Northamptonshire Safeguarding Children Board

Serious Case Review

Conducted under Working Together to Safeguard Children 2015

Child R and Family R

Overview Report

Lead Reviewer Moira Murray

11 January 2016

1 Introduction and Background to the Review

1.1 Child R died at home at the age of 9 weeks whilst in the care of his parents, referred to as Mother and Father 2. He was the fifth child of the family and was their third child together. Child R was the younger brother of Child 3, aged 4 and Child 4, aged 2 years 10 months. Mother had two older children from a previous marriage to Father 1, Child 1, aged 8 and Child 2, aged 7. All family members were present at the time of Child R's death. Child R was born at home, delivered by Mother. Father 2 was also present at his birth. The emergency services were called and paramedics attended, after which Mother and Child R were transported to hospital. Mother stated that she did not know that she was pregnant with Child R and his birth came as a complete surprise. Child R was a healthy baby and had a birth weight which was in keeping with a potential gestation of between 36 – 40 weeks.

1.2 This was Mother's second concealed pregnancy. She received no antenatal care when pregnant with Child 4, who was also born at home, delivered by paramedics.

1.3 Mother and Child R were discharged from hospital 48 hours after Child R's birth. On 20 December 2014, East Midlands Ambulance Service (EMAS) responded to an emergency call from Father 2 stating that Child R was not breathing. It was explained that Mother had slept with Child R on the sofa overnight and woke up to find him cold and unresponsive.

1.4 Child R was taken to Hospital A where he was sadly pronounced dead. An open finding was recorded of "*an unascertained unexpected sudden death in infancy",* at an Inquest into Child R's death. No criminal proceedings have been brought in this case.

1.5 The Community Midwife and Health Visitor who visited after Child R's birth had no concerns about the care provided to him. Concerns had however, been raised when Child R was born by Midwifery Services with Children's Social Care, given that this was Mother's second concealed pregnancy. At the time of Child R's death a Core Assessment under Child In Need procedures was in progress because of a long history of missed health appointments and neglect in relation to his siblings.

2 The Review Process

2.1 The standing Serious Case Review (SCR) Sub Group met on 5 March 2015 and recommended that the threshold had been met to undertake a SCR in accordance with Working Together 2015: abuse or neglect of a child was known & suspected. The child had died and there are concerns about the way in which agencies worked together to safeguarding the child.

2.2 This recommendation was endorsed by the Independent Local Safeguarding Children Board (LSCB) Chair on 13 March 2015.

2.3 Amy Weir, who has chaired and written numerous Serious Case Reviews, was appointed Independent Chair of the SCR Panel on 6 March 2015. Moira Murray was appointed as Lead Reviewer/Overview Report Author on 6 March 2015. Both the Chair and the Overview Report Author were independently appointed to undertake the review by Northamptonshire Safeguarding Children Board and had no previous involvement with the case.

2.4 A Panel of Senior Managers from each of the agencies involved was appointed to support the process. Panel members and agencies who provided reports to the review are listed in the Terms of Reference. **The Terms of Reference for the review can be found in Appendix 1.**

3 Methodology

3.1 The methodology used for this Serious Case Review has been a blended approach, taking elements of the process and coverage set out in *Working Together 2010* and combining this with the focus on learning and public accountability encouraged in *Working Together 2015*. This has been done to build on current arrangements and experience for producing IMRs and obtaining a secure chronology and robust individual analysis by each involved agency, but adding the greater involvement of practitioners and clinicians and encouraging reflection and learning from the circumstances and context of the case.

3.2 Each agency involved has been required to produce an Individual Management Review, but with the direction that this should have a clear focus on the issues and likely areas for learning set out in the Terms of Reference. Rather than interview staff in the traditional way, a SCIE systemic approach by the IMR author and the Lead Reviewer (if required) and were aimed at encouraging reflection on practice and performance. Another feature of the methodology was greater collaboration with practitioners, with a multi-agency briefing at the start of the process and a workshop later in the process to discuss emerging findings.

Scope:

The time period for this Review is 1 January 2014 to 31 December 2014

Publication – The LSCB will need to decide whether this Serious Case Review should be published, given the publicity surrounding the inquest and the effect that publication may have on Child R's siblings.

4 Narrative of Key Events

Family Composition

Mother	Mother of all five children
Father 2	Father of Child 3, Child 4 and Child R
Father 1	Father of Child 1 and Child 2
Child 1	Half-sister
Child 2	Half-sister
Child 3	Sister
Child 4	Brother
Child R Date of Death 20/12/2014	**Subject**

Family History

4.1 Although outside the timeframe of the Terms of Reference, information has been provided from agencies which is considered relevant to the Serious Case Review process. It is for this reason that the early family history has been summarised below.

4.2 In June 2004, when she was 22 years old, Mother was admitted to A&E having said to have had a seizure, her first in three years. Mother said that two weeks prior to her arrival at A&E she had ten seizures. Mother explained she had been diagnosed with epilepsy at the age of 4 and medical records state that these had ceased by the time she was 8 years old. It is documented that the seizures may have been due to a head injury sustained from assaults by her father. However, as a child, Mother's follow up outpatient appointment was not attended and there was no evidence of a further follow up appointment being made. It cannot be concluded that Mother acquired a brain injury during her childhood.

4.3 Due to the history given by Mother, she was admitted to hospital overnight and was then discharged with Epilim. Mother did not attend (DNA) any of the follow up appointments. At the time of her admission, Mother stated that she was homeless and not registered with a GP. Hospital staff made a referral to the on call duty Social Worker and the Housing Department.

4.4 In late September 2005, Mother was 14 weeks pregnant with Child 1. By this time, she was registered with the GP Surgery A and were living with Father 1, the father of her unborn child. It is not known where the couple was living at this time; however, Mother did attend antenatal appointments at the GP surgery and was referred for Consultant led care because of her epilepsy. During this pregnancy it was noted that Mother was Rhesus Negative[1] and she was happy to have anti-D injections, as and when necessary.

4.5 Child 1 was born on 29 March 2006. The delivery was normal and Child 1 was healthy. Mother attended child health and immunisation appointments.

4.6 By February 2007, Mother was pregnant with her second child. Housing records show that in March 2007 she was registered as the sole tenant of council accommodation, although Mother was at that time living with her husband Father 1.

4.7 On 5 September 2007, Child 2 was born at Hospital A. Mother had only attended four antenatal appointments during her pregnancy. Hospital appointment letters were returned as 'unknown at this address', although Mother was registered with the same GP Practice. The delivery was normal and the baby was healthy.

4.8 In May 2008, Mother effected a mutual exchange with her mother-in-law and moved to the family's current accommodation. Father 1 remained in the same accommodation with Mother and the two children until October 2008 when the couple separated (and later divorced) and he moved to his own accommodation.

4.9 In June 2010 Mother was pregnant and was seen at the GP Surgery 1. The expected date of delivery was December 2010. Mother was now living in the family home, with Father 2, who was the father of her unborn child. She received regular antenatal care up until 18 weeks, but was not seen again until 34 weeks. Mother stated that her reason for not keeping appointments was because she was in Scotland as her father was dying. After she was seen at 34 weeks, Mother was not seen again by midwifery staff until she delivered. Mother would have expected to be seen at least eight times by her midwife during the pregnancy. This was especially important given that she said she had epilepsy and was Rhesus Negative.

[1] See Appendix 2

4.10 Mother had a normal delivery and a healthy baby, Child 3, was born on 11 December 2010. Mother was now living with Father 2 and her two children from the relationship with Father 1. During her pregnancy with Child 3, Mother's BMI was recorded as 34[2]. Within two and a half hours of giving birth, Mother and baby disappeared from the ward before the new born examination had been completed. The Community Midwife 1 was informed and on making an emergency home visit found Mother back at home. Mother stated that the reason for leaving the hospital was she thought she had been discharged. Mother and baby were noted to be well.

4.11 On 9 September 2011, Mother presented at the GP Surgery 1 requesting a termination. Mother explained that she had become pregnant as a result of a failure of contraception. After examination she was thought to be less than 16 weeks pregnant. A referral letter to Hospital A for a termination of pregnancy was prepared by the GP Practice, however, this was not sent. The reason why the letter was not sent is not recorded in Mother's GP medical records. However, Mother did not return to the Surgery to ascertain what had happened to the referral and did not proceed with the termination. NB Mother's explanation of her pregnancy with Child 4 can be found at section 6 of this report.

4.12 Mother was not seen by a health professional until 26 February 2012, when Child 4 was born at home, delivered by paramedics. Mother told the paramedics that she was expecting twins. She repeated to hospital staff that she was expecting twins, although there is no record of any ultrasound obstetric scan to indicate that this was the case. Mother also maintained that she had left her medical notes variously with the GP or at a friend's house.

4.13 Child 4 was a healthy, full term baby. It was apparent that Mother had accessed no antenatal care during her pregnancy. Post-natal care was provided by Community Midwife 1, who knew Mother and was surprised to hear that she had delivered a baby as she was not aware that she was pregnant. As the Community Midwife attached to GP Surgery 1, Community Midwife 1 had provided ante (albeit limited) and post-natal care following Child 3's birth. She would therefore have expected to see Mother, had she attended, for antenatal care. Due to Mother's concealed pregnancy the hospital safeguarding team was notified and a referral made to the Children & Young People Initial Contact Team. The referral resulted in no further action by Children's Social Care, who considered there was no necessity for intervention, having made welfare checks with the school and Health Visitor. Mother continued to maintain that she had received antenatal care.

[2] A Body Mass Index of over 30 is considered to be obese.

4.14 Mother's fifth pregnancy, which resulted in the birth of Child R on 18 February 2014, was her second concealed pregnancy. Child R was born at home in the bathroom. Mother maintained throughout to family members, health and social care professionals that she did not know she was pregnant and that his birth was a complete surprise. Mother and baby remained in hospital for 48 hours and then discharged home. Child R was a healthy baby, although initially his temperature was low at birth. Tests proved that like his mother, Child R, was Rhesus Negative.

4.15 Community Midwife 1 attended mother and baby for ten days postnatally, before transferring to the health visiting service. Mother was given advice by midwifery and health visiting staff about safe sleeping, the dangers of co-sleeping, alcohol consumption and smoking (Mother smoked throughout all of her pregnancies and continued to smoke after the birth of all the children).

4.16 Because Mother had not accessed maternity care throughout her pregnancy, before her discharge from hospital a safeguarding referral was made to the Named Midwife at Hospital A. The Named Midwife made a referral to Children's Social Care. A Multi Agency Safeguarding Hub (MASH) referral was completed, which resulted in a Tier 4 Assessment being commenced.

4.17 A six week post-natal check was undertaken on Child R at the GP Surgery on 1 December 2014. However, when the Health Visitor called at the family home on 18 December to complete Child R's six week check there was no reply. Child R had not received any immunisations at the time of his death.

Father 2

4.18 There is little known information about Father 2. At the time of Child R's death he was in full time employment. Father 2 volunteered at a local youth club in the evenings, which enabled the children to participate in the facilities and activities available. From information available to the Review, Father 2 got on well with all the children, including his two step children.

4.19 Father 2 did not have any major health problems and was registered at a different GP Practice to Mother and the five children.

4.20 At the time of Child R's death, Father 2 had been sleeping in the upstairs bedroom, whilst Mother slept on the sofa in the downstairs sitting room.

Father 1

4.21 On 2 September 2011, Father 1 contacted the NSPCC because of his concerns about the care his two daughters were receiving from their Mother. The concerns stated that Child 1 and Child 2 had unclean and damp clothes and that Child 3 (not his child) was not meeting her developmental milestones. There were further concerns that Mother was not supervising the children adequately and the physical cleanliness of the house was unacceptable. The referral was passed to Children's Social Care. Checks were undertaken to ascertain whether there was any contact from the school or the Health Visitor. The response was negative. The Initial Contact was closed, with no further action. A letter was sent to Mother advising her that a referral had been received.

4.22 In February 2012, Father 1 contacted Children's Social Care, again concerned about the care his children received. He reported that there were large areas of mould on the floor in the kitchen and on the cooker, and alleged that Mother would fall asleep, leaving the children unsupervised. Father 1 stated that Mother was pregnant with twins and not coping well. Children's Social Care advised him to seek legal advice and the contact was closed.

4.23 Similar concerns were reported to Children's Social Care in March 2012 by Mother's sister, who said that the home conditions were poor and smelled of urine; the children had no bedding and were infested with head lice. Mother had given birth to Child 4 just days previously. Children's Social Care decided that the Health Visitor would monitor the situation and the Initial Contact was closed.

4.24 Father 1 commenced private law proceedings in January 2013 in respect of Child 1 and Child 2. During the proceedings Mother raised concerns about Father 1's mental health and his supervision of the children during contact. The outcome of the proceedings was resolved in April 2013, when the court was given assurances by Father 1 that any mental health concerns were not current and that the children would be suitably supervised during contact. Contact arrangements were agreed by consent.

4.25 Father 1 raised concerns with the school by email in July 2014 about the recurrent bouts of head lice Child 1 and Child 2 experienced (Father 1 stated that he consistently treated their hair during contact), their general level of hygiene and Child 2's delayed educational development. Father 1 was advised to contact Children's Social Care.

The Children

Child 1 and Child 2

4.26 As a baby, Child 1 missed infant health checks and immunisation appointments. On 23 July 2007, when aged 16 months, she was referred to A&E by her GP as she was unable to weight bear on her left leg. Examination at the hospital showed that Child 1 had a tender left ankle and was unable to move her left ankle and knee. The injury was said to have occurred when Child 1 was playing on a wooden floor when she started crying uncontrollably. Mother said she was in the kitchen at the time the injury occurred. X-rays reviewed by the Orthopaedic Registrar diagnosed an undisplaced spiral fracture of the left tibia. This fracture is commonly considered accidental when there is a clear explanation, usually a fall e.g. while running/playing with some entrapment or restriction of movement of the foot, producing a twisting stress on the bone. The Hospital Trust's Safeguarding Chronology of Events was completed, but there was no comment in the contemporaneous records on how staff judged whether or not this injury was accidental, and whether or not a safeguarding referral should have been considered. Child 1 was brought to an Orthopaedic outpatient appointment by both her parents and was later discharged as the injury was healing well.

4.27 In November 2012, when aged 6, Child 1 was admitted to A&E. From the information available it is not clear as to whether she was referred by her GP. A history was given that whilst at school and running in the playground, Child 1 tripped and fell, landing on her elbow. It is not known if this information came from Child 1 or from her parents. Following an x-ray of the elbow there was no clear evidence of a fracture or soft injury, however, following a further x-ray, a plaster of paris back slab was applied. When Child 1 was reviewed the following week by the Consultant, it was decided to remove the plaster. There was no evidence of bruising or swelling and Child 1was discharged from orthopaedic care.

4.28 Child 2 had a history of missing health and immunisations appointments as a baby. She also needed to wear glasses because of poor eyesight and for management of a squint in both eyes. Mother did ensure that Child 2 attended all of her ophthalmic appointments, with one exception, which was booked for the day prior to Child R's birth in October 2014.

Relevant information of concerns recorded by the school prior to the period under review

4.29 Both Child 1 and Child 2 attended School A. The school is larger than the average sized primary school with 457 pupils on role and converted to an academy in 2012. The majority of children come from a white British background. The number of children in receipt of the Pupil Premium (including free school meals) is average however there is a higher than average percentage of disabled children and those with special educational needs on role. Neither Child 1 nor Child 2 were considered to have special educational needs, although both were reported to be below what would be expected of a child of their age in all areas. There were no concerns about the attendance of any of the children.

4.30 There was a history of Mother not attending Termly Learning Conferences (meetings for parents to discuss their child's progress). She did, however, attend a meeting on 26 February 2013, when the school was concerned about Child 1's tiredness and lack of academic progress, and was asked to offer more support at home. Mother was not pregnant at this time, but had four children, two of whom were under three.

4.31 The school recorded the following concerns about Child 2:

- On 16 October 2013, Child 2 informed a member of school staff who was undertaking individual work with her that she had not had breakfast that morning. "*(Child 2) said that she had lost her cup the previous night and couldn't find it. Due to this she was naughty and couldn't have breakfast*". There is no evidence on the school records as to whether Mother was spoken to about this disclosure.

- The next morning, Child 2 was late and when asked by the school whether she had eaten breakfast she said "*no, as her younger sibling, (Child 4) was poorly*". The school contacted Mother who said that Child 2 had breakfast every day. Mother said she would speak to Child 2 and provide more snacks. (In the Reception class, children had access to snacks throughout the day, but in other years the children had no such access).

- On 13 November 2013, Child 2's class teacher reported to the Family Support Worker (employed by the school) that she had been seen picking up someone else's dropped food in the dinner hall and had attempted to eat it. There is no evidence in the school records as to whether Mother was spoken to about this incident. It was, however, recorded that Child 2 should be included in a group to look at emotional wellbeing and self-esteem. There is no recorded evidence in the school records that this happened, although the Family Support Worker confirmed to the Education IMR author that Child 2 did attend the group. Child 2 was six years old.

Concerns recorded by the school during the review period

4.32 The following concerns were noted:

- On three occasions during September and October 2014, concerns about the cleanliness of both Child 1 and Child 2 were raised by the school with Mother. The children were reported to be wearing dirty clothes, smelling of damp, and both girls had infestations of head lice.

- On 13-14 October 2014, Child 2's class teacher recorded that she was '*covered with nits crawling all over her skin. The following day she stated that there were bite marks on (Child 2's) neck from the nits and blood scabs on her neck*[3]*'*. The school spoke to Mother who agreed for the school to treat Child 2's hair with conditioner, but maintained that she "*had treated the lice and blamed the school and their half-sibling [Child 4 aged 2 years 8 months]*" for the current infestation. The school Family Support Worker, when interviewed for the review, said that Mother was difficult to engage with, could be defensive, often kept conversations short and resisted all offers of support from the school.

- In March 2014, Child 2 was recorded as not having her glasses with her in school. Mother reported that she was awaiting contact from the hospital to collect them and was irritated that the glasses had not come sooner.

- On 29 April 2014, Child 2 and Child 1 both disclosed that they had not had breakfast that morning. Mother was contacted and said that the girls had had a full breakfast, which consisted of fruit and reiterated that the children always had breakfast.

- Father 1 contacted the school via email on 16 July 2014 to raise his concerns about the children having recurrent head lice. The Head Teacher responded stating that they would look into the matter, but advised him to report his concerns to Children's Social Care.

- On 15 December 2014, the school spoke to Mother, concerned because Child 1 aged 8 and Child 2 aged 6 were seen walking together unaccompanied to school. Mother responded by saying that she "*lets them walk across the road as she can see them from the back door."*

[3] Nits are lice eggs. Thus this description is incorrect. It could have been that the child was infested with lice or that the blood blisters were caused by another parasite e.g. bed bugs.

4.33 The school did not refer any of the above incidents to Children' Social Care. The concerns were dealt with by the school's Family Support Worker, who was supervised by the school's Designated Safeguarding Lead. The school had access to the School Nurse who was employed by Northamptonshire Health Foundation Trust (NHFT), but did not consider it appropriate to refer Child 1 and Child 2 to the service when they had nit/lice infestation or when concerns about their appearance and accounts of not having breakfast were disclosed.

Child 3

4.34 Child 3 was born in December 2010 following a normal delivery. After Child 3's birth a similar pattern to that of her siblings developed of missed appointments for health checks and immunisations. On 24 December 2011 when she was just over a year old, Child 3 was admitted to Hospital A for four days with pneumonia. Mother remained with her during this time.

4.35 Child 3 attended the nursery at School A. The only concern noted about her by the school was in July 2014 when Mother was spoken to about the cleanliness of Child 3's lunch box.

Child 4

4.36 Child 4 was born at home after Mother failed to engage with antenatal care services throughout her pregnancy. Following Child 4's birth there was little if any interaction with health care professionals and it was not until Child 4 was aged 2 years 9 months that he received his first childhood immunisation. This was as a result of the Health Visitor gaining access to the home following Child R's birth.

Child R

4.37 Child R was just nine weeks old when he died. It is known that he was a healthy baby when discharged from hospital and at his six week check he was described as '*clean and well cared for and appeared content*.' Mother was breast feeding him, as she had all his siblings, and this was reported as going well. He appeared to be developing appropriately for his chronological age at the time of his death.

5 Voice of the Children: the children's experience living in the family

5.1 The family lived in a three bedroomed house. It was described by the professionals who gained access, as being overcrowded for five children, and cluttered with toys and furniture. Mother acknowledged that the size of the house was not suited to the needs of the family, but did not wish to move to a larger property, as she was happy with the school and the area.

5.2 The Core Assessment undertaken by Children's Social Care described the house as being tidy downstairs, but the bedrooms upstairs were not '*so well kept.'* The Social Worker also raised the issue that the lack of storage space to accommodate the children's belongings presented a fire risk. Both parents smoked. The kitchen and bathroom were due to be refurbished by the Council. On attending the property in response to an emergency call concerning Child R, the East Midlands Ambulance Service confirmed this description, describing the home as '*being cluttered'.*

5.3 Father 1, the father of Child 1 and Child 2, had said that the house was dirty with mould in the kitchen, and Mother's sister was so concerned about the conditions in which the children were living that she contacted Children's Social Care. Father 1 also expressed his concerns that his children were not only being neglected, but were also being tasked with responsibility for caring for their younger siblings.

5.4 From these descriptions it can be concluded that the environment in which the children lived was cramped and overcrowded. At the same time, the Social Worker noted that there was a computer in the living room for use by the older children, plenty of books and toys, as well as bikes, tricycles and scooters. The children's drawings were displayed on the walls.

Child R

5.5 The student Health Visitor who gained access to undertake Child R's new born visit, recorded that Mother appeared to have the equipment required to care for a new born baby, including a Moses basket and clothing. It was not recorded as to where the Moses basket was situated in the home. Mother was observed to be handling Child R well, responding to him and talking to him in a soft and gentle manner when he cried. The 'Voice of the Child' was captured and documented in the health visiting notes as "*mummy looks [at] me with love, handles me gently, keeps me safe and comfortable, responds to my cues quickly and speaks to me in a gentle voice tone."* Mother was also reported as responding to Child R appropriately when he was distressed.

Child 4

5.6 Child 4, Child R's older sibling, was present when the student Health Visitor visited and was said to be responded to in a sensitive and positive way by Mother when he wanted attention. It is known that Child 4 was not yet attending nursery, although it was planned that he would go to School A nursery when old enough. There is no information available to the review as to whether Child 4 attended a play group or socialised with his peers. The Core Assessment stated that the family was close and that the older children enjoyed being all together and enjoyed their younger siblings.

5.7 When concerns were raised by the Social Worker undertaking the Core Assessment about Child R and Child 4 not attending for immunisations and health appointments, Mother said she was too busy to take them. Father, however, stated that he would take the day off work to ensure that this occurred. Similarly, when the unkempt and dirty condition of the older girl's clothes was raised with Mother, she maintained that the laundry was difficult to keep up with with so many children around.

Child 1, Child 2 and Child 3

5.8 Child 1 and Child 2 attended School A and Child 3 attended the nursery school. Staff frequently raised concerns with Mother about the children being regularly infected with head lice. Father 1 had raised similar concerns with the school on numerous occasions, and told the Social Worker during the Core Assessment that he had observed his daughters '*scalps to be scarred as a result of lice infestation*'. The school was very much aware of the impact the children's appearance had on their emotional and social well-being. The children regularly came to school wearing grubby, damp and ill-fitting clothes, and their Father reported that they arrived for contact smelling of urine. Despite this, the three girls were reported by the school to have a good circle of friends and were popular with their teachers. However, an indication of the children's awareness of their appearance, especially the condition of their hair, was given to the Social Worker during the Core Assessment when they told him that "*they were embarrassed by this and were worried that other children might reject them as a result of their infestation*".

5.9 Mother maintained that she treated the children's persistent head lice, but clearly this was not the case. Because of concerns about the impact the children's appearance had on their interaction with and acceptance by their peers, the school persistently requested that Mother treated their hair and washed their clothes. On one occasion the school reported that Child 2 was seen to have lice falling out of her hair and a decision was made to treat the condition at school because of the serious impact this was having on her friendships. The school recorded that Child 2's appearance was more concerning than that of Child 1.

5.10 In addition to the concerns about the children's appearance, Child 1 and Child 2 articulated several times to their teachers that they had not had breakfast. The school did raise these disclosures with Mother, however they accepted her assurance that the children had breakfast every day. As a result, the school decided to accept Mother's word and did not consider that the children's account was truthful. When Child 2 was observed to be picking food off the school dining hall floor, staff decided that it did not indicate that Child 2 was hungry, as she and her sister appeared well fed. The reasons for Child 2's behaviour were not pursued. These incidents raise serious questions as to the level of understanding school staff had of the indicators of neglect, the need to listen seriously to children and for appropriate action to be taken. These disclosures and incidents were not seen in the context of the overall picture of neglect which the children were experiencing. None of these concerns were considered sufficiently appropriate or concerning for the school to make a referral to Children's Social Care.

5.11 Although the school seemingly thought they were acting in the children's best interests by treating their hair and washing their clothes, more could have been done to promote Child 1 and Child 2's well-being if a referral had been made to Children's Social Care. Their appearance, lice infestation and disclosures of not being sufficiently fed, should have at the very least initiated a CAF/Early Help Assessment. Unfortunately, this did not happen and the children could have only concluded that they were not believed when they disclosed they were hungry. The school's actions and 'good intentions' in what they saw as helping the children not to be ostracised by their peers, were misguided. By deciding that the situation could be dealt with 'in house' the school negated their responsibilities to ensure that safeguarding children concerns were referred to the statutory authority. Even when Children's Social Care contacted the school to ascertain if there were any concerns, they responded by stating there were none, apart from the children having nits/lice.

5.12 The picture that emerges from the little that is known about the children's lived experience in the home is one where there appears to be loving parents and positive relationships between the children. However, this needs to be set against a background of evidence of the children experiencing intermittent but recurring neglect. Recent research,[4] which followed 138 neglected children found that: *"Working with neglected children and their families was dogged by 'inescapable errors' which we argue will always occur in work over time and need to be deliberately interrupted. Parents were difficult to engage, and over time abuse and neglect were often minimised so that referrals about children did not lead to sufficient protective action. Parents were given too many chances to change and files lacked information on the development of children on which decisions about intervention could be based*."

[4] *Working Effectively with Neglected Children and Their Families – What Needs to Change?* Elaine Farmer, Eleanor Lutman, article in BASPCAN Child Abuse Review, June – August 2014

5.13 In the case of this family, none of the concerns raised about the children resulted in an assessment being undertaken by Children's Social Care until after Mother's second concealed pregnancy. Such intervention following a specific incident/event reflects the research findings referred to above, which found that *"In the absence of a trigger event, there was often no intervention to safeguard children, even when they experienced severe or chronic neglect over long periods*." A key practitioner message from this research was that "*a new approach to working with neglected children is required, which will chart patterns of children's developmental and other progress so that they can be recognised over time – rooted in collecting evidence which could be used in care proceedings if required."* [5]

6 Engagement of the Parents in the Review Process

6.1 The report author and the LSCB Safeguarding Project Officer met with Mother at the family home in early January 2016. Child 4 was also present. The process and purpose of the Serious Case Review, as well as the possibility of the report being published, was explained to Mother and she confirmed that she was happy to participate in a discussion.

6.2 Mother did not know she was pregnant with Child R until she went into labour in the bathroom. She had been cleaning the bathroom and suddenly felt sick with extreme stomach pain. Child R had been born within 15 minutes of her going into labour, and explained that all her labours had been very short. She explained the usual sleeping arrangements during Child R's short life. She and Father slept together in their bedroom, with Child R in his Moses basket next to her. As Father worked long shifts she would often come downstairs after Child R's midnight feed so that Father was not disturbed. She would then sleep on the sofa, with Child R in his baby chair. On the day Child R died, Mother said that the family got up at around 6am and they all had breakfast together. She then went back to sleep on the sofa at around 6.30 – 6.45, with Child R laying against her. When she woke up at about 9am, Child R was not breathing.

6.3 Mother confirmed that as with all her children, she breastfed Child R. At the time she was tired, as it was pretty exhausting looking after 5 children. She explained that sleeping with Child R on the sofa was unplanned and that she was totally against parents co-sleeping with children.

[5] ibid

6.4 When asked about her past medical history, Mother said that she had experienced seizures in the past and had taken Epilim for about a year before becoming pregnant with Child 1. However, she was not on medication for epilepsy during the pregnancy and did not have consultant led care for her first or any of her subsequent pregnancies. She was aware of her Rhesus Negative status, and had anti-D injections during her first three pregnancies. She said that she had attended ante-natal appointments for these pregnancies, but had not done so for Child 4 as she was struggling to come to terms with the death of her father. Mother had not realised she was pregnant until seven and a half months into the pregnancy. She had wanted a termination but then changed her mind. She didn't know why she had not sought ante-natal care, but was scared that there may have been something wrong with Child 4 as she had not had any anti-D injections.

6.5 Mother had not taken Child 4 to any of his immunisation appointments as she was unsure whether to have him immunised. There had been press reports of the side effects of immunisation. A friend's child had been immunised and had later been diagnosed with autism. Child 4 had been immunised when he was two and a half after student Health Visitor had called following the birth of Child R. Mother said that she 'loved' the student Health Visitor because he made her laugh and all the children liked him. She did not feel she got on better with him compared to other Health Visitors; it was just that the children liked him so much, he put her at ease and he seemed so understanding.

6.6 When asked about support from her extended family, Mother said that her mother lives abroad. She does not see her often as she does not get on with her step-father. Mother did, however, receive a great deal of support from Father 2's family, who had 'adopted her'. The relationship with her ex-husband and the father of her two eldest children, to whom she was married for fourteen months, was now much more positive and the children have frequent and regular contact with him.

6.7 The family was recovering from Child R's tragic death and Mother said they spoke openly about him. When asked by Mother where Child R was, Child 4 replied that '*he was in their hearts'* and patted his chest.

7 Evaluation of the way in which agencies worked together

Professional curiosity: observations regarding the household, relationships within the household, interaction and family dynamics

7.1 From reviewing the history of this family, it is apparent that there was a serious failure to engage with professionals by Mother. This in turn has meant that there is limited knowledge available to the review about relationships and family dynamics within the household. From what is known, it would appear that during her first pregnancy with Child 1, Mother did engage with midwifery services and received appropriate antenatal care. This was at a time when she was married to Father 1. It may have been that he was able to encourage Mother to engage with health services, and it was her first pregnancy. Once Child 1 was born, however, a pattern developed of non-attendance at health appointments. It is important to note that Child 1 sustained a spiral fracture when she was 16 months old, but how it happened is not clearly explained in the medical records. The injury did not, however, initiate a referral to Children's Social Care.

7.2 When Mother became pregnant with Child 2, although she did receive some antenatal care, she engaged less with universal health services than she had during her first pregnancy. Given her Rhesus Negative status, her alleged history of epilepsy and non-attendance of health appointments for Child 1, this should have raised concerns amongst health professionals about Mother's care of herself, her unborn child and the welfare of Child 1.

7.3 After Mother and Father 1 separated in 2008, Mother started a relationship with Father 2. It is evident that from this time onwards there was far less professional engagement with the family, compared to the little that had occurred previously. Nothing is known about the Father of Child 3, Child 4 and Child R, apart from his being in full-time employment and that he volunteered at a local youth club. Mother's refusal to let professionals into the household continued and the children consistently missed appointments for immunisations. Concerns began to be raised by Father 1 about the care his two daughters were receiving. He contacted the NSPCC and Children's Social Care about these but to no effect. It was not until private law proceedings were instigated in respect of his children that Father's concerns were brought to the attention of Cafcass. These concerns were then appropriately raised by Cafcass with Children's Social Care. During the proceedings, Cafcass learnt that although there had been a number of contacts about neglect of the children, and which included Mother's concealed pregnancy with Child 4, Children's Social Care had closed the case.

7.4 When Father 1 raised his concerns, Children's Social Care had had no contact with Mother, essentially because of her refusal to engage. Children's Social Care had, however, been informed by Mother's sister of the concerns about neglect of the children. In February 2013, Mother had not responded to a telephone message or a follow up letter from Children's Social Care. Health Visitor 2, had visited the family on three occasions over a period of three weeks in March 2013, shortly after Child 4 was born. She informed Children's Social Care that there was '*no smell of urine [as had been stated by Mother's sister] and that (Child 4) was being breast fed and was gaining weight*". Child 3 was not seen by the Health Visitor as she was asleep upstairs. No concerns about food were raised and advice about smoking was given by the Health Visitor. On the basis that the Health Visitor had no concerns and from inquiries Children's Social Care made with the school the initial contact was closed. This was with the knowledge that Mother had received no antenatal care whilst pregnant with Child 4, had concealed the pregnancy after requesting a termination when 16 weeks pregnant and had given birth to the baby at home.

7.5 The decision by Children's Social Care to close the initial contact on the basis of this information without undertaking an initial assessment shows a distinct lack of professional curiosity. The significance of what can be described as disguised compliance by Mother in her initial engagement with the Health Visitor (further visits by Health Visitor 3, were unsuccessful) was not recognised by health or social care professionals. Neither was the implications of Mother's concealment of her pregnancy with Child 4. The role of Father's compliance with Mother's actions appears not to have been considered at all by any of the agencies both prior to and during the period under review.

7.6 Cafcass had similar difficulty in making contact with Mother as Children's Social Care had experienced. The agency was, however, more proactive and the lack of engagement was brought to the attention of the court. The court was provided with the following advice about management of the case on 19 February 2013: *"It is concerning that Northamptonshire Social Care would appear to have closed the case as a consequence of (Mother) not engaging with that department. The lack of risk assessment is also of concern as the midwife stated in 2012*." The Cafcass allocated worker advised the court that he was unable to proceed with the case until Mother had been interviewed.

7.7 As Mother did not attend the court hearing in February 2013, the case was adjourned to enable the Cafcass worker to interview her. It was only at that point that Mother cooperated and expressed her views about Father 1 having contact with the children. Arrangements for contact were then agreed by consent, however, Father 1's concern for his children did not abate, as illustrated by his contact with the school in July 2014 and his contact with Children's Social Care on 21 October 2014, which happened to coincide with a referral from the Safeguarding Midwife (20 October 2014) concerning the circumstances of Child R's birth.

Was there sufficient professional curiosity regarding neglect within the household?

What was the school's view of the children's lives? How did they support the children in their education and welfare?

7.8 In 2003, Lord Laming[6] said that, "*in addition to being willing to challenge their own biases, social workers when necessary, should demonstrate 'healthy scepticism' and respectful uncertainty in their dealings with families. This should be matched by an organisational culture which promotes openness, constructive challenge and self-criticism*". This recommendation was echoed in Lord Laming's progress report concerning the protection of children in 2009, and is a feature of the Monroe Review, 2011. Thus, by the time Children's Social Care became aware of the family, the concept of '*professional curiosity'* should have been embedded in the practice of social care, education and health practitioners.

7.9 Whilst midwifery services involved with Mother's two concealed pregnancies made appropriate referrals to Children's Social Care in February 2012 and October 2014, concerns about neglect of the children were not subject to scrutiny until after the birth of Child R and the contact made by Father 1 in October 2014.

7.10 In February 2013, the school became concerned about Child 1's tiredness, lethargy and inability to concentrate, resulting in a lack of academic progress. By the time of Child R's birth in October, concerns had escalated to both Child 1 and Child 2 disclosing they had not had breakfast, of Child 2 picking up food from the floor of the school dining hall and attempting to eat it, of Child 2 not having her glasses, of both children having significant periods of nit/lice infestation and of them coming to school wearing dirty clothes smelling of damp, which on at least one occasion were washed by school staff. Yet, although recorded, it was decided by the school that these concerns did not warrant a referral to Children's Social Care, nor did they seek to initiate a CAF/Early Help Assessment. The matters were dealt with internally by the school Family Support Worker.

[6] The Victoria Climbie Inquiry: report of an inquiry by Lord Laming, 2003

7.11 It was decided by the school that because Child 1 and Child 2 were "*not small girls….they both seemed well fed and are probably bigger than their peers. Whilst (Child 2) picked up food off the floor and was caught trying to steal money to buy snacks this was put down to her age and was viewed as (Child 2) taking an opportunity to eat something rather than savaging (sic) for food*." Such an assessment indicates a lack of awareness of the importance of listening to children, takes little account of the reasons why Child 2 and her sibling were seeking food and also displays a confidence in the conclusion that because the children did not appear undernourished, they were not hungry or telling the truth about not having breakfast. At no point were the children referred to the School Nursing Service or advice sought. Although an academy, just like any other school in the county, the school had access to the School Nursing Service provided by Northamptonshire Health Foundation Trust.[7] The Education IMR states that the Family Support Worker would contact the School Nurse as "*a first point of call for health advice. They used to be able to ring the School Nurse, however, they now need to submit a referral. The School Nurses are available for advice on specific cases or general advice."* The review has been informed that the school did not consider that involvement of the School Nurse was appropriate for Child 1 or Child 2's head lice as "*this was not a continual infestation but a few incidences which are not uncommon in Primary School settings*."

7.12 Whilst the school may not have considered the children's lice infestation to be continual, the severity of the infestation, particularly in the case of Child 2, as described by her teacher (paragraph 4.32, bullet point 2) was an obvious concern. Similarly, Mother's refusal to engage in treating the infestation and the children's general poor presentation should have prompted school staff to seek advice from the School Nursing Service. However, this did not occur. Information has been provided to the review that the named Specialist Community Public Health Nurse for the school would have had a conversation with the head of the school or named school link at the start of the academic year to support joint planning for the school that year. In addition, the needs of children may be addressed outside the school setting via a clinic contact or telephone liaison.

7.13 The decision taken by the school that concerns about the children did not warrant a discussion with the School Nurse is concerning. It provokes the question as to what was the school's awareness and understanding of role of the School Nurse, as well as recognition of neglect in children. This issue will be addressed as a recommendation arising from this review.

[7] A School Nurse in Northamptonshire has on average two secondary schools and a cluster of feeder primary schools, i.e. an average of 17 named schools per School Nurse, the majority of whom work part-time. NCC, as commissioners of the service have committed to increasing the resource to deliver the service over the next 4 years.

7.14 Contact was made with Mother on the occasions that the children said they had not had breakfast and when she stated that this was not the case, her word was accepted. It was however, the view of the Family Support Worker that Mother could be defensive, 'kept conversations short' and refused offers of support. Because Mother did not engage with the school, the school took the view that support should be focussed on Child 1 and Child 2 and provided by the 'in house' Family Support Worker, which in their view was "*equal to the level of support a CAF/(Early Help Assessment) would have provided."* This resulted in Child 1, when in Year 3, receiving 'preparation for learning' when she arrived at school each day for five months and Child 2 receiving weekly intervention focussing on emotional health and well-being.

7.15 The conclusion reached by the school that concerns about the children did not meet the criteria for a CAF/Early Help Assessment is difficult to understand. If a CAF/Early Help Assessment had been initiated, albeit with Mother's agreement to participate, early intervention on a multi-agency basis would have been available. If Mother had refused to engage, as would probably have been the case, this should have provoked further questions by professionals about whether the children were receiving appropriate care. This view is further supported by the school stating that they were in the process of initiating a CAF/Early Help Assessment when Children's Social Care began their assessment of the family following Child R's birth.

7.16 It was not until the referral from the Safeguarding Midwife following Child R's birth in October 2014, that Children's Social Care actively became directly involved with the family. The decision was for a Child In Need, not a Child In Need of Protection assessment to be initiated.

7.17 It is evident that the decision by Children's Social Care not to investigate concerns expressed about the neglect of the children were based on information provided by the Health Visitor and the school. At that time, Children's Social Care decided not to undertake an initial assessment to ascertain whether such information was correct, despite being aware of a history of the children consistently missing health appointments, the description of the children and the home by Father 1 and Mother's sister, and the concealed pregnancy when Mother was pregnant with Child 4.

7.18 The review has been informed that Mother's status of being Rhesus Negative was not included on the referral made to Children's Social Care from the hospital following the birth of either Child 4 or Child R. This omission was particularly significant, given the dangers presented to both mother and unborn child of a woman being Rhesus Negative. A detailed explanation of the possible dangers in pregnancy of a mother having this blood group can be found on page 38 of this report. It is important to note however that to prevent harm, Anti-D medication is given to all Rhesus negative pregnant mothers at 28 weeks gestation, at delivery or when there has been bleeding in the pregnancy. Anti-D prevents the mother from producing antibodies against her baby. Mother was fully aware that she was Rhesus Negative during all five pregnancies, but did not seek Anti-D medication for either of her last two concealed pregnancies.

7.19 At no time was consideration given by any agency to using the *Neglect Assessment Tool*, which is *Northamptonshire's Scale for Assessing Neglectful Parenting*[8] and can be downloaded from the Northamptonshire LSCB website. The Neglect Assessment Tool was available during the period under review and prior to Child R's birth. The lack of use of this assessment tool can be seen as either an absence of awareness of its existence, or as a lack of professional curiosity about the need to assess whether the children were suffering neglect on the part, not only of social work practitioners, but also by health staff and the school.

7.20 Given the history known to the Community Midwife and Health Visitors of Mother's refusal to access health care for herself, her unborn children and her children, concerns about neglect should have been given far greater importance by the health professionals who knew the family. Whether this did not happen because all the babies were born healthy, were not considered to be of low birth weight and Mother breast fed all her children, which in turn may have accounted for a lack of professional curiosity on the part of health professionals, is a question which is raised by this review. Whilst it is recognised that the Midwifery and Health Visiting Services faced considerable pressures, Mother's history of neglectful parenting raised significant risks to her, given her own medical history and to her children, which should have raised the profile of the case to one of safeguarding due to neglect.

[8] http://northamptonshirescb.proceduresonline.com/pdfs/neglect_assess_tool.pdf

7.21 The Education IMR makes reference to the Neglect Assessment Tool being available on the LSCB website from July 2014 onwards, but cannot be sure as to whether staff at School A were made aware of its availability. The IMR states that the school considered the concerns presented by the children to be '*low level'.* Although not documented, according to the IMR Author, the Family Support Worker used the Northampton County Council Thresholds and Pathways document to identify risk and level of need to the children, and concluded that they were at level 2. It is not known whether the Family Support Worker's assessment was based on a comparison of Child 1 and Child 2 to the general presentation of other children attending the school, i.e. they were essentially no different to their peers or whether each episode of concern was viewed as an individual incident. If the latter was the case, and given that no holistic assessment was undertaken of the concerns presented, there would have been little recognition of the children suffering persistent neglect.

7.22 The review has been informed that the role of the Family Support Worker was to "*build relationships, engage and support parents to remove barriers to learning for pupils."* It is known that the Family Support Worker had difficulty in engaging Mother who was described as being defensive whenever concerns about the children's academic achievement or their appearance were raised. Mother's response was to decline any offers of support, especially concerning the treatment of head lice, as she told the Family Support Worker that she was "*doing some medical training and knew all about head lice*".

7.23 Although the Education IMR states that Child 2's class Teacher did log concerns about Child 2, "*which would have been passed on to the Family Support Worker……or dealt with by the class Teacher*"[9], there is no documentation to indicate that such concerns were discussed or that they were noted on the school's "cause for concern form".

7.24 The Family Support Worker received supervision from the school's Designated Safeguarding Lead, however the 'supervision sessions' took the form of conversations and were not formally recorded. The Family Support Worker could, however, seek "*support and advice on cases and how to progress them*." Child 1 and Child 2 were considered by the Family Support Worker to '*display protective factors'*. This assessment was apparently based on the fact that the children "*played appropriately, came to school and were engaged whilst there with staff and pupils. They appeared to be happy and were observed being appropriately affectionate and having a loving relationship with their Mother*."

[9] A process which was apparently peculiar to this class teacher and not compliant with the school's safeguarding policy and procedure.

7.25 The school offered the children opportunities for their 'voice to be heard' in the additional support given to Child 1 and Child 2. It was the school's view that the children were open and positive in their descriptions about family life, and thus presented no cause for concern. Such an assessment negates the children disclosing that they had had no breakfast on several occasions, of Child 2 picking up food from the floor and attempting to eat it, of the children's unkempt and dirty appearance and of periods of them being infested with head lice. The school however maintain that it was only after Child R's birth that the situation warranted consideration for the initiation of a CAF/Early Help Assessment, by which time Children's Social Care were already involved in an assessment.

Children not brought to brought health appointments: what did health professionals do to engage the family, did this raise concerns and were these concerns escalated?

7.26 From a review of the GP family health records there is no indication, as to what measures were taken to promote engagement with health professionals to ensure childhood immunisation schedules and developmental reviews were adhered to. As the Primary Health Care IMR Author points out, there was an absence in the medical records of any discussions with Mother regarding longitudinal non-compliance with childhood screening and immunisation programmes. The review has been informed of the process for arranging the immunisation of children. Immunisations are offered to all children and their parents by a letter issued by Public Health England to the Parent/Carer informing them of their appointment time and date. In Northamptonshire, if a child is not brought for their immunisations appointment at the GP Surgery, the Practice should inform the Child Health Information Service (CHIS). The child is offered three further appointments via the GP, and if after that they are still not brought for an appointment, CHIS informs the Health Visitor and the family becomes 'hard to reach'. It is then the Health Visitor's responsibility to act as a facilitator for the family to access the immunisation on behalf of the child, either by direct delivery or supporting them to attend the GP Practice. The process for ensuring this information is appropriately communicated is variable.[10] It is apparently unclear from a review of the GP records whether concerns relating to Mother's non-engagement were discussed or escalated to partner agencies. What is apparent, however, is that the Health Visitors limited involvement with this case, due to the mother not wanting to engage with services, whether they were aware that not all the children had been immunised, were not successful in resolving the situation until a student Health Visitor gained access to the home after Child R's birth[11].

[10] In the north, where CHIS is on SystemOne (electronic records system), all the communication to Health Visitors would be via SystemOne. In the south, where CHIS are not on SystemOne, it is all done by phone calls and paper communications.

[11] Information has been provided to the review by the Designated Doctor that arrangements to track and respond to immunisation have been strengthened, and are now more robust.

7.27 Failing to engage with healthcare, non-attended appointments and failure to arrange childhood immunisations was highlighted within the associated GP surgery safeguarding policy as potential indicators of neglect. However, although the Health Visiting Team were aware of the family history of repeated non-attendance, there is little evidence to indicate that there was communication between the GP surgery and the Health Visiting Service as to what action to take or whether to escalate such concerns. There is no indication in the health visiting records that such concerns were discussed by the GP with the parents, neither is there evidence that the lack of developmental checks for the children was explored. From information available to the review, provided by the Northampton Health Foundation Trust IMR report: "*The family history of non-engagement and 'Did Not Attend' health appointments in addition to 2 concealed pregnancies and known social care involvement was known to the Health Visiting Team, this appeared to reflect the level of health visiting service offered to the family but did not trigger an increase in level of concern and therefore the case was not discussed in formal supervision meetings or indeed escalated*."

7.28 A student Health Visitor was allocated to the family after Child R's birth. He was aware of the family history of non-engagement and that there had been a referral to Children's Social Care following Mother's concealed pregnancy with Child R. A scheduled 'New Birth Visit' was classed as 'no access', even though Mother had been telephoned to arrange the visit. This is not recorded in the health visiting records and is based on discussion with the student Health Visitor. The successful 'New Birth Visit' was achieved on 30 October 2014 when the student Health Visitor made an unannounced visit and gained access. In all, a total of three visits were carried out by the health visiting service before Child R died, including the 'New Birth Visit'. All of these were conducted alone by the student Health Visitor and were unannounced but under the supervision of his health visiting mentor.

7.29 The student Health Visitor is to be commended for gaining entry to the home and seeing all of the children (the older children were on half term holiday at the time of the October visit). As a result of the family history, it was decided that Child R and Mother should be part of the Universal Plus Health Visiting Programme. Subsequent to the 'New Birth Visit' two further successful visits took place on 6 & 26 November 2014. During the latter visit the student Health Visitor was able to undertake Child 4's 2.5 year developmental assessment, this was undertaken within the home environment and did not require Mother to take Child 4 to the appointment. The student Health Visitor discussed his concerns about the concealed pregnancy and non-attendance at health appointments with Mother and gave a clear indication as to what was expected of her by health and other professionals. He recorded that he had no concerns about the care that Child R and Child 4 received. As a result of the student Health Visitor's persistence Mother kept her appointment on 14 November 2014 for Child 4 to have the first of his immunisations.

7.30 Mother's long history of non-engagement with professionals was manifested as early as 2004 when she failed to attend follow up appointments after her admission to hospital following possible seizures. Mother's lack of willingness and apparent increased inability to engage with health professionals continued throughout the four pregnancies, following Child 1's birth, to the point where Mother did not access antenatal appointments for her last two pregnancies. It was noted in her medical records that Mother was epileptic[12], as well as being Rhesus Negative, conditions which presented high risk to both herself and her unborn child. Yet, she was adept at avoiding contact with health professionals, except on her terms. This is exemplified by Mother's failure to engage with another member of the Health Visiting Team after the student Health Visitor told her that he would not be able to undertake Child R's six week developmental check as he was at the end of his training as a health visitor and was due to go on annual leave. When the Health Visitor called as arranged on 18 December 2014, two days before Child R's death, there was no reply.

Professional awareness, level of concern and risk assessment concerning Mother's two apparent concealed pregnancies

7.31 The GP was aware that Mother was pregnant with Child 4 in September 2011 when she presented at the surgery, requesting a termination. On examination she was thought to be less than 16 weeks pregnant and explained that the pregnancy was unplanned due to a failure of contraception. The GP agreed to refer her to hospital for a termination, however the review has learnt that the referral letter was not sent by the Surgery. In the event, Mother did not proceed with the termination and it was not until she went into labour at home that health professionals became aware that she had continued with the pregnancy.

[12] Although no professional had seen her experiencing a seizure.

7.32 Once Mother decided to continue with her fourth pregnancy the expectation would have been for her to access antenatal care. This she did not do. When considering the definition of concealed pregnancy, as defined in the *Northamptonshire Safeguarding Children Board Concealed Pregnancies Practice Guidance*[13] it is evident that Mother did conceal this pregnancy:

"A concealed pregnancy is when:

- *An expectant mother knows she is pregnant but does not tell any professional; or*
- *An expectant mother tells another professional but conceals the fact that she is not accessing antenatal care; or*
- *A pregnant woman tells another person or persons and they conceal the fact from all health agencies"*[14]*.*

7.33 It is known that Mother informed the GP that she was pregnant and then requested a termination, which was not actioned. It is also known that as the pregnancy progressed, although not seeking antenatal care, Mother maintained to her ex-partner and her sister that she was expecting twins; neither of whom were seemingly aware that she was not accessing antenatal care. It is not known to the review, at this stage, as to what Father 2's knowledge was of the pregnancy or his reaction to it. It is also not known whether he was culpable in Mother's refusal to access health services. This refusal to engage with services is especially concerning given Mother's Rhesus Negative status and history of alleged epilepsy.

7.34 Given Mother's deception, professionals had no awareness of the risk presented to herself or her unborn child during this pregnancy. The situation was repeated when she became pregnant for the fifth time with Child R. In this instance no one allegedly knew that Mother was pregnant as she maintained that she did not know herself. Whether this was a denied pregnancy, rather than a concealed pregnancy needs to be considered in the context of the following definition: "*a denied pregnancy is where a woman is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant."*[15]

[13] Uploaded onto the Northamptonshire Safeguarding Children Board in July 2015, with an e-bulletin circulated to staff at the same time.
[14] Northamptonshire SCB: Concealed Pregnancies Practice Guidance, page 4
[15] Spinelli, 2005, as referenced in Northamptonshire SCB: Concealed Pregnancies Practice Guidance, page 4

7.35 When Child R was born the health and social care professionals who had contact with Mother assessed that Mother was genuinely surprised when she gave birth at home without medical assistance. Mother's insistence that she did not know she was pregnant was accepted by Midwives and the Social Worker who undertook the Core Assessment. Additionally, Mother's assertion that she was unaware that she was pregnant with Child R is at odds with information supplied to the review by the Police IMR. The IMR author makes the point that although the Officer in Charge of the investigation into Child R's death took "[*Mother] at her word that she did not know that she had been pregnant with (Child R), however the Social Worker reported at the information sharing meeting that [Mother] had told him that she had known she was pregnant but was shocked when (Child R) arrived early*." This disclosure serves to support the conclusion that Mother did know that she was pregnant, but was either in denial or deliberately concealed her pregnancy from professionals.

7.36 The reasons for the concealment or denial of pregnancy have been the subject of research papers for the last 40 years, however it is a phenomenon which can be evidenced throughout human history. Recent Serious Case Reviews and Child Death Inquiries "*have highlighted evidence of considerable ambivalence or rejection of those pregnancies, with a significant number having little or no antenatal care. The consistent message from Serious Case Reviews is that all professionals must have an understanding of concealed pregnancy in order to provide effective intervention to the unborn child and the mother".*[16]

7.37 Although health professionals made referrals to Children's Social Care following both these pregnancies, Social Workers did not consider that Mother's concealed pregnancies presented a safeguarding concern. It is unfortunate that the safeguarding procedures as set out in Northamptonshire Safeguarding Children Board Practice Guidance on Concealed Pregnancies was not available until after Child R's sad death. If the Guidance had been available it is to be hoped that professionals would have followed the safeguarding procedure, which states that: "*If a woman has arrived at hospital either in labour (when a pregnancy has been concealed or denied) or following an unassisted birth an initial assessment must be started and a multiagency strategy meeting convened. In all cases the need to convene a Child Protection Conference must be considered*"[17]. When Child 4 was born a referral was made to Children's Social Care by the hospital Safeguarding Midwife. This resulted in an initial contact being opened, with welfare checks (with Mother's consent) being undertaken with the school and the Health Visitor. The Children's Social Care IMR states that neither check raised any concerns about the family and it was agreed that the Health Visitor would monitor the situation and would re-refer the family if required. The contact was closed, with no further action.

[16] Ibid page 5
[17] Ibid page 15

7.38 Following Child R's birth, a referral was appropriately made to the MASH by the Safeguarding Midwife, which resulted in a decision that a Tier Four Assessment was required. An initial assessment was initiated, which was followed by a Child In Need Core Assessment. Despite knowledge of the previous concealed pregnancy and the concerns expressed about the neglect of the older children, there was no multiagency strategy meeting and no consideration was given to a convening an Initial Child Protection Conference. Sadly, this case has highlighted the need for professionals to follow procedural guidance for concealed pregnancies[18] which is now available, and about which information has been circulated to all partner agency staff by the LSCB Business Office. The need to reinforce the importance of this guidance will be a recommendation arising from this review.

Sleeping arrangements within the household and health messages to promote safer sleeping to both parents

7.39 The sleeping arrangements within the household were not detailed on the Core Assessment as it was simply noted that that the bedrooms were not as well kept as the rooms downstairs. No information about the family's sleeping arrangements were recorded on the health visiting records, and it is not a requirement for Health Visitors to inspect bedrooms. Messages about safe sleeping arrangements were given to Mother and the student Health Visitor asked her to demonstrate which sleeping position Child R was placed in his Moses basket. The risks of passive smoking presented to infants and young children were also pointed out to both parents, and Mother maintained that she did not smoke inside the house. Messages on the dangers of co-sleeping were also relayed to Mother. It is not known whether Mother's decision to sleep on the sofa with Child R on the night which led to his tragic death was a one off arrangement or whether it was more long standing. All that is known is that Mother stated at the time of the incident that she was sleeping downstairs with Child R, in order not to disturb Father and the other children. Sadly, the devastating consequences of parents co-sleeping with babies became all to apparent to Child R's parents and were particularly highlighted in the Coroner's findings at the Inquest into Child R's death.

7.40 Northamptonshire Safeguarding Children Board is about to launch a Safe Sleeping Campaign. The leaflet and posters produced as part of the campaign are clear about the risks of co-sleeping and provide information to parents in simple language which is easy to understand. Although this particular leaflet would not have been available to Mother at the time of Child R's birth, she would have been given a leaflet setting out the importance of safe sleeping arrangements for her baby.

[18] The Practice Guidance is multiagency guidance issued by the LSCB

'Think Family/Think Child'

7.41 Working Together to Safeguard Children, 2015 states that "*High quality assessments are holistic in approach, addressing the child's needs within their family and wider community*"[19] This is the fundamental basis of a 'Think Family' approach, but which seeks to help parents/families secure better outcomes for their children through more effective and better co-ordinated interventions by all agencies. In order to undertake such a holistic approach, the child needs to be at the very centre of the assessment.

7.42 In this case it is apparent that the family was not viewed holistically. The school recognised that there were concerns about the older children, but attempted to deal with the situation 'in house'. No advice was sought from the school Nursing Service; no Child In Need/Child In Need of Protection Referral was made to Children's Social Care. When Social Workers contacted the school to ascertain whether there were any concerns about the children, the school responded that there were none which warranted intervention.

7.43 There was a lack of knowledge about the dynamics of the family on the part of the health agencies involved, not least because the primary health care electronic records system did not easily lend itself to accessing information where children and parents had different surnames. Mother used a different surname in her dealings with agencies, both Fathers were registered at different GP surgeries and the children had different surnames. Unless an address check was undertaken at the time of consultation with the GP, links would not have made to encompass each member of the family. This presents a problem for GPs accessing and linking the records of all family members with different surnames during routine consultations.

7.44 Although Health Visitors and the GP were aware that the children were not brought to immunisation appointments, the responsibility for immunising children rested with the GP Practice. It was not until after Child R's birth that the student Health Visitor was able to ensure not only that Child 4's developmental check was undertaken, but that he also caught up with his immunisations. Given Mother's reluctance and apparent inability to engage with health services, whether midwifery or health visiting, there were difficulties for agencies to share and assess information about the well-being of the children.

[19] Working Together to Safeguard Children, HM Govt, 2015 page 20

7.45 Following the concealed pregnancies of Child 4 and Child R, however, the Safeguarding Midwife made appropriate referrals to Children's Social Care on each occasion. The Health Visiting Service was also informed. The response of Children's Social Care to the first referral was to close the case after making initial checks with health professionals and the school. When a second referral was made concerning Mother's second concealed pregnancy, Children's Social Care decided that the case warranted a Child In Need core assessment. This decision was fundamentally flawed. Both referrals should have been assessed as raising safeguarding children concerns. If a strategy meeting had been convened following Child 4's birth, information between agencies would have been shared on a formal basis, which in turn may have led to an Initial Child Protection Conference being called. This was a missed opportunity to consider this family holistically. The same procedures should have been followed when Child R was born. Given the history of concealed pregnancies and neglect of the older children, it was not appropriate for this case to be dealt with as one of Child In Need. There was sufficient concern for a Child Protection Conference to be convened and for statutory child protection procedures to be invoked.

7.46 Instead, professionals involved with the family considered that Mother was a loving parent, who had bonded with her children, not least because she breastfed them. There is no indication that her parenting capacity or that of Father 2 was assessed, indeed as is the case in many Serious Case Reviews, very little was known about him. It is evident that Father 1 was deeply concerned about his two children and went to concerted efforts to raise these concerns with agencies and the Court. Although Children's Social Care did undertake enquires on receipt of Father 1's referrals, their investigations were not sufficiently rigorous and did not encompass a 'Think Family' approach.

8 Findings

8.1 It is recognised that identifying neglect in children is complex. All those attending the practitioners learning event held in September 2015 concerning this Serious Case Review were agreed that neglect is particularly difficult to evidence and that it takes time. Practitioners also said that parents needed to be given the opportunity to change and the changes then needed to be monitored for a period. It needs to be noted however, that this should not be at the risk of children suffering significant harm. It is evident that there was persistent, if intermittent neglect of the children in this family, however, such concerns were not viewed holistically, which resulted in no referral being made to Children's Social Care by the school or the Health Visiting Service. A participant at the learning event advised that the *Making Children Safe* leaflet available in Northamptonshire gives clear guidance on what constitutes neglect and considered that the school could have used this document to help them come to a decision about escalating concerns, however, this was not utilised. It is unfortunate that due to an urgent issue un-expectantly arising, no one from the school or Education Department was able to attend the learning event for this issue to be further explored.

8.2 In addition, there was no indication that any professional utilised the *Neglect Assessment Tool*, which is *Northamptonshire's Scale for Assessing Neglectful Parenting*. This assessment tool was agreed and put in place by the LSCB to be utilised by partner agencies in order to assist professionals in effectively assessing neglect. The need for all agencies involved in neglect cases to work together in the best interests of the child is a fundamental requirement of safeguarding children. The Assessment Tool was available to download from the LSCB website during the period under review. Unfortunately, it was not used by anyone working with this family. Such provision is there to assist professionals, not only in making assessments, but also in providing a working document at which the welfare of the child is central.

8.3 Since Child R's death, the Local Safeguarding Children Board has produced Practice Guidance concerning concealed pregnancies, which provides definitions of concealed and denied pregnancies, and the procedures required to be followed in such cases. Had these procedures been available at the time, a strategy meeting would have been required to be convened after Mother's first concealed pregnancy, followed by an assessment to ascertain whether there were safeguarding concerns which needed to be explored by way of an Initial Child Protection Case Conference. Information would have been shared on a formal basis between agencies which would have offered an opportunity to consider the case holistically. It is acknowledged that this guidance was not available at the time, however, there was no recognition by Children's Social Care or the Health Visiting Service that Mother's concealment of her last two pregnancies presented safeguarding concerns, which should have triggered formal child protection procedures already in place.

8.4 In their review of new learning from Serious Case Reviews[20], Brandon et al state that "*For the first time we have a clear understanding of the extent to which neglect features in serious case reviews. This sets a good foundation for further exploration of the learning about neglect in these cases. We know that neglect was an underlying feature in at least 60% of the serious case reviews*". The consequences of neglect ranged from being a factor in suicide cases to deaths related to but not directly caused by maltreatment, including Sudden Unexplained Death in Infancy (SUDI).

[20] New Learning from Serious Case Reviews: A two year report for 2009-2011, Brandon et al, DfE 2013

8.5 This finding is a stark indication of the scale of neglect in England and of the need for professionals to be able to assess when a child is being neglected and when intervention is required. Neglect of children crosses the spectrum of ages and is often an underlying feature in physical and sexual abuse cases. It is a major form of maltreatment that is not always recognised or effectively addressed. Analysis of research[21] shows that neglect is the one area where the scale and nature of the problem requires a systemic and systematic response. It requires above all an active and pre-emptive response by all the agencies involved. Early intervention and focus on the improving outcomes for children at risk of and suffering neglect is essential.

8.6 This did not happen in this case, as unfortunately the school decided that the issues were not significant enough to bring to the attention of Children's Social Care. From the information available, it is apparent that the school assessed the presentation of the children as being 'good enough' and any concerns they had about neglect did not reach the threshold for referral.

8.7 As well as the school, the family was known to Health Visiting Services. However, despite two concealed pregnancies, missed health development appointments, a lack of take up of immunisations for all the children and concerns about the lice infestation of the older children, no referral was made to Children's Social Care. Reassurance was given by the Health Visitor when Social Workers inquired about the children that, what concerns there were, could be dealt with by the Health Visitor. At the learning event all those attending agreed that the family was '*low on the radar'* for professional concerns. The Midwife had no concerns about Mother's capacity to parent her five children. The comment was made that "*there was nothing out of the ordinary, there were no flags for concern, and Mother was described as being no different to any other Mother*". This comment is to say the least surprising, given that Mother was Rhesus Negative and had concealed two pregnancies. During discussion of the need for professionals to understand the need for families to engage, professionals made the comment that consideration needed to be given to the family's own interpretation of what constituted engagement. Given that Mother considered herself and her children to be well; the need for engagement with health professionals was not a priority.

[21] Developing an effective response to neglect and emotional harm to children, Ruth Gardener, University of East Anglia and the NSPCC, January 2008

8.8 However, this review has highlighted the need for professionals to consider their own interpretation of what constitutes parental engagement. Mother breastfed all of the children. She was known to Community Health Professionals and yet despite all of the concerns detailed above, was seen as *'no different to any other Mother.'* Whilst recognising the importance for professionals to acknowledge their own prejudices, the need to carefully consider what constitutes acceptable or '*good enough'* parenting is crucial if the welfare and best interests of children are to remain at the forefront of professional practice. The question needs to be posed as to whether the view of professionals of Mother's parenting capability was in any way influenced by her breast-feeding all the children, and until Child R's tragic death, no significant harm had befallen any of the children.

8.9 Whilst it is evident that the threshold for statutory intervention in cases of neglect is high, it is also apparent from this case that professional understanding of what constitutes neglect and its effect on children requiring intervention is of significant concern.

8.10 Whilst Children's Social Care did eventually become involved after the birth of Child R, it was on the basis that the case was one of Child In Need and not one of safeguarding. If the case had been assessed on a holistic basis, underpinned by a chronology of events, it would have been apparent that there was evidence for consideration to be given to convening an Initial Child Protection Conference. Professionals involved did not adopt a 'Think Family' approach, in part because there was no forum for information to be formally shared and for risk to the children to be assessed. However, sufficient consideration was not given to what it felt like to be a child living in the home environment. This is especially poignant in respect of the older children, who were aware of and had concerns about their appearance, especially the condition of their hair.

8.11 In this context the findings of Lord Laming are particularly relevant:

"Staff across frontline services need appropriate support and training to ensure that as far as possible they put themselves in the place of the child or young person and consider first and foremost how the situation must feel for them. They need to be able to notice signs of distress in children of all ages, but particularly amongst very young children who are not able to voice concerns and for whom bedwetting, head-banging and other signs may well be a cry for help"[22].

[22] The Lord Laming: Protection of Children in England. A Progress Report, 2009

8.12 Child 1 and Child 2 told their Teachers that they had not had breakfast on several occasions. The school acknowledged that the children were at risk of being seen to be different by their peers because of their appearance and lice infestation, an issue which the children voiced to the social worker. However, professionals failed to listen to them and regrettably the system was too fragmented to be child centred. Each agency was working within their own discipline and did not see the family as a whole. Working Together to Safeguard Children, 2015 makes it very clear that "*Effective safeguarding systems are child centred. Failings in safeguarding systems are too often the result of losing sight of the needs and views of the children within them, or placing the interests of adults ahead of the needs of children*"[23]. In this case it was not until a Core Assessment was initiated under Child In Need procedures that information about the needs of the children was beginning to be put together. It was whilst this assessment was in process that Child R sadly died.

8.13 Messages about co-sleeping, safe sleeping, alcohol consumption and smoking were given to Mother by the student Health Visitor. In addition, Mother was given advice of the need for the children to be immunised and to attend health appointments. It is all too evident however that Mother was only willing to partially comply with the advice and requests made. She did allow the student Health Visitor access to the home, during which she displayed how Child R was laid down safely in his Moses Basket. Mother did allow the student Health Visitor to undertake a developmental assessment of Child 4 and for him to be immunised. She was noted to display care and affection towards the children. Once the student Health Visitor completed his course practice placement however she reverted to non-engagement with the health professionals who followed.

8.14 It is noted that the student Health Visitor did not appropriately document the findings of his visits to the family in health records, and it is accepted that this issue is being addressed by Northamptonshire Health Foundation Trust.

8.15 Mother's inability to engage with health services was a pattern which had developed over a number of years. Such non-engagement, both before, during and after the birth of her children meant that Mother knowingly put herself and her children at risk. This was further compounded by her past history of alleged seizures and her Rhesus Negative status. Sadly, Mother did not adhere to the advice provided by health professionals about the dangers of co-sleeping, which was to lead to Child R's tragic death.

[23] Working Together 2015, page 9

9 Conclusions

9.1 This review has identified the need for agencies to make use of the assessment tools and guidance provided by the LSCB to enhance and inform professional practice. If professionals from all agencies had utilised the Neglect Assessment Tool and worked together more coherently, it could be anticipated that there would have been a better understanding of the risks presented by Mother's behaviour, and a thorough assessment of neglect would have been undertaken with a child centred approach. This may not have led to the prevention of Child R's death, however, it would have enabled risk to be robustly assessed and for the children to have been appropriately monitored.

9.2 The inquest found that there was no suggestion that Child R had been ill-treated or harmed prior to his death. However, the Coroner emphasised the dangers of parents' co-sleeping with their babies, and the pathologist stressed that there is significantly increased risk of unexpected death in infancy when alcohol is consumed.

9.3 This case exemplifies the dangers of co-sleeping and it is sadly not the only case to have come before the Northamptonshire Coroner in recent times. Nationally, over 300 babies a year die suddenly and unexpectedly. Northamptonshire is above the national average for babies who die suddenly and unexpectedly[24]. Since December 2014, there have been five baby deaths in Northamptonshire where risk factors of co-sleeping have been identified. It is known that such risks are further increased if parents:

- Are smokers (no matter where or when)
- Have recently drunk alcohol
- Have taken medication or drugs
- Feel very tired

9.4 Sadly, in this case, three of the above indicators were known to have been evident. The need for agencies to ensure that the consequences of co-sleeping is robustly relayed to parents has never been greater. The impending Safe Sleeping campaign to be launched by the LSCB will seek to reinforce this message to parents and professionals, together with dissemination of the findings of this Serious Case Review to partner agencies.

[24] Taken from the NSCB leaflet and based on figures for December 2014 – May 2015

10 Recommendations for the LSCB to Consider

10.1 (a) All professionals/agencies are fully aware and conversant with the Practice Guidance on Concealed Pregnancies, available on the LSCB website (since July 2015).

(b) The Practice Guidance to be followed in all cases of Concealed Pregnancy.

10.2 (a) All professionals/agencies are fully aware and conversant with the Northamptonshire Neglect Assessment Tool.

(b) The Neglect Assessment Tool to be used in all cases of neglect.

10.3 All professionals to highlight the dangers and potential consequences of co-sleeping to parents as a result of the tragic outcome of this case and others like it. This message to be reinforced by the LSCB Safe Sleeping Campaign launched in January 2016.

10.4 A review of the safeguarding training delivered to schools is undertaken to ensure that teachers and others working in school settings are aware of the process and procedure for identifying neglect in children and the procedure for making a safeguarding/Child In Need referral to Children's Social Care and Early Help.

10.5 Awareness is raised amongst Health, Education and Social Care professionals of the damaging effects to children's health and emotional well-being of persistent lice infestation. Parents to be made fully aware of the means to treat such infestations by all professionals.

10.6 Reassurance has been provided to this review by the Designated Doctor for Safeguarding Children that arrangements are now in place, which should allow for scrutiny and appropriate action to be taken, where a child remains unimmunised for over a year, as was the case for Child R's sibling. However, the Northamptonshire Safeguarding Children Board should request a report giving assurance on current systems, an analysis of any potential gaps in the system, and options for improvement.

10.7 The findings of this review are disseminated to all partner agencies of the Safeguarding Children Board to remind them of the importance of the need to recognise, assess and intervene in cases of neglect at an early stage, so that the consequences resulting from neglect are avoided and outcomes for children improved.

Appendix 1

SERIOUS CASE REVIEW

Child R

DOB: 18.10.2014, DOD: 20.12.2014

SCOPE & TERMS OF REFERENCE

The Serious Case Review Panel took the decision that, with reference to the requirements as set out in Chapter 4 of *Working Together to Safeguard Children* (2015) that the threshold was met to commission a Serious Case Review in respect of Child R.

The purpose of the review is to identify improvements which are needed and to consolidate good practice. LSCBs 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 the LSCB 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;
- Reviews of serious cases should be led by individuals who are **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[25]. Engagement with the family will be managed by the NSCB.
- Final reports of SCRs **must be published**, including the LSCB's response to the review findings, in order to achieve **transparency**. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must be described in LSCB annual reports and will inform inspections; and

[25] 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.

- 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.

SCRs and other case reviews should be **conducted** in a way which:

- 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 is a blend of traditional and new: with agencies involved with the family required to complete Internal Management Reviews that should be clearly focussed on addressing the issues for consideration outlined below. 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 IMR Authors and the Lead Reviewer (when conducting conversations and writing their reports):

- Voice of Child R;
- Voice of four other siblings within this household;
- What was professionals curiosity and observations regarding the household; relationships within the household, interaction and family dynamics;
- Was there sufficient professional curiosity regarding neglect within the household;
- Numerous DNA health appointments; what did health professionals do to engage the family, did this raise concerns and were these concerns escalated;
- What was professionals awareness, level of concern and any risk assessment undertaken with regard to the mother's two apparent concealed pregnancies;
- What were the sleeping arrangements within the household and, in particular, what health messages were given to promote safer sleeping to both parents;
- Did this family reach agency safeguarding services and what did each agency do;
- What was the school's view of the children's lives; how did they support the children in their education and welfare;
- Were professionals considering all holistically rather than individually; were links made to all the children, taking into account their different surnames;
- Did professionals consider the parenting capacity and / or any particular needs of these parents and;
- Role of fathers.

The time period for this Review is 1 January 2014 to 31 December 2014

Agencies should include any significant contact prior to this timeline with regard to both parents and all children that could be relevant to the learning aims of this Review.
Agencies should consider this case in the light of other recent SCRs held nationally and locally. Further reference will be made to this in the IMR Author and Practitioner briefing.
Agencies should also consider recent unexpected sudden infant deaths and the associated modifiable factors.

- Co-sleeping
- Parental smoking
- Parental use of alcohol
- Concealed pregnancies

Internal Management Reviews are not required to provide extensive background information, but should concentrate on addressing the core issues identified above. This is in line with the greater discretion in methodology and concentration on learning and improvement as set out in *Working Together 2015*.

IMR reports are required from the following agencies:

- Safeguarding and Children's Social Care
- GP Services
- Northamptonshire Healthcare Foundation Trust (NHFT) – (to include health visiting and mental health)
- Northampton General Hospital - (to include midwifery)
- Education – (in respect of siblings)

Statements of Information are required form the following agencies:

- Northamptonshire Police
- East Midlands Ambulance Service
- Housing
- CAFCASS

A template for the IMR reports and Statements of Information will be provided.

SCR Panel is to consist of the following representatives:

- Independent Chair
- Independent Lead Reviewer
- Safeguarding and Children's Social Care
- NHFT
- NHS England
- Nene and Corby Clinical Commissioning Groups
- Safeguarding Project Officer
- Rainsbrook Secure Training Centre

Appendix 2

Definitions

a. Concealed Pregnancy

There is not a universally recognised definition of concealed pregnancy so various agencies have written their own definition.

A concealed pregnancy is when a woman knows she is pregnant but does not tell anyone or those who are told conceal the fact from all caring and health agencies. It may also be where a woman appears genuinely not aware she is pregnant. Concealment may be an active act or a form of denial where support from appropriate carers and health professionals is not sought.

West Sussex Local Safeguarding Board.

A concealed pregnancy is one where, through fear, ignorance or denial, a woman does not accept or is unaware of the pregnancy and so does not access support from appropriate carers or professionals.

Stoke-on-Trent and Staffordshire Safeguarding Children Board 17/07/2012

b. Pregnancy, Rhesus Negative and Anti-D.

We all have an identified blood group i.e. O, A, B or AB and a rhesus status e.g. positive or negative, this we inherit from our parents.

When a woman becomes pregnant we test her blood for several things one being her rhesus status to see if she is Rh D negative or Rh D positive.

If a woman's status is Rh D positive or of she and her baby's father is Rh D negative then there are no concerns about blood incompatibility. However, if the woman is Rh D negative and the father of the baby is RhD positive we need to be mindful that the baby could be Rh D positive like its father and that might potentially cause problems in this pregnancy but particularly in subsequent pregnancies.

This is because some of baby's Rh D positive blood could get into mother's Rh D negative blood stream and she would then produce antibodies against the baby's blood which might not cause a problem for this baby but if not treated could cause problems for subsequent pregnancies.

To prevent harm to all Rh negative mother's potential pregnancies Anti-D is given at 28 weeks gestation, at delivery or when there has been bleeding in the pregnancy. Anti-D prevents the mother from producing antibodies against her baby.

References

Working Effectively with Neglected Children and Their Families – What Needs to Change? Elaine Farmer, Eleanor Lutman, article in BASPCAN Child Abuse Review, June – August 2014

The Victoria Climbie Inquiry: report of an inquiry by Lord Laming, 2003

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Northamptonshire SCB: Concealed Pregnancies Practice Guidance, page 4
Spinelli, 2005, as referenced in Northamptonshire SCB: Concealed Pregnancies Practice Guidance

Working Together to Safeguard Children, HM Govt, 2015

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