Reviewing Officer had known Miss W over a period of seven years and therefore had insight into Miss W, the family dynamics, and impact of those adverse childhood experiences. This professional was also the Independent Reviewing Officer for Miss W's brother. From what was known and recorded there were several red flags and there appeared a lot of reliance on what mother had said which could have been tested.

Practice point
Social Workers to consult the Independent Reviewing Officer when assessing parents who are open to the Care Leavers Service, who may no longer be involved but have a long-term perspective and knowledge to share.

The Social Worker who had undertaken Pre-Birth Assessments for L (and earlier for R) has moved on from Suffolk County Council, however Social Workers who were involved subsequently reflected that the referrals had followed quite closely on from the Pre-Birth Assessments which had been positive. They therefore focussed on the presenting issues in the referrals and addressed those as required. The subsequent Social Work Assessments was not seen as an opportunity to look at the wider picture and on reflection they felt that the positivity of the Pre-Birth Assessments could have impacted on the approach to the new assessment. One Social Worker liaised with the author of the Pre-Birth Assessments before visiting the home to talk it through which was good practice.

Practice point
Assessments that are holistic and dynamic. Whilst recent past assessments might be the starting point, to give them too much weight risks confirming past outcomes without thorough enquiry.

When thinking about Miss W's history of care, Social Workers opinions was that this was not a factor in the Social Work Assessments in that more leeway was given, they felt the no further action outcome was based on the evidence and observation. I cannot comment on the Pre-Birth Assessments in this regard, however there were several adverse childhood experiences that were known and recorded within the assessment but not given the weight they might have been. This is not to say that this is because of Miss W's care experience, but perhaps more about understanding what the information is highlighting.

The Leaving Care service commented that they had been concerned about Miss W but emphasised this was in context of a young parent caring for two very small children. The Social Work team had consulted with the Leaving Care worker as part of the Pre-Birth Assessments, and one subsequent Social Work Assessment but the information recorded was that they had no concerns over mother's care of the children. During conversations with the Leaving Care worker, it was clear that there were troubling family dynamics, and that maternal grandmother still harboured a high level of hostility towards the Local Authority which potentially could influence Miss W in how she viewed Social Care involvement. The Leaving Care Service felt that not enough weight was given to their concerns in this case and at times in others. The recording within assessments suggested either the concerns were not voiced clearly, or they were misinterpreted.

Practice point
Clear conversations between Leaving Care and Social Work teams resulting in shared understanding of the concerns and how these are expressed to parents jointly are important.

There also seemed to be some confusion as to how best to convey worries with a manager from Leaving Care escalating to a County Safeguarding Manager for advice on what to do about raising the concern. The response from the Safeguarding service was to speak with the Social Work team management. This was two days before L died. There is a Suffolk Safeguarding Partnership Escalation Policy in place if more informal efforts have not worked.

The Health Visitor reflected that she had seen the family at home after being alerted that the family had moved to Bury St Edmunds; this was when L was 15 days old. Haverhill health visiting service had contacted Miss W and it was then that Health became aware of the move and the transfer out was instigated. During the home visit the Health Visitor saw both children and the sleeping arrangements which were safe with a moses basket next to the bed. Also at the property was a man who was identified as the children's uncle. In discussions the Health Visitor did not know of the concerns that would be generated by another male being at the property as this had not been shared and she advised that she may have looked through a slightly different lens regarding his presence if she had been aware.

Conversations with the GP and the Health Visitor confirmed that there had been no recorded requests for health checks on R or mother at the surgery. In addition, there were no copies of the Pre-Birth Assessment or Child in Need plans. Health colleagues advised this made it difficult at times to know

what the plan is, especially if they do not receive copies of the Child in Need notes. If the allocated Health Visitor cannot attend the Child in Need meeting and another goes in their place, health visitors are reliant on the worker returning and writing up their own notes which varies.

For Social Workers it can be difficult at times to coordinate and ensure all professionals are part of all Child in Need meetings. When other professionals are on leave or unwell and there is no stand in, this creates challenges. As in other agencies, Social Workers are expected to undertake administrative tasks alongside case work and unlike in child protection cases, there is no allocated resource to help with this work.

Practice point
Supportive mechanisms to be put in place to assist Social Work teams so that health colleagues receive electronic copies of Child in Need plans and notes of meetings as standard.

Practice point
Vulnerable families that move across health visiting and GP areas require timely coordination when transferring to avoid confusion and delay and at times this can be challenging. Consistent closer working between Child in Need professionals would support this information being shared sooner.

Baby M In conversation with the Social Workers reflection found that at times, the Pre-birth Assessment accepted at face value what parents said at the time without undertaking necessary background checks. In addition, the Social Worker commented that most of the assessment had been completed by phone which provided a limited opportunity to observe and for parents to engage fully and that this was not ideal and something to take forward as learning in the future. (Although not period of lockdown, COVID processes in place and Social Worker had been unwell).

Regarding information that Norfolk Social Care had held for father, it seemed in discussion that the Social Worker or the supervisor did not realise the importance of it or how it would impact on the assessment. The Social Worker felt her inexperience at that time meant she did not ask further questions that she would do now and, importantly, think deeper about what the information might mean for M. This was a key piece of information which would have likely moved this family from Child in Need to Child Protection planning. Both the Parenting Capacity Assessment and the Psychologists report has been read as part of this review. These documents provided a great deal of insight into Mr Ds life and how he manages his own relationships and feelings which would have been invaluable.

Further to this, the extent of Mr Ds involvement with Norfolk Local Authority became apparent when CAFCASS made some initial enquiries following Suffolk's application at Court for an Interim Care Order. Some of the information was known to the Social Work team but it had not been considered or explored fully within assessment and therefore no real analysis of this had taken place. CAFCASS considered the chronology of events in the family's life needed strengthening and the absence of a completed Pre-Birth Assessment highlighted the need for a deeper understanding of this family.

Practice point
Supervision in Pre-Birth Assessment work needs to unpick information and events with Social Workers and provide meaningful direction, especially for newly qualified Social Workers. Pre-Birth Assessment work can be high risk and high stakes and approached with this understanding in supervision to ensure information is followed up, checked, and analysed so that supervisors and Social Workers understand what the situation is rather than what they may be told it is by parents.

In discussions with the Practice Manager, it was agreed that case notes highlighted Mr Ds involvement with Norfolk, but that supervision did not provide any direction in terms of follow up enquiries. The Practice Manager advised that supervision in this instance needed strengthening and should have followed up to clarify if background checks had been completed and then discussed the outcome as

well as further liaison with Norfolk. The Practice Manager advised that discussions had already been held with the supervisors as part of the management teams own learning in this case.

It was noted that no Family Network meeting was held, and this might have pooled the family resources more formally and helped in the Pre-Birth Assessment, acknowledging that one face to face visit and 2 telephone calls was not sufficient for the Pre-Birth Assessment which had been referred timely and therefore had some time to plan for and complete. The Practice Manager noted that the Social Worker had been unwell and not in work and consequently the Pre-Birth Assessment was not completed (written up and authorised) until 6 weeks after M was born, therefore it was the prior Social Work Assessment that the decision for Child in Need was based on alongside case notes and discussions with the Social Worker when in work.

Miss F Health Visitor advised that an antenatal visit had been completed when Miss F was 27 weeks pregnant and both parents were present. Safer sleeping was discussed with parents as standard practice. The Health Visitor knew a Social Work Assessment had been completed but was waiting to hear the outcome. Following this she contacted the Social Worker in November 2021 to introduce herself and asked for the plan after parents advised that they knew who the named professional was.

Practice Point
Families in Child in Need cases need the same level of relevant information sharing and professional collaboration as families in Child Protection processes.

The Health Visitor did not attend the virtual Child in Need meeting but visited the maternal grandparents. When speaking with the Social Worker the Health visitor advised she had discussed safer sleeping and how to cope with a crying baby but had not seen the bedroom and was concerned as there was an unpleasant smell in the home. The Social Worker advised she had seen the bedroom and provided advice to the parents about improvements.

The identified plan in supervision was for case closure when M was four weeks old, and this did not take place as Pre-Birth Assessment was not written up. However, management oversight from the case supervisor was clear this was to be closed as soon as possible due to the positive assessment.

Baby N A new Social Worker took on the then unborn Ns case in September 2021 following the departure of the allocated Social worker who had completed the Pre-Birth Assessment recommended Child in Need. There was no opportunity for a case discussion or handover visit and it was very much about getting to know the family as quickly as possible. The Midwife felt positive about how parents were coping despite the difficulties with accommodation.

In discussions with the Social Worker, reflection took place regarding the Pre-Birth Assessment and the difficulties that father had experienced in his young life including the violence witnessed at home leading to an Interim Care Order and then permanence in the form of Special Guardianship Order with maternal grandmother. His difficulties with sleep and struggles at times to manage his emotions and the noted arguments between the couple. The very recent Child Protection concerns for him in relation to exploitation and gangs and that at the point of his baby's birth, his own case was closed to Social Care from a short-term Child in Need plan which highlighted father vulnerabilities in terms of his emotions and drug use. Talking it through with the Social Worker felt these were issues which needed unpicking within supervision.

The role of supervision is to look beyond the presenting issue and consider the other known factors and how this might impact on the family now and in the future. The Practice Manager reflected that the supervision was lacking depth and in addition the Pre-Birth Assessment was not read and authorised by the manager who would have known the adverse childhood experiences of father, the family dynamics and impact as she supervised both Social Workers working with the family. Reflection was that Mr K was almost missing from the Pre-Birth Assessment and his views were not evidenced

and that had the concerns and vulnerabilities been considered and analysed it could have moved from Child in Need to Child Protection.

Practice point
Social Care Practice Managers to have final authorisation for all Pre-Birth Assessments.

Mr Ks and Ns case was open to the same social work team and therefore provided good opportunity for meaningful conversations between the allocated Social Workers. Mr Ks Social Worker invited the then unborn baby's Social Worker to a core group meeting and so the knowledge was shared and this evidences a measure of good practice. Mr Ks Social Worker had a positive working relationship with Mr K and understood the family dynamics and both parents own relationships. It was felt that the issues that had required a Child Protection plan had diminished, and Child in Need planning was appropriate for him at that point. However, with the known issues that Mr K struggled with, and N being born two days after Mr Ks case closure, the situation felt fluid and in conversation with one Social Worker the view was expressed how important the Pre Birth assessment is in understanding the family dynamics, what support will really look like in reality and in Ns case where his parents were staying as "guests in people's homes" needed to be explored more. This factor is present in both M and Ns case.

The Child in Need plan in place for Mr K did not address the fact that he was about to become a parent or how this might impact on his own emotions or behaviour, even though it was highlighted in the danger statement and the case was closed with N being born the following day.

Practice point
Where children who are about to become parents have been subject to Child Protection plans, the Child Protection conference chair alongside the operational team will ensure the plan acknowledges and addresses potential impact for the new parent as part of the new Child in Need plan.

Practice point
For children who become parents and have been open to Social Work teams, consideration for their case to remain open as support for their own needs in the short term until routines are in place.

Mr K during this time was open to the Youth Justice Service from 15.10.21 until the 18.02.22 in relation to the Youth Caution Offence due to cannabis use. The youth justice worker reflected that Mr K had initially engaged very soon after being allocated to him and he had had a positive meeting during a home visit where he had met paternal grandmother and seen N in his moses basket and Mr K spoke of his training work and how he wanted to lessen his cannabis use because of N. The work would have been focused on cannabis and the Law. On 09.11.22 following the actual administration of the caution, Mr K appeared to disengage from the service. The work would not have been long term but likely 2-3 sessions.

Youth Justice Service was not invited to Child in Need meetings and in Ns case there was a short timespan for this to take place but for wider thinking, this could be important for parents, especially young fathers (who may not have many other professional supports). Reflecting, the youth justice worker was not aware of the Mr K family history when he visited the home. He met with maternal grandmother but was not aware of the history or dynamics and on reflection this knowledge prior to visits is important.

Practice point
Where Youth Justice Service is involved with a young person who is about to or have just become fathers, Social Care and Youth Justice Service to ensure relevant information about family history and dynamics are shared to inform Youth Justice Service practice. If the young person has recently closed to Youth Justice Service, the Social Worker to include them in Pre-Birth Assessment.

One point that has stood out in the review is how engaging professionals found parents to be as people. Both the Midwife and the Health Visitor highlighted this as has Mr Ks previous Social Worker. Mr K has had significant involvement with the Local Authority as a child and young person, however he has remained open to professionals to a certain extent and speaks with clarity, feeling and common sense especially when speaking about the events covered in this report. He has observed that he felt patronised at times by some professionals, due to his young age. However interestingly all professionals reported how likeable and engaging Mr K is and enquired about the couple and there appeared genuine interest in how they are doing. Again, this highlights how different individual perceptions are and how this can be interpreted by both families and professionals.

The Health Visitor has moved on from the Health Service, but discussions were held with another health colleague who had oversight of the electronic recordings from the time period and the issue of safer sleeping again was present and that this was evidenced as discussed. The new baby visit to N took place on the 23.09.21 but there were no details recorded of Child in Need reviews in the baby's notes and limited liaison between the Social Worker and the Health Visitor. The last home visit was completed on 25.11.21 by a different Health Visitor and there appears to have been a plan to have a discussion regarding parents' cannabis use and how their plan to reduce usage was going. From discussions it seems as though the different health visitors may have had different professional opinions regarding the level of concerns.

Practice Point
Health Visitors to discuss with their safeguarding leads in reflective supervision if levels of planning are not felt sufficient.

Parents perspectives and reflections

This section of the report follows on from the professionals' perspectives and reflections and provides a personal account of how parents felt about the involvement of services both in terms of the Pre-Birth Assessments and any subsequent services. For the parents who had Social Care involvement as children this added another dimension to how they experienced the more recent episode of work. As the reviewer, I would like to take a moment to express appreciation for L, M and Ns parents' agreement to take part and for L and Ns parents who agreed to talk about a terrible time in their lives when suffering from their loss.

Parents understand this is about exploring the period before and after their babies were born and to see if there is any professional learning for the future. Part of this work needed to consider family history and dynamics and any significant involvement with Children's Social Care because these aspects would be relevant to the Pre-Birth Assessments. These therefore have been included.

Baby Ls mother Miss W was visited at home and seemed open and thoughtful during the conversation and despite her distress at times was able to speak about some of her own life experiences which have been difficult even prior to this tragedy. I include this as her life history entwined naturally within the conversation and therefore would be important within any assessment that needed to think about mother's support network.

Miss W said she was "fine" with Social Workers and had had them all her life. She knew that "*you had to work with them*" and felt she had learnt how to do this. She observed that "*they do support you, but the past goes against you".* When younger as a child in care Miss W believed she wasn't listened to but as she got older, she thought she was. She said, "*when children talk, they have a voice*" It seemed she spoke with a wisdom that can be found through the lived experience.

Miss W recalled she had received advice around babies sleeping safely in both pregnancies from the Midwife and Health Visitor and shared she had the leaflets and understood the risks around sleeping

with your baby. Miss W reflected she believed she had more support with her first baby and acknowledged this was due to her living arrangements in a supported mother and baby accommodation which had a professional network around families. When she moved to Bury St Edmunds to her own property, this on hand support was no longer in place.

When thinking about the assessments that had been undertaken, Miss W was unaware of the Pre Birth Assessments for L but remembered the one she had taken part in for her first child, R. Miss W advised she was also unaware of the two subsequent Social Work Assessments following the birth of baby L saying, *"I didn't have any assessments, Social Workers came round to check but that was it."*

In conversations with the Social Worker about planning before L was born, Miss W remembers being asked about what relationships she had around her. Miss W had told the Social Worker that her mother was "supportive" and that this was accepted. Miss W reflected that she wasn't asked about the quality of that relationship or what it looked like, so she didn't say. More recently she has reflected that Social Care would have been aware of her own mothers parenting and the situations of her adult siblings and didn't understand why this wasn't considered more.

Miss W said when thinking about her baby that she had all the home set up safely for L but the night of her death she was not at home but sleeping at her own mother's property which was not equipped with a bed and moses basket. Miss W said that *"it could happen to anyone"* and wants to, when the time is right, work with parents around the important health and safety issue of ensuring babies always sleep safely.

Miss W is focused on the supervised family time she has three times a week with R who is in foster care and is working with the Local Authority and hopes that she can be reunited with her daughter in due course. Miss W also shared that she is expecting another baby with a new partner and although this pregnancy came as a surprise, she is happy with this although it does not take away from the pain of Ls death.

Baby Ls father Mr B said he was not included in any assessments for either L or R or sent any reports. He was at Rs birth and recalled looking after her for over four months with Miss W. He remembers meeting a Social Worker after R was born who he felt did not like him and Miss W had told him he couldn't see R because Social Care said so. He does not know more as Mr. B says he was not spoken to directly at that time. He advised Miss W was afraid of Social Care as he understood many people are. He has not had any direct conversations about what happened to L with any professional and was notified of her death by the prison chaplain.

Mr B accepts that they had a difficult relationship and were "immature" as a couple but believes he should have been involved in assessments, whatever Miss W had said to the Social Worker as he is the children's father. He reflected that he knew he had a criminal record and a history with the Police but that he came from a good family and never had Social Care involvement as a child himself. He knows that there are bad people but not everyone is like that. Mr B stated that the negative things, like the arguing and criminal history, is always stuck with him and Social Care "*don't believe that people can change and that they need to focus on fathers more"* He wants to see R and from liaising with the current Social Worker for R, Mr B is being kept up to date and is included as part of Care Proceedings.

Baby Ms mother Miss F reflected that during the time before M was born, she didn't feel worried about talking to some professionals, saying she liked the Midwife and spoke to the Health Visitor. Miss F also feels that she is kept up to date with what is happening by her current Social Worker which is important to her. Miss F felt that she worried about Social Care in general and how they work saying, "*When you ask for help, you're made to feel like you can't cope. But when you don't ask for help, you're made to feel bad because you should have asked."*

Miss F cannot recall seeing a Social Work Assessment or a Pre-Birth Assessment. Miss F was aware she was on the list for support from the Family Nurse Partnership, but this didn't take place. Miss F said she "*would have taken any kind of help*". Miss F also cannot recall seeing a copy of the Child in Need plan.

Miss F advised she understands why her son is in foster care (because of the injury he sustained) but hopes M can return home. Miss F felt that "*things get twisted…. they are going to listen to the Social Worker*" and feels that some things written subsequently have misrepresented her. Miss F stated she would have left the baby's father had she read the reports that Norfolk Social Care Services had completed about him. Miss F knew that when the Social Worker arranged the 'Claires Law' disclosure for her to hear from Police about the convictions Mr D had, she chose not to believe them. Her partner, she felt, convinced her they were untrue. Subsequently following a domestic incident between them, Miss F realised there was truth in the information and ended the relationship. Miss F maintains she did not see the assessment report that was later referred to which added to the concerns about the father of M and her capacity to protect M from harm.

Miss F reflected that a family network meeting might have been helpful, to include her family pre-birth and after as her parents had been supportive to her.

Baby Ms father advised that he has found it difficult since his son sustained the injury saying, "*after the accident I turned to alcohol to cope with everything."* Mr D also commented that he didn't fully understand why Social Care had been involved and felt he had been given differing reasons and that some of the reasoning only became clear after Ms injury, specifically, his own history. Mr D shared he was unaware that previous assessments undertaken regarding his other child were unsuccessful. He felt that both he and Miss F embraced the help, but he felt that "*they were being watched and didn't know why, we knew we were young parents but that was all, and we were accepting help because we needed guidance."*

Baby Ns mother and father remain in a relationship and appeared relaxed and supportive of one another during the conversation. Both parents shared that they felt "*they needed to do what was asked"* of them. They advised that "*you don't picture social services in a good way*" and that "*you can't be yourself*". This is an important aspect for professionals to acknowledge and in contrast to how professionals perceived their working relationship with the parents.

Mr K observed that with all the professionals and meetings the one thing they needed was a proper place to live in. He felt that this was not given enough priority in the Child in Need work. Parents said in the "*whole two months* (of N's life) *we were moving round*." All professionals agreed Miss S' flat was not good enough for the family (damp, mould). Parents remembered that the Midwife wrote a supporting letter to the council and the Social Worker liaised with the property owner but that he would not provide a notice of eviction to allow Miss S to access accommodation quicker.

They spoke about the impact of this transient living on their lives and that sometimes it was hard to know where they would be and so professionals couldn't always get in touch to visit. Miss S reflected that her and the baby's medical notes might be at another address and that it felt disorganised.
Mr K observed that now Miss S had her own place, and this was appropriate but," *it was too late*" (he meant for them as a family with N).

Regarding assessments, they could not recall seeing one and felt, looking back, some things were not explained to them. They didn't know the reason for the assessment other than what the Social Worker had told them at the beginning which they said was "*because Mr K had a Social Worker*". Parents
said that if they had seen the assessment, they would have understood better. Part of this they also felt was that the Social Worker did not visit for the purpose of the Pre-Birth Assessment, but it was conducted by telephone-this means there was no opportunity to observe interactions between parents

or undertake individual sessions with each parent. Mr K and Miss S recalled the Social Worker coming out for the Social Work Assessment which preceded the Pre-Birth Assessment.

Parents shared that sometimes they felt patronised because of their young age (17 and 18 at the time). Dad spoke highly of his own Social Worker during his Child Protection and then Child in Need process saying, "*she was a legend*" and she listened and tried to help him. He felt this so strongly, they invited the Social Worker to the funeral who attended.

Both parents recalled the safer sleeping conversations with the Midwife and understood what it meant. Both parents said living in different places meant they had to make do with what arrangements were in place where they were staying (at paternal grandmothers' home when N died).

Collectively L, M and Ns parents' reflections are powerful and an important part of this review. For parents who have had significant involvement with Children's Social Care over the years this unsurprisingly will impact on how they feel about recent involvement in their lives and for parents who did not have significant involvement, opinions are often formed from friends, family, and the media about what to expect alongside their own feelings.

When Pre-Birth Assessment is undertaken it is important that professionals really consider the impact of this work on parents and the implication that is often unsaid but thought of by parents, which is that their baby could be taken away from them which is undoubtedly an immobilising fear for parents. For L, M, and N this was not in professionals' thoughts and therefore the Child in Need plans agreed reflected this. However, from conversations with the parents, this was their starting point and remained an underlying fear despite on the whole positive Pre-Birth Assessments.

Sharing of information and reports with parents is essential not only at the end of assessment but to include them as the work develops in what is a period of great change for any family but especially when parents are young and at times vulnerable. In reviewing the reports and recordings for L, M and N, it is evident that visits and conversations took place with parents, Child in Need reviews were held, and supervision discussed the progression of the work, and the babies were looked after through Midwifery and then Health Visitor care. However, when listening to parents, the impact of the work is less clear. Mr K spoke openly and stated that what they really needed was somewhere to live as a family. All the planning carried out did not achieve that for them. The overarching theme of the impact of the work was that parents believed they needed to co-operate with the assessment and were worried about Social Care involvement to a lesser degree for some. In conversations parents acknowledged that the Child in Need plan that resulted from the Pre-Birth Assessment and closure for L and plans for closure for M and N acknowledged that professionals were positive, yet they did not fully understand what was being done to them or with them.

The Pre-Birth Assessment procedures are set out within Suffolk County Council policy; however, these do not detail how to tackle the barriers that can prevent good practice when trying to work alongside parents. Professional relationships with parents are built through mutual trust and respect which is gained through openness, honesty, and understanding of the power dynamics with the professional and families. Pre-Birth Assessment work is a balance of listening to parents coupled with incisive risk assessment and being open about this. The national review into the murders of Arthur Labinjo-Hughes and Star Hobson commented that *"there is a need for skill in blending care and control functions" and this is pertinent for* Pre-Birth Assessment work which is potentially high risk and when parents can be at their most vulnerable. Time and consistency are other elements that are important in building trust. A change of professionals, which is sometimes unavoidable, but which needs a level of understanding of the impact this can have on parents who may feel they have to tell their story again, or as one parent stated that a new professional will advise parents to do something differently which is confusing.

Key findings, Practice Points and Recommendations/Action Planning.

L, M and N are individual and unique and as such each child is distinct within the report. However, some similarities both in terms of practice and missed opportunities have been found. Speaking with professionals and families has provided valuable insights alongside the reports and documentation.

This has led to the following recommendations.

- Suffolk Safeguarding Partnership to raise the profile of safer sleeping and associated risks across partner agencies including support to increase knowledge of this area for Social Workers.

- Suffolk Safeguarding Partnership works with partner agencies to embed recognition that house moves and temporary living arrangements are seen as *situational risks* for babies which need proactive plans that recognise and addresses before babies are born.

- Closer working together between Social Care and Health in Pre-Birth Assessment and Child in Need processes.

- Suffolk Safeguarding Partnership to increase recognition of the importance of the Health Visitor's role and help advocate a return to working together in partnership with families and professionals including home visits to meet the needs of families outside the Child Protection process in line with the requirements of the Healthy Child Programme.

- Parents own life experiences are explored in depth and understood. For young parents who are care experienced it is important to connect with professionals who have known them over a prolonged period of time.

- Fathers are central and must be included whether they are living with the family or not.

- The understanding and use of family network in Pre-Birth Assessments. Professionals need to understand the family dynamics. While parents may highlight family as support, professionals need to explore and be respectfully challenging.

- Supervision is used effectively to explore risk and hypothesis. Supervisors in Social Care to follow up that information has been verified or explored, that raises or lowers concern which could change the trajectory of the case.

- Pre-Birth Assessment to remain open until after the baby is born and there has been time for stress testing of plans and support. Practice managers to have oversight of this and authorisation of all Pre-Birth Assessments.

- Hospital discharge planning meetings to be considered for Child in Need cases as part of the plan for younger parents, and parents with other vulnerabilities including where there are several addresses and uncertainties. Health to request this if felt necessary.

- Recognition of the power imbalance between agencies and parents. Relationship based case work that starts with this awareness is essential.

Table of Practice Points.

1	*The presenting issue was understood to be concerns of father visiting the property against the Pre-Birth Assessment advice and the housing provider was spoken with. However, consultation and relevant information sharing needs to take place between all involved agencies if assessment is to be reliable and comprehensive. Leaving Care were worried about Miss W's choice of relationships and the impact of being young and parenting two small children. Liaison with the team could have explored these issues further. Health, if updated during the Social Work Assessment, could have updated their systems and been aware for any future contacts with the family.* *In addition, conversation with Mr B was not pursued and his motivation for why he told probation he was visiting Miss W and R and then recanted when this information was passed to Social Care was not explored within the Social Work Assessment.*
2	*When recommendation is case closure in Pre-Birth Assessment (and subsequent Social Work Assessment), consideration of potential impact for families who may be moving to another area at a time of change for the whole family. For Miss W this meant changing health visitor, midwife, and surgery, close to L being born whilst moving away from a supported living environment.*
3	*Initial professional thinking which becomes accepted in an assessment may be at risk of being replicated in subsequent assessments if information is not sought out that may challenge or question this theory.*
4	*It was known information that Miss F had experienced periods of poor mental health including self-harm, and this was part of the reasoning for the referral from Midwifery. However, there is no evidence of recorded checks with Miss F's GP or follow up with ICENI regarding her reduction work for alcohol and cannabis and therefore the assessment relied on mothers self-reporting that she was feeling stable, and this was in the past. Mr B had advised he had completed assessment with ICENI also for alcohol and cannabis use but had not consumed these since February 2021 and this appears to be based on father's own reporting.*
5	*For M, decisions were made based on the initial Social Work Assessment as well as case discussion as the Pre-Birth Assessment had not been written up or authorised. Key elements in fathers' life had not been explored or understood and therefore was an unknown quantity which is likely to heighten risk. A key aspect of supervision in Pre-Birth Assessment is to help analyse what is known and provide direction where more information is required to make an informed decision about risk.*
6	*The omission of information from reports from Norfolk County Council that could have been included in the Pre-Birth Assessment led to a flawed assessment and plan. The information contained within the psychologist report regarding father would have very likely increased the recognised risk of significant harm to M and would have resulted in a child protection plan before birth. In addition, the knowledge that Mr D had been effectively ruled out by Norfolk County Council as*

	a carer for his older child if included and considered within the Pre-Birth Assessment would have raised additional concerns
7	*Case closure took place at an important point for Mr K - two days before N was born without settled accommodation for N and with Mr K about to become a father. Whilst Social Care remained involved with the family through N, this was not in Mr Ks own right as a vulnerable 17-year-old who experienced anxieties and very recent Child Protection involvement. Mr K had developed a trusting working relationship with his Social Worker, and this could have continued (as she remained case responsible to the siblings) until some measure of stability was in place and there were some months to go before Mr K was 18.*
8	*Although some good practice is evident in liaison between the Social Workers for the then unborn N and Mr K, the Pre-Birth Assessment does not explore in depth the dynamics of paternal family and Mr Ks place in this or use other involved professional's insight in any depth.*
9	*Babies who are moved between addresses need to be viewed through a situational risk lens and require active plans which recognises frequent moves as a potential risk for families.*
10	*All professionals who have worked with children recently (not only current allocated workers) to be notified sensitively by their agency and offered an emotional wellbeing session in recognition of the impact this can have on professionals.*
11	*Social Workers to consult the Independent Reviewing Officer when assessing parents who are open to the Care Leavers Service, who may no longer be involved but have a long-term perspective and knowledge to share.*
12	*Assessments that are holistic and dynamic. Whilst recent past assessments might be the starting point, to give them too much weight risks confirming past outcomes without thorough enquiry.*
13	*Clear conversations between Leaving Care and Social Work teams resulting in shared understanding of the concerns and how these are expressed to parents jointly are important.*
14	*Supportive mechanisms to be put in place to assist Social Work teams so that health colleagues receive electronic copies of Child in Need plans and notes of meetings as standard.*
15	*Vulnerable families that move across health visiting and GP areas require timely coordination when transferring to avoid confusion and delay and at times this can be challenging. Consistent closer working between Child in Need professionals would support this information being shared sooner.*
16	*Supervision in Pre-Birth Assessment work needs to unpick information and events with Social Workers and provide meaningful direction, especially for newly qualified Social Workers. Pre-Birth Assessment work can be high risk and high stakes and approached with this understanding in supervision to ensure information is followed*

	up, checked, and analysed so that supervisors and Social Workers understand what the situation is rather than what they may be told it is by parents.
17	*Families in Child in Need cases need the same level of relevant information sharing and professional collaboration as families in Child Protection processes.*
18	*Social Care Practice Managers to have final authorisations for all Pre-Birth Assessments.*
19	*Where children who are about to become parents have been subject to Child Protection plans, the Child Protection conference chair alongside the operational team will ensure the plan acknowledges and addresses potential impact for the new parent as part of the new Child in Need plan.*
20	*For children who become parents and have been open to Social Work teams, consideration for their case to remain open as support for their own needs in the short term until routines are in place.*
21	*Where Youth Justice Service is involved with a young person who is about to or have just become parents, Social Care and Youth Justice Service to ensure relevant information about family history and dynamics are shared to inform Youth Justice Service practice. If the young person has recently closed to Youth Justice Service, the Social Worker to include them in Pre-Birth Assessment.*
22	*Health Visitors to discuss with their safeguarding leads in reflective supervision if levels of planning are not felt sufficient in the case.*

Research evidence

National Child Safeguarding Practice Panels review, **'Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm.**' This suggests multi-agency action to address pre-disposing risks of SUDI for all families, and with targeted support for families with identified additional needs; ensuring that safer sleep advice and risk assessment are joined up with wider considerations of safeguarding risk and plans to work with families to address safeguarding concerns; systems and processes that support effective multi-agency practice in working with families, particularly those at high risk of abuse or neglect. According to the study, the most effective programmes were those that started prior to the birth of the child and continued after and were conducted by individuals that the families trust and believe.

During the conversations with some Health professionals the issue of pressures from cuts to the services offered and the impact of this came to the fore when thinking about families that move across areas which means transfers of records and a change of health professional including GP and health visitor and midwife if mother is pregnant. Service cuts can mean that a family has been in a new area for some time before being alerted if the family does not get in touch. Health Visitors are not able to undertake supportive visits outside of the national offer and this means much joint working that used to be in place between health and SC cannot happen and lessens the opportunity for Health Visitors to offer support to vulnerable families. **The Institute of Health Visitors in a 2019 position statement** (see appendices) call for, "*Recognition of the advanced specialist nature of the health visitor's role*

returning autonomy to work in partnership with families and others to meet the needs of all families in line with the requirements of the Healthy Child Programme".

The National Review of Non-Accidental Injuries in Under Ones includes real examples where the risks from male carers or fathers were not identified with serious and at time fatal consequences. This is relevant to baby M who was harmed at home when his father is believed to have injured him. An area explored within the review is chance or opportunity, alongside the unique feature in such cases is the extreme vulnerabilities of all babies. If the situation arises where the man (in this review all subjects were male) becomes angry or frustrated and there are a number of known adverse childhood experiences the consequences are very likely to be severe for that child. From the interviews conducted it appeared that the incident was at times triggered by a normal occurrence (baby crying for example) but this extreme reaction usually due to a low frustration threshold was also in response to events in the past and at times last weeks-poor mental health, financial and relationship problems. It is therefore important to understand what adverse childhood experiences present (for any adult) and what impact this could have on a child when assessing risk.

References

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https://suffolksp.org.uk/assets/Working-with-Children-Adults/Policies-CYP/Escalation-Policy/2021-11-10-SSP-Final-Escalation-Policy-v6.pdf

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