Northamptonshire Safeguarding Children Partnership

Northamptonshire Safeguarding Children Partnership

Child Safeguarding Practice Review

Child Az

Overview Report

Lead Reviewer

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1. Introduction

1.1.1 Child Az was born in October 2019 at home in Northamptonshire. Child Az had two older siblings, Sibling 1 aged 4 and Sibling 2 aged 3. The parents were of Eastern European heritage. Mother had little if any understanding of English, however Father spoke and understood English reasonably well. When an interpreter was required the language spoken was Russian.

1.1.2 In September 2019, when Mother was 34 weeks pregnant the family was found in a local park and appeared to be homeless. At the time Father had lost his job and having no recourse to public funds the family had been evicted from their privately rented accommodation due to rent arrears. The parents and children arrived at Hospital A&E and emergency accommodation was found. Children's Social Care had been made aware by the Housing Department that the family was facing eviction and a Single Assessment had been initiated prior to their eviction.

1.1.3 Longer term rented accommodation was found for the family and the outcome of the Single Assessment was for the Children to be made subject to Child in Need plans. Because of Sibling 1's additional needs the case was then transferred to the Disabled Children Team until Child Az's death. The last time the children were seen by a Social Worker was at the end of January 2020, when no concerns were noted. Due to the Covid Pandemic the UK went into lockdown in mid-March 2020.

1.1.4 On 15 April 2020, Father made an emergency 999 call as Child Az was not breathing. Despite attempts to resuscitate him, Child Az sadly died. He was six months old.

1.1.5 Given the involvement of agencies with the family prior to Child Az's death, consideration was given by the Safeguarding Children Partnership as to whether the case met the criteria for a Child Safeguarding Practice Review under Working Together to Safeguard Children, 2018. It was decided on 13th May 2020 that the case did meet the criteria for such a review to be commissioned.

Parallel Processes

1.1.6 The parents were arrested after Child Az's death, however Police decided that they should not face criminal charges related to wilful neglect of a child.

1.1.7 An Inquest into Child Az's death took place on 2nd June 2021 and an open verdict was recorded. The coroner's narrative raised concerns in respect of unsafe sleeping.

Terms of Reference, Methodology and Scope

1.2.1 Full details of the terms of reference and methodology for the review can be found in Appendix 1, as can details of the agencies involved, and the Lead Reviewer.

1.2.2 A multi-disciplinary Learning Event for practitioners was held on 30 November 2020. Due to the Covid Pandemic the event took place virtually, using Microsoft Teams. The event was particularly well attended, with twenty three participants, especially given the circumstances of a Pandemic

and proved to be worthwhile, with practitioners engaging in helpful discussions and insightful suggestions for improvement of practice. The Lead Reviewer would like to thank all those who attended and the Safeguarding Children Partnership staff for arranging and facilitating the event. Discussions arising from the event have informed the learning and recommendations arising from this review.

1.2.3 **The time period for the review is from 1 January 2019 until 17 April 2020.** The start date is the approximate time Mother would have become pregnant and the end date is two days after Child Az's death to allow an understanding of events immediately after his death.

1.2.4 **The issues for consideration in the review are as follows**:

- What is your agency's understanding of each child's voice, the recording of their voice and your understanding of their voice?
- What is your agency's understanding of this family as individuals and as a family unit in their home living environment?
- Is there any evidence that this death, taking place during a period of 'lockdown', had any impact on the safeguarding of the children?
- Analyse the root causes and professionals' feelings around their judgement and consideration of 'what is good enough' in terms of the family's poverty.
- Should and could agencies have recognised the likely significant alcohol misuse and in terms of the domestic abuse incidences likely being linked to intoxication, is this information now shared in domestic abuse notifications to health visitors.
- Discuss consideration of possible foetal alcohol spectrum disorder with maternity and paediatric colleagues to fully explore and capture learning from this case.
- Explore with health visiting services as to whether it was appropriate for this family to be managed at a universal level of service provision.
- The single assessment appeared to focus on the family's homelessness, closing the case once the family were re-homed, despite wider issues of neglect and lack of clarity around the parent's previous children.

Involvement of family members in the review

1.2.5 The parents were informed that a Child Safeguarding Practice Review had been commissioned and welcomed the opportunity to contribute to the review. The Lead Reviewer met with Mother and Father on 19 February 2021 via Microsoft Teams. An interpreter, who was known to the parents and who was familiar with the case, was present throughout the meeting and translated for both parents.

1.2.6 A note taken during the meeting was translated into Russian and shared with the parents for comment and matters of accuracy. The note was accepted by the parents as an agreed record of the meeting. The Lead Reviewer would like to thank the parents for their time and contribution to the review, which has been helpful and informative. Thanks, are also extended to the interpreter, and to the staff member from Northamptonshire Safeguarding Children Partnership Team who took a note of the meeting.

1.2.7 Information provided by the parents is included throughout this report.

2. Summary of Key Events:

Family History Prior to the Period under Review

2.1.1 Father told the Lead Reviewer that he came to the UK in 2008, in his words '*for a better life*'. Father explained that he had children in his home country from a previous relationship with whom he was in contact every day. Mother also had children in her home country but was not in contact with them. The parents said they met in the UK. Siblings 1 and 2 were born in Northamptonshire and have British citizenship. Neither Mother nor Father have any family or friends in the UK but explained that they did not feel isolated as they had been supported by members of a local church. Both parents stated that they did not drink alcohol to excess.

2.1.2 Father has previous convictions for alcohol related offences and Mother was sentenced to a period of eight months imprisonment in 2015 following a conviction for fraud. Father cared for Sibling 1 during the period of Mother's imprisonment, with no involvement from statutory agencies. A month prior to Mother's imprisonment Police had been called to two incidents of domestic abuse in relation to Father, both of which were alcohol related. Neither incident resulted in criminal prosecution, but a Public Protection Notice (PPN) was submitted by Police Officers in respect of Sibling 1.

Period Under Review: 1 January 2019 - 17 April 2020

2.1.3 Sibling 1 was referred to a Paediatrician in February 2019 due to concerns about developmental delay. Sibling 1 was then four and a half and was assessed to have a learning ability at maximum age of 16 – 24 months. Sibling 1 had been having significant input from a Speech and Language Therapist and although attending a mainstream school, she later transferred to a school appropriate for her special needs. It was noted that Father brought Sibling 1 to the appointment and no further clinical follow up was considered necessary. The Paediatrician's record states that Sibling 1 was born three weeks after Mother's arrival in the UK, which was contrary to information provided by the parents. However, when Sibling 1 underwent a Child Protection Medical in October 2019, Mother told the examining Consultant Paediatrician that this information was incorrect and that she had been in the UK for ten years.

2.1.4 By the end of March 2019 Mother was almost ten weeks pregnant with Child Az and had booked into Hospital for maternity care. Several weeks later, in mid-April, Father contacted the Police at 10:10 am to say that Mother was pregnant, drunk and they had argued. Due to resource issues and the incorrect spelling of the names of the parents when the call was initially received, there was a delay of eight hours before Police Officers attended the address. (see paragraph 4.1.29 for further discussion)

2.1.5 On arrival, the officers found Mother had '*sobered up'* and was very apologetic. Father explained that Mother had been drunk and had refused to look after the children. Father had wanted to leave the home to buy food but could not do so because of Mother's intoxication. Father told the officers his primary concern was that Mother was drunk when pregnant.

2.1.6 Both parents maintained that this was a one off incident and that neither of them had alcohol related problems. The Officers did consider whether a safeguarding risk was posed to the children but decided that the children appeared well cared for and although in need of some repair, the property was suitable for them. The parents stated that regular visits were made by the midwife, and all was well with the unborn baby's development.

2.1.7 The Officers submitted a DASH[1] PPN and also a Child Safeguarding PPN. There was no involvement with the family by Children's Social Care. It would seem that this was due to the Police MASH not sharing the information with Social Workers in the MASH, a situation which has been rectified since the review.

2.1.8 Midwifery records show that Mother attended antenatal appointments throughout her pregnancy with Child Az. Regular ultrasound scans showed that the foetus was small and there were concerns about Mother smoking during the pregnancy, but she said she was not drinking. Mother was referred for foetal growth scans.

2.1.9 On 5 September 2019, when Mother was 34 weeks pregnant, the Hospital Midwifery Service was informed by a Targeted Support Worker that the family would be evicted from their property on 10 September 2019 due to non-payment of rent from December 2018. The family was not eligible for emergency accommodation as Father could not provide evidence to support eligibility. Given the family would be homeless the Targeted Support Worker stated that a Multi-agency Safeguarding (MASH) Referral would be completed. The Midwife was unable to make contact with the Safeguarding Midwifery Team at the Hospital but did inform the Community Midwife of the situation and made a safeguarding referral to the MASH.

2.1.10 A MASH referral was received from the Targeted Support Worker on 6 September 2019 and given the imminent eviction, a Children and Families Assessment was initiated on 10 September 2019. On 11 September 2019, the Targeted Support Service received a voicemail from Father stating that here were in a local park, with '*no money, nobody to help us, we are outside'*. A further message from Father was received by the Targeted Support Service later that night, to say that the family was at the Hospital A&E. The practitioner unsuccessfully tried to call Father back and left a

[1] Domestic Abuse Stalking and Harassment

message with Social Services Out of hours number. A referral was made to the MASH the next day. (Source: information provided by the Targeted Support Service).

2.1.11 On arrival at A&E, the family appeared to have few possessions, apart from the clothes they were wearing, and the children had no socks or shoes. Arrangements were made for the parents and children to be accommodated in emergency housing, and staff at the Hospital gathered together food, clothes, toiletries, nappies and toys for the family. Following a period in emergency housing, Father found private accommodation, which the family moved into at the end of September 2019.

2.1.12 Sibling 1 had joined the Reception Class of Primary School I in September 2018, with an Early Help Assessment (EHA) in place. It quickly became apparent that Sibling 1 had global developmental delay resulting in significant Special Educational Needs, which Primary School 1 could not manage. The school made referrals to educational psychology, the Speech and Language Team and the Community Paediatrician. A request for a statutory assessment was also made. An Education, Health Care (EHC) Plan completed in August 2019, described Sibling 1 has having global cognitive developmental delay and speech and language difficulty. The EHC described significant concerns about Sibling 1's vulnerability, including her frustration because of lack of speech, lack of awareness of danger, constant vigilance by staff to prevent her hurting herself, e.g. putting objects in her mouth, including scissors and lack of toilet training, requiring assistance to dress herself, only willing to eat certain foods and not having the social skills to stay for school lunch thus having to go home at lunchtime.

2.1.13 Information provided to the review by Primary School 1 indicates that the School was advised the issues within the Early Help Assessment (EHA) had been resolved, resulting in the case being closed in December 2018, given that the statutory assessment process had been initiated to investigate Sibling 1's special needs. The case became one of Child in Need, following the family becoming homeless in September/October 2019. Primary School 1 was informed that this was also because the initial assessment had highlighted concerns about parenting capacity. During the course of the Assessment, the parents were offered the opportunity to accommodate the children under Section 20, Children Act 1989, which they refused. The children were made subject to Child in Need Plans.

2.1.14 Primary School 1 became concerned in October 2019 when Sibling 1 presented in school *with 'a bruise and a large scab on her tummy'*. Sibling 1 was unable to communicate how the injury had occurred and the parents were also reluctant to engage with the school. Primary School 1 took advice from MASH and a referral was made. A Section 47 Child Protection Medical was undertaken, which Mother attended with the Social Worker. The Consultant Paediatrician concluded that the injuries were consistent with Mother's account that they had resulted from Sibling 1 sliding down the stairs on two occasions and were carpet burns.

2.1.15 A Child in Need meeting took place in October 2019, at which Children's Social Care considered closing the case as there were no Child Protection concerns. Primary School 1 disagreed, given the case was originally deemed to be one of Child in Need because of homelessness and parenting capacity concerns, which they considered were still prevalent. There were also concerns about the support Sibling 1 was receiving, given her additional needs and speech and language delay. Thus, the case was transferred to the Children with Disabilities Team. (Source: report from Primary School 1)

2.1.16 In early October 2019, Mother went into labour, resulting in Child Az being born at home with assistance from Paramedics. Mother and baby were transferred to hospital and no abnormalities were found following a medical examination of Child Az. The Named Midwife for Safeguarding informed Children's Social Care of Child Az's birth.

2.1.17 On their return home, Mother and Child Az received regular visits from the Health Visitor. Due to Child Az being below the 0.4th centile, Universal Plus Health Visiting Services were provided. Mother was breast feeding Child Az and Father was frequently in attendance when the Health Visitor called. The Health Visitor was concerned about Child Az's low growth rate, but once he moved above the 0.4th centile, the service was stepped down to one of Universal Health Visiting. By the time Child Az was due his six week development check, he was not registered with a GP and Mother was advised by the Health Visitor to register him, which she did.

2.1.18 Child Az was not seen by the Health Visitor from mid-December 2019 onwards, which was in part due to the Covid Pandemic.

2.1.19 The case had transferred to the Disabled Children's Team in October 2019. At a Child in Need meeting in November 2019, the Social Worker had agreed to support the parents to seek a school placement nearer the family's new home. The review has received information from Primary School 1 that after Child Az's birth, Sibling 1 stopped attending school until she was allocated a place at a Special Needs School in April 2020. This meant that Sibling 1 was not receiving education for six months. Primary School 1 has informed the review that Sibling 1's lack of school attendance was because her parents could not physically get her there. Father was working, Mother had a new born baby, as well as Sibling 2, and Sibling 1, a child with significant needs and no transport. During this time Primary School 1 kept in weekly telephone contact with the family and provided items for the baby.

2.1.20 A home visit was made by the Disabled Children's Team Social Worker to the family in November 2019, and a Child in Need meeting was held in late February 2020. However, there was no further input from Children's Social Care from this date onwards before Child Az's death in April.

2.1.21 Father called the Emergency Services on the evening of 15 April 2020 as Child Az was found not to be breathing. Police and Paramedics attended the home and Child Az was transported to hospital. Police officers remained with Siblings 1 and 2, when the parents were taken to A&E. Both parents were said to have been drinking, with Father appearing to be drunk.

2.1.22 Following Child Az's death, the parents returned home to care for the children. It was not until the following day that Police Officers visited the family home and found both parents heavily intoxicated. Mother and Father were arrested and subsequently bailed. The children were taken into Police Protection and placed in foster care, where they remain. No charges were made against the parents, who have regular contact with the children.

3. The Voice of the Child: what was daily life like for Child Az?

3.1.1 Child Az was born into a family which had experienced poverty and homelessness, however this did not detract from the love that his parents and siblings had for him. When meeting with the Lead Reviewer, both parents spoke of how they and Child Az's siblings loved him very much, with Sibling 1 stroking his head and often wanting to hold him. Child Az was described as a '*very gentle and calm baby*'. The children could not understand that he had died.

3.1.2 The parents recognised that Child Az was born quite small, smaller than his siblings, but said he was healthy. Child Az was breast fed and slowly began to gain weight over a period of time. He had just started to eat solids prior to his death. Father explained that the Health Visitor had confirmed that Child Az was gaining weight.

3.1.3 Whilst it is unclear as to whether Child Az's size and birth weight may have been a result of foetal alcohol syndrome, his growth remained consistent and was at the expected centile at the time of his death. The review has been informed that this suggested Child Az was being fed appropriately and was gaining weight at an expected rate.

3.1.4 Father denied that the family was homeless and described to the Lead Reviewer the efforts he had made to provide accommodation for the family. He had made frequent visits to the Housing Department when it became apparent that the family was to be evicted but the Housing Department did not accept his documentation that the family was eligible for emergency housing. When they had been evicted, Father had found a hotel for them to stay in temporarily and on the night they were found in the park, their belongings were at the hotel. Father strenuously denied that he, Mother and the children had nothing but the clothes they were wearing that night. This account is not consistent with the information provided to the review by the Targeted Support Service, as discussed at paragraph 2.1.9

3.1.5 Both parents were concerned and anxious that whilst they were facing eviction, the Social Workers undertaking the Child and Family Assessment offered them the opportunity to place the children in the care of the Council. Neither would agree to this proposal.

3.1.6 It is evident that the parents were of significantly limited financial means. Father was unemployed and the parents relied on food banks to feed themselves and the children. When Police Officers were called to their previous accommodation in March 2019, it was described as clean but *'in need of DIY'*. The Health Visitor did not raise any concerns about the condition of their newly rented home when she visited following Child Az's birth, however it was evident that the home furnishings were sparce and the ability of the parents to provide for the children's clothes and toys was impacted by poverty.

3.1.7 Despite both parents stating that they drank in moderation, it is apparent from information provided to the review by agencies involved with the family that this was not the case. Police records evidence that Father had convictions for offences, which were alcohol related; Police Officers were called to the family home on at least three occasions when both Mother and Father had been drinking, resulting in arguments; on the night that Child Az died both parents had been drinking and it is questionable whether because of this they did not realise their baby was in distress. At the time, all the family were in the living room watching a film. There was a mattress on the floor with sheets and pillows. The parents were alerted by Sibling 1 that there was something wrong with Child Az who was lying on the mattress and appeared not to be breathing.

3.1.8 Whilst alcohol clearly featured in the home environment, there is no documented evidence that Child Az's poor growth rate prior to his birth and his low weight during his short life was related to Mother's alcohol consumption. Whilst pregnant Mother maintained that she was '*tee-total'*, yet she was known to be drinking in the early stages of pregnancy and was a smoker. Since his death, there has been no finding that Child Az suffered from foetal alcohol syndrome. However, it is concerning that Mother was breast feeding him and whilst he did gain weight, he remained on the 0.4^{th} growth centile until his death.

3.1.9 Child Az's death has hugely impacted on his parents and his siblings, not least resulting in the removal of the children from the care of their parents. It was manifest from speaking to the parents that Child Az was a baby who was very much loved and is deeply missed.

4 Key Issues and Analysis of Practice

Recognition of the Impact of Poverty and Homelessness on Children

4.1.1 The scale of children living in poverty and who are homeless as stated in recent government and charity produced statistics makes sober reading and reflects the enormity of the challenge faced by professionals working with children and families who find themselves in these circumstances. According to figures taken from the Department for Work and Pensions and published on the Child Poverty Action website[2], 4.3 million children (31% of the population) were living in poverty in the UK in 2019 -2020. A report produced by Shelter dated 3 December 2019 found that 135,000

[2] https://cpag.org.uk/child-poverty/child-poverty-facts-and-figures

children in the UK were homeless, living in temporary accommodation. This was the highest number in 12 years[3]. Such findings include Child Az and his siblings.

4.1.2 Despite Father stating that the family was not homeless when the parents and children were found in a park at 10pm in September 2019, the situation was that they had been evicted from their accommodation with no recourse to public funds. The degree of poverty which the family was experiencing was so apparent that when they arrived at the Hospital A&E staff did their utmost to provide essential food and provisions for them before they left the hospital. Such compassion and concern on the part of the A&E staff is commended. It is also an indication of the necessity for frontline staff to respond to the needs of a destitute family living in the UK in the 21st Century.

4.1.3 It is to Father's credit that he found permanent accommodation for his family by the time Child Az was born. The family have been helped by their landlady to furnish their home, for which both parents expressed their appreciation when they met with the Lead Reviewer. It emerged during the Practitioners Learning Event held on 30 November 2020 that the landlady had bought furniture and had arranged for friends and neighbours to donate clothing to the children.

4.1.4 At the Learning Event one of the issues discussed was the home conditions in which the children were living and whether the degree of poverty was recognised. Although, the furniture was described as '*old and tired*' by one practitioner, there were no concerns about the condition of the property. It was '*clean and tidy and there was evidence of a small amount of toys, with coats and shoes in the hallway*'. Others described the flat as '*small and cluttered*'. A representative of the East Midlands Ambulance Service commented that '*the home was better than some other houses they attend*' and that *'on both ambulance visits [i.e. when Mother was giving birth and on the night when Child Az died] neither crews raised safeguarding concerns in terms of the living conditions.'* Such observations perhaps serve to highlight what professionals have come to accept as reasonable living standards for children.

4.1.5 Further discussion by practitioners highlighted that once the family moved into their new accommodation Father was able to find work, Sibling 1 was in receipt of Disabled Living Allowance and they could claim housing benefit. Thus, life was looking more positive, and the Social Worker from the Disabled Children's Team was able to focus on the needs of Sibling 1 and her education. It was noted however that '*two weeks before Child Az's death the building industry had shut down completely [because of the Covid Pandemic] and if you were a family living week by week, it would not take long for life to become very difficult. This may have impacted on the family's ability to cope and perhaps using alcohol was a coping mechanism.'*

4.1.6 Whilst it cannot be evidenced that it was the case that the parents were '*using alcohol as a coping mechanism'* it is apparent that families who rely on a weekly income, supplemented by benefits

[3] https://england.shelter.org.uk/media/press_release/a_child_becomes_homeless_in_britain_every_eight_minutes

and food banks are living a fragile and challenging existence. The impact on the lives of Child Az and his siblings of the precarious nature of their parents' ability to provide for their needs was significant. Whether alcohol misuse was a means for the parents to deal with the challenges they faced is a question raised in this review. However, it is apparent that the parents had a lack of awareness that something was seriously wrong with Child Az on the night he died, which was seemingly impaired by their consumption of alcohol.

The Impact of the Covid Pandemic

4.1.7 It can be said that the necessary, emergency measures introduced by the government in response to the Covid Pandemic did impact on the welfare of the children in this family. It is known that Father's employment ceased at the point of lockdown, which added to the financial pressures on the parents, Sibling 1 had not attended school for five months at the time the lockdown measures were introduced, and the family was not visited by Children's Social Care or the Health Visiting Service.

4.1.8 Given the vulnerability of Sibling 1 and the isolation of the family, with the concerns detailed in this report, which were known at the time, efforts should have been made to monitor the children and ensure at the very least that the need for Sibling 1 to be allocated a school place was escalated.

4.1.9 The Covid Pandemic resulted in a withdrawal of services, which in turn led to a lack of monitoring of the children's wellbeing. However, it has been learned from information provided to the review from Primary School 1 that the lack of involvement by Children's Social Care had occurred before Pandemic emergency measures were instigated.

The involvement of Partner Agencies

Children's Social Care

4.1.10 Although referrals had been made by the Police following incidents of domestic violence between the parents, as well as a referral from the Probation Service when Mother was facing a custodial sentence, it was not until a referral from Housing in August 2019 when the family was facing eviction that Children's Social Care became involved. In the first instance the family was referred to Targeted Support for an Early Assessment plan to be put in place. Following the referral in September from the Targeted Support Worker, a Children and Family Assessment was initiated, and the children became subject to Child in Need plans. There was, however, no pre-birth assessment of Mother, which was a missed opportunity for agencies to share information about the family and for both Children's Social Care and Maternity Services to assess any possible risk to the unborn baby.

4.1.11 Given the history, which is acknowledged has become apparent as a result of this review, of domestic abuse, alcohol misuse, Mother's period of imprisonment, financial difficulties, homelessness and the significant additional needs of Sibling 1, a pre-birth assessment should have

been a priority. If this had been undertaken, the past history of the family may have become known, resulting in appropriate agency intervention. Maternity Services acted correctly in making a Safeguarding Referral to MASH after the Targeted Support Worker alerted them to the family's impending eviction. This should have led to further enquires by Children's Social Care as to whether there were any concerns about the unborn baby.

4.1.12 Once the Child Protection Medical of Sibling 1, held on 7 October 2019, concluded that the injuries were consistent with carpet burns, the case was then transferred to the Disabled Children's Team. This decision appears to have been reached on the basis that the children were not at risk and as the family were no longer homeless, they did not meet the threshold for a Child in Need Plan. Information provided to the review by the Disabled Children Team shows that discussions took place between Team Managers to clarify whether Sibling 1 met the criteria for the Disabled Children Team to become involved. The Team Manager for the Safeguarding Children's Team considered that Sibling 1 would benefit from a specialist Social Work overview and assessment to ensure that all her needs were being met in relation to her disability. Following a Child in Need meeting the case was then transferred to the Disabled Children Team and a Social Worker allocated. However, once the specialist assessment by the Disabled Children's Team was completed, it became apparent that the need for Sibling 1 to be allocated a place at a special needs school was the main priority, which raised the question as to whether there was a role for the Disabled Children Team to continue to be involved with the family (see below).

Disabled Children

4.1.13 The focus of the work undertaken with the family by the Disabled Children Team was on identifying a suitable school placement for Sibling 1. No safeguarding concerns were identified, however the Social Worker relied on Father to interpret during visits and Child in Need Meetings. This went against the practice of the Safeguarding Team which used a Russian interpreter throughout their involvement with the family. The significance of this decision is discussed at paragraph 4.1.33.

4.1.14 An analysis provided to the review, by the Service Manager, of the Disabled Children's Team involvement with the family concludes that '*there was a lack of clarity regarding the role for the Disabled Children's Team (DCT) and also whether or not Sibling 1 meets the threshold criteria for DCT. The issues presented are related to her education, school place and her EHCP (Education Health Care Plan) and this would not ordinarily be a role for DCT. Having reviewed the evidence being presented to DCT at the time it is my view that Sibling 1 does not meet the criteria for DCT and should not have been opened to the team and there was no role identified.*' (Source: Key Event Analysis and Learning, DCT report)

4.1.15 It is evident from information provided by Primary School 1, from the Lead Reviewer being given access to the EHC Plan for Sibling 1 and from the diagnosis of the Consultant Paediatrician that she was a child with significant global developmental delay. Sibling 1's needs were such that she was assessed as being worthy of qualifying for Disabled Living Allowance, however, this decision did

not correlate with her meeting the criteria for service provision from the Disabled Children's Team.

4.1.16 From reviewing the EHC plan, Sibling 1 was considered to have additional needs from the time she started nursery in 2017. Staff at the nursery identified that she was experiencing difficulties with her development and referred her to the Portage and Early Years team and the Speech and Language Therapy (SALT) team for support. When Sibling 1 arrived at Primary School 1, her needs were such that she required constant supervision and one to one support in reception class. She had difficulty in articulating and would point to make herself understood. Sibling 1 needed staff assistance in using the toilet and when she arrived in the Reception Class she was wearing nappies. She was well below age related expectations and during Reception Year, Sibling 1 was achieving levels of 18-20 months for her communication and interaction skills and levels of 16-24 months across all other areas.

4.1.17 It is recognised that disabled children are the children most vulnerable to abuse.[4] Because of her limited means of communication, Sibling 1 could not describe what her home environment was like. It is important to recognise that when the family became homeless in September 2019, Sibling 1 was attending Primary School 1, where she could be monitored, to the extent that the school appropriately made a MASH safeguarding referral when she was found to have unexplained marks on her tummy. Once Child Az was born, Sibling 1 stopped attending Primary School 1, for the reasons described in para 2.1.18. Primary School 1 became increasingly concerned about Sibling 1's wellbeing and when attempts to contact the Disabled Children Team Social Worker to ascertain what was happening failed, the school made a referral to the Educational Inclusion and Partnership Team (EIPT) in January 2020.

4.1.18 The response received was that the EIPT could not support the school because Sibling 1 had an EHC Plan and an allocated social worker. Primary School 1 was so concerned about the lack of involvement with the family that on receipt of this reply they made a complaint to Northamptonshire County Council about both the input from Children's Social Care and the lack of response from the EHC team. It was not until March 2020 that the school received notification from the EHC team that a place would be available for Sibling 1 to join a Special Needs School in April 2020. Primary School 1 acted appropriately in passing all of the information they held, including the child protection information, to Sibling 1's new school.

4.1.19 The review is aware that there was a significant lack of involvement by Health and Children's Social Care practitioners from December 2019 onwards. Prior to his death, Child Az or Sibling 2 were not seen by a Health Visitor for six months (from December until Child Az's death in April) and direct involvement by the Disabled Children Team Social Worker with the family appears to have ceased in February 2020 when there was a Child in Need meeting. Given the known concerns about the level of poverty in which the family was living, alcohol consumption by the parents, previous referrals of Domestic Abuse related to alcohol misuse, the isolation which Mother was

[4] https://www.bl.uk/collection-items/safeguarding-disabled-children-in-england-how-local-safeguarding-children-boards-are-delivering-against-ofsted-requirements-to-protect-disabled-children?(page 5)

experiencing caring for a new born, and two young children, one of whom with additional needs, who was considered eligible for disability benefit, it is concerning as to why there was not more involvement by the Health Visitor and the Social Worker.

4.1.20 It would appear that once Child Az's weight stabilized he was stepped down to Universal Health Visiting Services (see below). In the case of the Disabled Children Team Social Worker, there appears to have been a lack of professional curiosity to ascertain that the wellbeing of all the children in the family was safeguarded.

4.1.21 The Disabled Children's Team Social Worker identified an appropriate school place for Sibling 1's special needs, for which the parents expressed their gratitude to the Lead Reviewer. However, given the focus of social work was on Sibling 1, it is questionable as to whether the needs of the other children in the family were missed, not least because the Social Worker identified that there was no role for a Child in Need plan, once a suitable school had been identified for Sibling 1, and recommended that the case be stepped down to one of targeted support. This was despite only Children's Social Care and the parents being present at the Child in Need meeting.

4.1.22 In the event the case was not closed to the Disabled Children's Team but formally remained open. As only Children Social Care and the parents attended the Child in Need meeting, partner agencies were not given the opportunity to decide whether there were ongoing issues that needed to be managed with a Child in Need Plan, led by the Safeguarding Team. This resulted in a lack of a clear 'step down' plan for the family, with support from universal services or if needed targeted services.

4.1.23 From 28 January 2020 until 16 April 2020 there was no contact with the family or activity on the casefile held by the Disabled Children's Team. It seems that once the family had secured accommodation and a school placement was found for Sibling 1, Children's Social Care considered there was no need for further involvement. This was just weeks before the UK went into lockdown as a result of the Covid Pandemic.

The GP, Maternity and Health Visiting Services

4.1.24 The GP Practice had no concerns about the family, apart from the issue of Child Az not being registered with the surgery until his immunisations and six week development check were due. When the family did attend the surgery, the parents did so jointly with the children, and all were well presented. No concerns were apparent at Child Az's six week development check or for any of his siblings.

4.1.25 The Midwifery Service raised the issue of domestic abuse with Mother on three occasions, and she denied that this was a problem. There were concerns about the growth of the foetus and suitable arrangements were put in place to monitor the situation. Midwives appropriately contacted the MASH when it was known that the family was facing homelessness, but as has been detailed above, there was a lack of response from Children's Social Care to ascertain whether Midwifery Services needed to be involved in the Children and Family Assessment. This was a missed opportunity.

4.1.26 The Health Visitor was the professional who had the most engagement with Child Az and his family, having made six visits to the family home. There was no contact with Mother by the Health Visiting Service prior to Child Az's birth, however health records show that the family moved house resulting in three different postcodes and a period of homelessness, which meant they crossed over between 0-19 Health Visitor Cluster Teams within Northampton. At the time of the family's presentation at A&E, the Health Visiting Service had been informed and a Health Visitor (who has since left the service) did attend the Child in Need meeting in September 2020. It is therefore difficult to ascertain why a visit was not offered whilst Mother was pregnant, given the family's vulnerability.

4.1.27 It was evident that although gaining weight, Child Az's growth remained under the 0.4^{th} centile for most of his short life. The Health Visitor followed the Northamptonshire Healthcare Foundation Trust's Faltering Growth Pathway and accessed the infant feeding team for advice when Child Az's weight stayed below the 0.4^{th} centile. However, on the Health Visitor's last visit to Child Az in December 2019, he had gained weight sufficiently to reach the 0.4^{th} centile. The Faltering Growth Pathway advises that a baby after six weeks of age, who has settled on a centile after faltering growth, should be followed up for a weight assessment after three months. The Health Visitor having sought advice from the infant feeding team stepped Child Az down to a Universal Caseload. It would have been best practice if the Health Visitor had accessed clinical supervision from the infant feeding team to discuss a plan before stepping down Child Az's level of care. Due to the Covid Pandemic this was the last time Child Az was seen by the Health Visiting Team.

Police

4.1.28 Whilst recognising that calls have to be prioritised, the delay in Police Officers visiting the family in April 2019 when Mother was pregnant and drunk, leading to an argument with Father in front of the children needs to be seen as a possible missed opportunity to assess any risk presented to the children and the unborn child. This was especially so as Father had clearly stated that reason for the call was because Mother was pregnant and had been drinking for several days, there were two small children under the age of four at the address and he was contemplating leaving Mother.

4.1.29 The situation was not helped by the original call handler misspelling the names of both Mother and Father. If the correct spelling had been noted, officers would have been aware of a previous domestic incident which did involve violence, as well as the parents' criminal records.

4.1.30 In light of this review, the incident has been revisited by senior managers within the Force Control Room, Northamptonshire Police, which concluded that the Grade 2 Criteria for Police attendance was appropriate. This was because it was considered that there was no immediate risk to life or property. It has been clarified that the call was received on a busy Saturday morning, with a high volume of priority demands, which resulted in the delay of officers arriving at the premises. However, a telephone welfare check had been made in the interim. On arrival Police Officers were considered to have taken suitable action, recording risk to the children and mother was found to be compliant, remorseful, and sober.

4.1.31 A Police Officer in the MASH, who is no longer employed by Northamptonshire Police, incorrectly assessed that the information did not meet the threshold for sharing with other agencies. This was an inappropriate assessment. If the information had been shared within the MASH, further assessment could have been undertaken as to whether there was any risk presented to the unborn child and the two other children. The review has been informed that training on information sharing and the risk of children attributed to alcohol use has been delivered to offices.

4.1.32 The approach adopted by Police Officers who arrived on the scene of the night Child Az died was one which did not seemingly consider that his death may have been due to neglect. The initial investigation was not robust, and evidence was not secured, as assumptions were made that Child Az had died as a result of 'Sudden Infant Death' syndrome. Concentration by officers on the impact of Child Az's death would have on the parents and his siblings may have influenced the decisions made that night.

4.1.33 Children's Social Care Out of Hours Service should have been contacted by the officers and the children should not have been left at home in their care until the parents returned from the hospital. It was only when the Child Protection Team took over the investigation that it became apparent that neglect of Child Az may have played a part in his death, given it was thought that when Child Az arrived at A&E he may have died from vomit causing asphyxiation. The return of Child Protection Team officers the morning after Child Az died resulted in the children being Police Protected and the parents arrested, which was appropriate action.

4.1.34 Following the events of the night when Child Az died and the concerns in relation to the early police investigation, a de-briefing was convened by a Detective Chief Inspector at the earliest opportunity for all those involved in the case. The purpose of the meeting was not to apportion blame but to understand why police officers had acted as they had done. A discussion took place about the thought processes which led to the actions taken, with some officers feeling that there was a lack of support for them on the night that Child Az died. Advice was given as to where guidance and support could be accessed, and it was evident that none of the officers attending the scene had considered the possibility of neglect contributing to Child Az's death. The discussion proved to be an excellent learning process and the Detective Chief Inspector is to be commended for using this as a means for learning to improve practice outcomes.

The Importance of the Use of Interpreting Services

4.1.35 Although Father spoke English, it was not his first language. Neither was it the first language of Mother or the children. Yet, it is apparent that Father was frequently used to interpret by professionals on behalf of Mother and the children. The Social Worker from the Disabled Children's Team relied on Father to translate for Mother and the children, even though it was noted on the casefile that an interpreter should be used. It was known that Mother spoke practically no English and yet the Health Visitor did not consider it necessary to use an interpreter when visiting the home. When Father was not present, it seems that Mother was able in some

way to communicate with the Health Visitor, despite her isolation, given she had no friends in the UK and was dependent on Father.

4.1.36 Given that there was a history of domestic abuse it was inappropriate for professionals to rely on Father to act as an interpreter for Mother. Similarly, it is questionable as to how communication took place with the children to enable their voices to be heard. Whilst Sibling 1 had speech impairment, she was able to communicate that something was wrong with her baby brother. The importance of enabling children to be heard and listened to, as well as ensuring that adults are able to confidently speak through the use of interpreting services cannot be underestimated when safeguarding children.

Disguised Compliance

4.1.37 It is evident that both parents misused alcohol. This is manifest in Father's criminal convictions and contact with police. Mother claimed that she did not drink when she was pregnant, yet in the early stages of pregnancy Father called police officers because of his concerns that she had been drinking for days and was incapable of caring for the children. The degree of alcohol misuse is not known to the review, but it may have been a contributary factor on the night Child Az died because his parents seemingly missed signs that he was in distress.

4.1.38 Child Az may well have been harmed by antenatal exposure to alcohol, and alcohol consumption may hade impaired his parents ability to recognise that he was becoming unwell on the night he died. Health and Social Care professionals asked both parents about their alcohol use but they denied excessive or harmful use and alcohol concerns were not evident, except on the occasions that Police were involved.

4.1.39 The element of disguised compliance on the part of both parents concerning their use of alcohol cannot be ignored, however, it is also apparent that the distress caused by Child Az's death may have increased their alcohol dependency, as evidenced by their degree of intoxication the day after Child Az died.

5 Findings and Lessons Learned

5.1.1 The following is a summary of the lessons learned for the improvement of professional practice arising from this review:

The impact of poverty and homelessness on the lives of children

5.1.2 This case has highlighted the abject poverty of the lived experience of Child Az and his siblings. That professionals working with children and families may become accustomed to what is considered to be an acceptable standard of living for children is not intended as a criticism of those involved with this case. Poverty and homelessness are, however, issues which need consideration when a Child and Family Assessment is undertaken.

5.1.3 The assessment of the family appropriately concluded that the children were Children in Need. During the course of that assessment, the Social Worker proposed to the parents that the children could be accommodated under Section 20 of the Children Act 1989, as a means of alleviating the family's homelessness. This may have been on the basis of providing a temporary solution until the parents were able to find suitable housing. However, as Father explained to the Lead Reviewer, the parents found it deeply upsetting to suggest that this was an acceptable solution to the situation in which they found themselves, not least given that Mother was eight months pregnant. The offer was refused, and Children's Social Care funded the bed and breakfast placement until Father received money that was due to him to enable the family to move into more permanent accommodation.

5.1.4 Children's Social Care has assured the review that they understand their duty of care to support families when they are assessed as being in need and would seek to discuss options with families as to what would work best in those circumstances. However, they would always strive to keep families together if possible. Whilst the suggestion to accommodate the children under Section 20 may have been made with good intention, it demonstrates a lack of awareness on the effect that such an offer had on the parents, given that Father was trying his utmost to find suitable housing for Mother and the children.

5.1.5 At the initial stages of the assessment, apart from their homelessness, the needs of the children and unborn Child Az were not known. The Targeted Support Team was however aware of the family, had made a referral to MASH and had sought to assist the parents when they were facing eviction. Thus, for the Social Worker to suggest to the parents that the children could be removed from their care as a solution to their problem of homelessness was not child centred social work but merely offered a solution to the homelessness situation of the children. If the children were considered to be at risk of harm in their parents care, the appropriate action to take would have been to seek an Emergency Protection Order. Both parents expressed their distress and anger to the Lead Reviewer that the Social Worker had made such a suggestion to appease the situation and were left feeling fearful that the children would be removed from them. Father explained that it was for this reason that the need for him to find accommodation for the family became even more desperate.

5.1.6 Once Father had identified a place for the family to live, the case was almost immediately transferred to the Disabled Children's Team. This resulted in the focus of practice shifting to the needs of Sibling 1 with little account taken of the wider needs of all the children and the case being allowed to drift, most noticeably once lockdown came into being as a result of the Covid Pandemic.

5.1.7 The need for practitioners to carefully assess what can be put in place to support families facing the difficulties which Child Az family faced, whether the care provided to children by their parents is truly 'good enough' and to consider what provision can be put in place to enhance the lives of children facing homelessness and living in poverty is a lesson learned from this review.

Recognising when a child has additional needs and the vulnerability of disabled children

5.1.8 The children in this family were appropriately considered to be Children in Need. However, once it was assessed that there were no child protection concerns, the case was transferred to the Disabled Children Team. As a child with additional needs, Sibling 1 needed to be considered as a Child in Need. The transfer of the case to the Disabled Children Team, led to the focus of social work intervention being on the necessity to identify a Special Needs School place for Sibling 1. However, it has been clearly stated by the Manager for the Disabled Children Service that the case did not meet the criteria for the service. This review has highlighted what is essentially a national issue, which is, what constitutes a disabled child? The additional needs of Sibling 1 as detailed in this report were extensive and classified her as qualifying for disabled living allowance. However, Sibling 1's needs did not meet the criteria for the involvement of the Disabled Children's Team. Thus, the need for a clear understanding and protocol criteria for a case being allocated to the Disabled Children Team is a lesson arising from the review.

5.1.9 An additional lesson is the vital importance for those practitioners working with disabled children to be fully informed and trained in safeguarding awareness, so that there is not a division between those working in Safeguarding Children Teams and those working in Disabled Children Teams. Safeguarding is everyone's responsibility, as is the necessity to be aware that because a child is deemed to have a disability, they are a child first and foremost, whose wellbeing is paramount. Unfortunately, it can happen that when a case is transferred to a Disabled Children Team, the focus is on the immediate needs of the child with the disability, at the cost of undertaking a holistic view of the needs of all the children in the family. Similarly, Social Workers working in Child Protection do not necessarily recognise that a disabled child may be suffering abuse, possibly because of the difficulty in the child being able to voice what is happening to them, and/or there is a concentration on the needs of the other children in the family.

The importance of pre-birth assessments

5.1.10 The review has highlighted the importance of including a pre-birth assessment as part of a Child and Family Assessment when there are concerns about the vulnerability of an unborn child. If there had been communication with the Midwifery Safeguarding Team by Children's Social Care, it would have been apparent that a pre-birth assessment was required to ensure that all aspects of potential risk to unborn Child Az had been considered, not least Mother's alcohol consumption. This is a lesson learned from this review.

The sharing of information amongst partner agencies

5.1.11 As with so many Serious Case Reviews/Child Safeguarding Practice Reviews this review has detailed the necessity of sharing information between agencies if children are to be protected. In this case, although there was little known about the parents prior to their arrival in the UK, there was information available about their criminal convictions, misuse of alcohol and incidents of domestic abuse. If this information had been shared with Maternity Services, a more holistic assessment of Mother's vulnerability and that of unborn Child Az may have emerged.

The importance of safeguarding awareness amongst police officers

5.1.12 This review has exemplified the necessity for police officers who are called to incidents of domestic abuse and child injury or death to be aware of the need to prioritise the wellbeing and protection of children. The importance of safeguarding training and awareness of guidance in cases of unexplained child death is a lesson which has been taken seriously by Northamptonshire Police.

The use of interpreters

5.1.13 The review has been informed that the availability of an interpreting service was not an issue in this case, yet in many instances Father was used to translate English into Russian. The independence provided by the use of an interpreter in safeguarding children cannot be underestimated and is a lesson learned from this review.

Disguised Compliance

5.1.14 The level of alcohol consumption by the parents is not known to the review. However, it is apparent that both Mother and Father minimised their misuse of alcohol and professionals were unaware of the extent of Mother's drinking and whether this impacted on the wellbeing of Child Az and his siblings. There was information available to agencies which indicated that alcohol significantly featured in the parents' lives, as illustrated by the instances when police officers were called to the family home. Such information was not appropriately shared amongst agencies, which enabled the parents to deny the extent of their alcohol misuse.

6 Good Practice

6.1.1 The actions of the staff on duty in A&E when the family arrived at the hospital in a state of homelessness are to be commended as an example of good and compassionate practice.

6.1.2 The escalation of Primary School 1's concerns for Sibling 1 and their continued interest in the family's wellbeing, after she left the school, is an example of good practice.

6.1.3 The information sharing with Midwifery Services and the referral to MASH by the Targeted Support Worker was good practice, as was the referral to MASH by the Midwife.

6.1.4 The debriefing exercise undertaken by the Detective Chief Inspector following the death of Child Az is an example of good practice, which could benefit all partner agencies. The Police debrief was held specifically as a result of issues being identified in respect to the initial police attendance and investigation. The de-brief highlighted that many officers did not approach Child deaths with an open mind. As a result, all Detective Sergeants are given training in respect of the management of Child Deaths.

6.1.5 The visit to the family by the Child Protection Team the day after Child Az's death and the placing of the children into Police Protection was good practice.

7 Conclusions

7.1.1 This review has highlighted a family living in poverty, which resulted in them becoming street homeless. Whilst the parents had come to the attention of Police and the Criminal Justice System, there was no intervention by Children's Social Care until they faced eviction. Given concerns raised by Police, Midwifery Services, the School and Targeted Support Services, intervention by Children's Social Care should have taken place earlier. Once an assessment commenced after the family became homeless, there was a lack of professional judgement when it was suggested to the parents that the children could be accommodated under Section 20 of the Children Act 1989, especially given Mother's advanced pregnancy. The parents rejected the proposal and Father was able to find accommodation for his family.

7.1.2 The involvement of the Disabled Children Team concentrated on finding a Special Needs School place for Sibling 1 without looking at the bigger picture of the family's isolation and needs of all three children. Once that placement was identified, there was little contact with the Social Worker and because it was considered appropriate for Child Az to be stepped down to Universal Health Services, no Health Visitor saw the children after December 2019. Thus, the children were not seen for five months prior to Child Az's death and the impact of emergency measures because of the Covid Pandemic served to reinforce the family's isolation.

Recommendations for the Northamptonshire Safeguarding Children Partnership to consider

Recommendation 1

Partner agencies are to be reminded that when a child and family assessment is undertaken, especially when a family is homeless, a holistic assessment has to be made of the family's needs. The proposal for the local authority to accommodate children who are homeless and separate them from their parents is unacceptable professional practice.

Recommendation 2

Where there is concern about a mother's alcohol consumption during pregnancy, practitioners need to be aware of the impact on the unborn baby of the risk of foetal alcohol syndrome.

Recommendation 3

A shared understanding of the criteria for referral to the Disabled Children Team needs to be put into place throughout the Partnership. All Partner Agencies are to be reminded that a disabled child needs to be seen as a child first and foremost, who has additional needs. Any professional working with a family where there is a chid with additional needs to be aware of the safeguarding risks to all children in the family. Consideration should be given to offering practitioner training concerning the safeguarding needs of disabled children.

Appendix 1

Terms of Reference

CHILD SAFEGUARDING PRACTICE REVIEW

Ref099 – Child Az

SCOPE & TERMS OF REFERENCE

The Strategic Leads took the decision that, with reference to the requirements as set out in Chapter 4 of *Working Together to Safeguard Children (2018)* that the threshold was met to commission a Child Safeguarding Practice Review (CSPR) in respect of Child Az.

The purpose of the review is to identify improvements which are needed and to consolidate good practice. Northamptonshire Safeguarding Children Partnership and their partner organisations will need to translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

The following **principles** should be applied by Northamptonshire Safeguarding Children Partnership and its partner organisations to all reviews:

- There should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Child Safeguarding Practice Reviews should be led by an individual who is **independent** of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process[5]
- Final reports of Child Safeguarding Practice Reviews **will be published**, in order to achieve **transparency**.
- The impact of Child Safeguarding Practice Review on improving services to children and families and on reducing the incidence of deaths or serious harm to children must be described in Safeguarding Children Partnership annual reports and will inform inspections; and
- Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

Child Safeguarding Practice Reviews should be **conducted** in a way which:

[5] British Association for the Study and Prevention of Child Abuse and Neglect in Family involvement in case reviews, BASPCAN, further information on involving families in reviews.

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

The methodology agreed for this review focuses on the requirements set out in Working Together 2018 with agencies involved with the family required to complete a comprehensive Chronology that includes analysis of each entry as appropriate. There will be an accompanying short summary report that details key events with greater detail about actions already taken.

There will also, and in parallel, be a process of greater collaboration through conducting conversations with the practitioners and clinicians involved, and holding a multi-agency briefing at the start and near the end of the process, in order to identify learning and encourage reflection on their involvement; to examine the actions and decisions taken; and to understand the context.

Issues for consideration by Authors and the Lead Reviewer (when conducting conversations, writing chronologies and summaries):

- **What is our agency's understanding of each child's voice, the recording of their voice and your understanding of their voice?**
- **What is your agency's understanding of this family as individuals and as a family unit in their home living environment?**
- **Is there any evidence that this death, taking place during a period of 'lockdown', had any impact on the safeguarding of the children?**
- **Analyse the root causes and professionals feelings around their judgement and consideration of 'what is good enough' in terms of the families poverty.**
- **Should and could agencies have recognised the likely significant alcohol misuse and in terms of the domestic abuse incidences likely being linked to intoxication, is this information now shared in domestic abuse notifications to health visitors.**
- **Discuss consideration of possible fetal alcohol spectrum disorder with maternity and paediatric colleagues to fully explore and capture learning from this case.**
- **Explore with health visiting services as to whether it was appropriate for this family to be managed at a universal level of service provision.**
- **The single assessment appeared to focus on the family's homelessness, closing the case once the faily were re-homed, despite wider issues of neglect and lack of clarity around the parent's previous children.**

The time period for this Review is from 1 January 2019 to 15 April 2020.

The start date is the approximate time mother will have become pregnant with Child Az and the end date is two days after Child Az's death to allow an understanding of events immediately after Child Az death.

Agencies involved

Northamptonshire Police
Northamptonshire Children Trust
Northamptonshire Healthcare Foundation Trust
East Midlands Ambulance Service
GP Services

The Lead Reviewer

Moira Murray is a social worker by training and has undertaken numerous SCRs, Learning Reviews and Safeguarding Children Practice Reviews. She has been involved in safeguarding audits for the NHS, the voluntary sector and local authorities. She co-authored HM Government *Safeguarding Disabled Children Practice Guidance, 2009* whilst Head of Safeguarding at the Children's Society. She was a non-executive board member of the Independent Safeguarding Authority for 5 years, was Safeguarding Manager for Children and Vulnerable Adults, London 2012 Olympics and Paralympic Games; has undertaken a review for the Foreign & Commonwealth Office, reviewed the BBC post Jimmy Savile and undertaken safeguarding reviews of Premier League Football. Until recently she was the Senior Casework Manager in the National Safeguarding Team, Church of England.