Torbay Safeguarding Children Partnership

REPORT OF THE CHILD SAFEGUARDING PRACTICE REVIEW REGARDING

C110, C111 and C112

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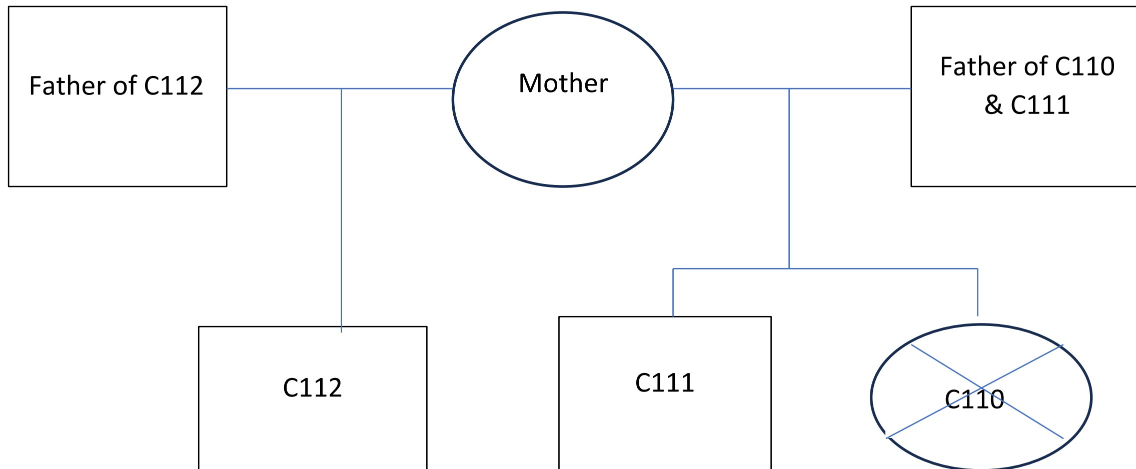
1. Family composition



2. The incident that triggered the review.

2.1 C110 sadly died in April 2024, she was 3 months old. She had been laid down for a nap on the sofa in the afternoon. C110 was left in the care of her father whilst the mother went to sleep in another room with C111. The mother woke to find C110 unresponsive, with blue lips. C110 had been placed on the sofa on her front, with her face free, wrapped in a heavy blanket.

2.2 C112 was being cared for by his father and was not in the family home at the time of the death.

2.3 Medical investigations of C110 showed a healing fracture and a child protection investigation was triggered concerning all three children. Subsequent examinations showed that C110 had fractures to her ribs. C111 also had healing injuries which included a fracture to his femur and multiple rib fractures.

2.4 Both C110 and C111 experienced harm, although, at the time of writing this report, it was understood that the injuries did not cause C110's death. Her death was thought to be due to safer sleeping advice not having been followed.

3. Key themes arising from this review include:

Key themes
The need to include an understanding of 'additional needs' when delivering safer sleeping advice
Enabling parents to overcome obstacles to following safer sleeping advice
Assessing the strengths and potential risks from male carers
Supporting care experienced parents
Closures of early help plans need to include contingency planning and clear pathways for families that may need to be re-referred into early help services.
Responding to incidences of missed antenatal appointments and babies not being brought to appointments

4. The review process.

4.1 This review commenced following the Rapid Review meeting held in June 2024. The recommendation from the Rapid Review Meeting was that a Local Child Safeguarding Practice Review (CSPR) should be undertaken. The National Panel later concurred with this view. The findings of the Rapid Review meeting in June 2024 shaped the terms of reference for this review which can be found in Appendix 1.

4.2 To capture the learning for this review information was drawn from the following sources:

- A combined multi-agency chronology of events
- Views of frontline practitioners
- Views of the Review Panel members
- 50 Responses to a questionnaire by local parents accessing midwifery and health visiting services in Torbay
- Reflections from a multi-agency practitioner event focussed on the engagement of fathers and co-parents
- A meeting with the mother of the children and father of C112

4.3 This review focuses on the period between 15th February 2022 and 29th April 2024.

5. Family Background.

5.1 The mother of the children was in care from the age of 16. She fell pregnant with child C112 and left her supported lodgings following a mutual agreement to end the placement when she was 18 years old. The mother moved into supported housing in February 2022, by which point, she and C112's father had separated.

5.2 The mother and C112 lived alone in supported housing until April 2023 when she moved to a rented flat.

5.3 The mother and the father of C110 and C111 met in March 2023, and he moved into the mother's flat in April. The mother fell pregnant and registered the pregnancies of C110 and C111 in June 2023.

5.4 It was known by all professionals supporting the mother through her pregnancies that she was a care-experienced parent and had an allocated personal advisor. It became known that the father of C110 and C111 had two other children from a previous relationship. It was only known that the father of C110 and C111 was also care experienced in November 2023, when he disclosed this to the mother's personal advisor.

5.5 Whilst it was known by those working with the family that the father of C110 and C111 had two children from a previous relationship, it was not known that these children had been the subject of a child protection investigation in a neighbouring authority. The full names of the children were not taken by the health visitor or personal advisor. This information only came to light after the death of C110.

5.6 There were no police attendances or observations made by professionals that implied there was any domestic abuse between the mother and the father of C110 and C111, although concerns about domestic abuse were raised after the death of C110.

5.7 There was no evidence of parental substance misuse or mental ill health of the parents of either C112 or C110 and C111.

5.8 The mother and C112 were provided early help between August 2022 and May 2023. The professional group working with the family consisted of the key worker from the supported housing provision, the personal advisor and the health visitor. The support offered to the mother and C112 ceased shortly after she moved out of the supported housing accommodation in April 2023.

5.9 C110, C111 and C112 were not open to Children's Services, prior to the death of C110.

5.10 By the age of 21 the mother had 3 children under the age of 2. She was seen as a capable young woman who had a car, a job, had managed well in the supported housing accommodation for 2 months and was 'a good mum'. She always appeared to be receptive to advice.

5.11 The father of C110 and C111 was described as 'hands-on' and nearly always present when the health visitor went to the family home.

5.12 Very limited information was recorded about the father of C112, until after the death of C110.

6. A pen picture of the children.

6.1 C112 was born in 2022 at 37 weeks. He was the first child of his mother and his father. He was born on the 20th centile and was breast and bottle-fed as an infant. He was 23 months old at the time of C110's death and was having regular contact with his father. At the time that this report was finalised, C112 and C111 were living with the mother, following the conclusion of the care proceedings.

6.2 C110 was a twin and was born prematurely in early January 2024. She was the first of the twins to be born. C111 was born one minute later. C110 was the smaller of the twins. Both children were cared for in the Special Care Baby Unit where they were later moved to a neighbouring hospital due to respiratory distress of C111.

6.3 Both twins were discharged to the family home two weeks after they were born where they remained until C110 was found unresponsive 3 months later.

6.4 Both C110 and C111 were developing as expected and the health visitor observed both twins to have similar attachments to their parents. C110 looked like her mother, she had blue eyes, light-coloured hair and fair skin.

7. Views of the parents and wider family.

7.1 Due to the ongoing police investigation into the injuries sustained by C110 and C111, the parents' contributions were restricted to their views on local Safer Sleep practices.

7.2 The father of C112 met with the author. He did not have any views about how Safer Sleep advice is given to parents as he and the mother had separated before C112 's birth.

7.3 The mother recalled having received advice about the safest way for the twins to be laid down to sleep. She recalled that this centred mainly on her wanting to use nests for the twins. She had used a nest when she had C112 so thought this would be helpful for her to manage the needs of all 3 children at once. When she was told it was not safe to place the twins in the nests, she said that she followed this advice and did not.

7.4 When she met with the author, she was aware of the current guidance, specifically the part where babies are safest sleeping on their backs. She recounted that both twins had been placed in incubators immediately after they were born as they were born premature.

The mother recalled that both twins were turned whilst in the incubators, i.e. they were moved from sleeping on their backs to their fronts and vice versa. She felt that the twins got used to sleeping on their fronts and slept better on their fronts. The mother reflected that it would have been helpful to receive advice about how to transition the twins from sleeping on their fronts to their backs – rather than being repeatedly told not to let them sleep on their fronts. To clarify this, the author asked if it was like being told not to smoke repeatedly but then not given patches etc to help to do so. The mother agreed this was a good analogy.

7.5 C110's mother went on to describe how she felt 'left' when she had the twins. She reported having a 'close' relationship with her personal advisor, but she had last seen her immediately after the twins were born. She said she didn't receive any support after that from anyone.

7.6 Lastly, she felt that all parents should be allowed to learn about doing baby CPR and how to manage choking for babies. She recalled she was shown baby CPR while the twins were in the Special Care Baby Unit, she reflected that at this time she had been under a great deal of stress. She was later provided with a leaflet on how to do baby CPR.

7.7 Her view was that for parents to be effectively shown how to resuscitate their baby in an emergency, it would be most helpful for health visitors to follow up the advice given in Special Care Baby Units with demonstrations in the community, using dolls or dummies.

7.8 The father of C110 and C111 was given the opportunity to meet with the author of the review and comment on the findings of the review. He chose not to.

8. Recent practice developments relevant to this review.

8.1 In May 2022 the Torbay and South Devon NHS Foundation Trust adopted the electronic patient record called SystmOne. Previously the only expectation of midwives at the booking of a pregnancy was to establish if there were any other children in the family. SystmOne prompts midwives to ask about contact with any other children, including those not living in the family home.

8.2 Torbay Children's Services have pre-empted the learning from this review by undertaking further training and development for the Care Experienced Service regarding their information sharing and safeguarding duties when supporting care experienced parents and their children.

8.3 A one-minute guide has also been produced setting out the distinction between a children's social worker and a personal advisor.

8.4 A recent JTAI inspection found that development was required to promote professional curiosity in practice, especially for health partners where children are living in neglectful circumstances or are victims of domestic abuse. In response to this finding a professional curiosity work stream has been commenced to promote the consistent application of professional curiosity. Torbay and South Devon Foundation Trust have undertaken a review of national resources regarding professional curiosity, to support the development of a Partnership resource linked to the Safeguarding Adults and Safeguarding Children Partnership priorities and identified learning. The resources enable staff to have a shared definition and expectations of organisations and professionals. They support the development of skills to enable 'curious conversations' utilising the 'Look, Listen, Ask, Consider' model. There has been a review of support pathways to link to the model which

guides staff to consistently consider vulnerabilities such as domestic abuse, family dynamics, and enables the skills and confidence to respectfully challenge when there are safeguarding concerns raised. This is underpinned by robust safeguarding supervision. Practice improvements have also been made for capturing this information and decision making in client records. This is highlighted in the future planning for Trust shared electronic patient records and information sharing responsibilities with other agencies.

8.5 Some of this development work applies to the findings of this review, especially understanding the strengths and risks that fathers and co-parents bring into families.

8.6 Since the summer of 2024 the ICON programme has been adopted in Torbay which is aligned with other Partnerships across Devon. This has included the roll out of training to primary and secondary health care and audit activity to test the impact of the training within practice.

9. Identified good practice.

9.1 The mother's personal advisor was proactive in seeking support in the mother's first pregnancy with C112 when the mother was homeless and pregnant. The personal advisor made a referral to a local supported housing provision. This provision offers a supported housing environment with on-site staff during office hours for parents aged 16 to 24 years old, including both couples and single parents. The accommodation includes self-contained furnished flats, a life skills centre and community areas which support health visitor drop-ins and a creche. The service aims to provide skills, knowledge and opportunities for parents to live independently and manage their future tenancies. This service extends to transition support when parents move out of the service. This is an excellent provision for new parents in Torbay.

9.2 The first midwife supporting the mother completed an Interagency Communication Form alerting the health visitor and GP that this family may have additional needs. This was followed up by a referral to the MASH to ensure that the mother had all the support required given that she was a young parent, had been in the care of the local authority as a child and had limited support. This proactive seeking of support for the mother and C112 was good practice.

10. Analysis and linked recommendations.

10.1 Analysis of Parental Returns to the Safer Sleeping Survey

10.2 Local parents and co-parents were asked to share their experiences of being provided with safer sleeping advice. This was supported by the Torbay 0 to19 service at antenatal contacts, new birth contacts and six-week contact for parents using their service in August 2024.

10.3 They were asked to comment on how safer sleeping advice was provided to them and reflect on why they had chosen not to follow this advice if this were the case. 50 responses were received from parents. The cohort included a mix of first-time parents and experienced parents. Representation from fathers and male co-parents was low at 6% or 3 of the 50 respondents.

10.4 100% of the cohort had received safer sleeping advice and most had received this before the birth of their baby or babies (in one case where the children were twins). Over 50% received this information from their health visitors. Other professionals that had provided

this advice included midwives, other 'visitors' and advice in an antenatal class. Most parents and co-parents received this information between 1 and 5 times. Most found the information to be helpful with only 1 respondent stating the information was unhelpful which was due to the advice having remained unchanged since the parent's previous child, they found the advice to be repetitive.

10.5 All of the parents and co-parents felt that the information was both helpful and easy to access. Comments included finding it useful to have a leaflet, access to advice on their mobile phones, links provided to the Lullaby Trust and access to videos and diagrams.

10.6 Respondents were asked to comment on why they had chosen not to follow the safer sleeping advice if this were the case. None of the parents in the cohort had chosen not to follow the advice.

10.7 Other comments that parents and co-parents shared included:

"Felt our health visitor was excellent and well informed with up-to-date knowledge"

"Whilst most of the people who gave me advice were friendly, helpful and genuinely willing to listen, having one midwife who did not listen to a word I said and went into graphic detail of a tragic incident left me feeling unhappy with how I had been treated and put my mental health in a very bad place just after the birth of my child".

"Information was very helpful for a second time mum with a 10 year gap between pregnancy reinforcing and updating previous knowledge and experience".

"It's good that the health visitor comes to our home".

"I was told swaddles aren't safe to sleep practice, but if using the right ones correctly, these should also be recommended as an option".

"I already have good awareness on safe sleeping as a 3rd time mum, but it was good to have my memory refreshed".

10.8 Safer Sleeping Advice for C110 and C111

10.9 The Torbay and South Devon NHS Foundation Trust in conjunction with Torbay Council launched a new approach to supporting parents and co-parents to reduce the risks of a Sudden Unexpected Death of an Infant (SUDI) due to unsafe sleeping practices. This launch took place in September 2023 and promotes a 'prevent and protect' model, as recommended by the National Panel in their report on SUDIs in 2020[1] and learning from Child Death Overview Panels [2]. The local approach offers a more individualised approach to advice for families, based on known vulnerabilities and introduces the offer for health visitors to see where the child is or will be sleeping.

10.10 The data available at the launch of the new model in Torbay in September 2023 and feedback from the parental survey suggest a picture of improving compliance on the delivery of safer sleeping advice by midwives and health visitors. 100% of respondents to the parental survey had received this advice.

[1] Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (publishing.service.gov.uk)

[2] Changes in background characteristics and risk factors among SIDS infants in England: cohort comparisons from 1993 to 2020 | BMJ Open

10.11 Evidence submitted for this review shows that the mother was provided with safer sleeping advice approximately 19 times during her 3 pregnancies. The father of C110 and C111 was told about safer sleeping on 3 occasions. It is recognised that there is a difference between the father having been present when safer sleeping was discussed, and safer sleeping advice having been discussed directly with him.

10.12 The health visitor reported that when she went to the family home, she was under the impression that the parents of C110 and C111 were following safer sleeping advice.

10.13 The mother and father of C110 and C111 did not present with the predisposing risk factors to significant harm that research has linked to an increase in the risk of SUDI, which include:

- domestic abuse
- neglect
- poor mental health or
- substance misuse[3].

10.14 However, some risks cited in research would have helped professionals to identify the newly formed family of C110 and C111 as having "additional needs". Namely:

- Lower socioeconomic status
- Poor or overcrowding accommodation
- Adverse childhood experiences
- Poor uptake of antenatal and post-natal services
- Prematurity or other vulnerabilities to the infant

10.15 What was known before the death of C110 was that the family were experiencing financial hardship, especially in the 2 months leading up to C110's death. The family of 5 were living in accommodation that comprised only two bedrooms and there was damp in the home. It was always known by the professionals supporting the mother that she was care experienced and in November 2023 the personal advisor was told by the father that he had been in care as a child. There was a history in all the pregnancies of poor engagement at ante and post-natal services and the mother's personal advisor shared that the mother was not always trusting of professionals as a result of having been in care herself. Both twins were premature and underweight.

10.16 Despite the 'prevent and protect' model introduced locally to assess the presence of any additional needs, the cumulative effects of the above and the fact that the mother was aged 21 with three children under 2, did not trigger a referral to the local authority's Early Help service. Had these factors been drawn together and the cumulative effects understood, this would have created an opportunity for the mother to have been more supported following the birth of the twins and not to have felt like she had been 'left'.

10.17 Another indicator of risk that was 'knowable' by professionals that made up the team around the family in the first pregnancy, was that the mother had not followed safer sleeping advice on 3[4] occasions. On one occasion she had left C112 on an adult bed alone and on another occasion, she had needed to be roused by staff in the supported housing

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[3] Out of routine: A review of sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm (publishing.service.gov.uk) p 6

[4] X2 in the supported housing and x1 observed in her own accommodation by her support worker.

accommodation having fallen asleep next to C112. It should be noted that the mother told the author she had not elected to not follow safer sleeping advice but had been extremely unwell.

10.18 This information that safer sleep advice had not always been followed was not passed on to the midwife and health visitor in the second pregnancy as it was not recognised as significant information at the time.

10.19 The father had been only partially truthful about his past.

10.20 What was not known by professionals was that the father of C110 and C111 had two children from a previous relationship and there had been concerns that he had previously caused physical harm to a child. The father experienced physical harm as a child which led him to be taken into care.

10.21 Research has shown that the additional needs identified in para 10.14 and the risks that the father of C110 and C111 brought to the family, elevate the risks of a Sudden and Unexpected Death in Infancy and significant harm in babies under the age of 12 months.

10.22 Neither the mother nor the father felt able to follow safe sleep advice although the information had been provided.

10.23 Submissions into the review suggest that the twins' preference for sleeping on their fronts was only discovered after the death of C110. The mother told the author that the twins had always preferred to sleep on their fronts. These perspectives are not mutually exclusive, and the difference is somewhat immaterial. The true lesson to be learnt from the mother's feedback is how professionals respond when parents are unable to follow advice due to the multiplicity of demands from babies, which can make following safer sleeping advice challenging. The mother's account suggested that the twins would cry and not settle when placed on their backs. The provision of safer sleeping advice needs to be considered in the reality of the demands, in this case, twins that would have been constantly crying due to being expected to settle on their backs and a 2-year-old child to care for. This is especially significant where research has indicated that factors such as parental exhaustion and "routine parenting activities" such as responding to "crying, vomiting or poor sleep"[5] have been found to be a trigger for acts of violence by men.

10.24 Lastly, ICON[6] advice which highlights the risks of a parent becoming overwhelmed by a baby's crying was offered to the mother, but not to the father of C110 and C111. This is unfortunate given that research shows a higher incidence of fathers or males shaking babies than mothers.

10.25 Steps have been taken locally to develop an evolved model of safer sleep practices following the publication of the National Panel review in 2021. This model promotes a more individualised approach for families, in line with best practice. In addition to the development of a more sophisticated model locally, there is evidence that safer sleep information is consistently offered to parents and carers and how this is given was viewed by local parents as both helpful and accessible. Local performance information also shows that practitioners are consistently offering this advice to parents.

10.26 What this review has shown is that the local model could benefit from an expansion to reflect the potential wider vulnerabilities of families that could indicate a higher risk to infants, including any history of not following the safer sleeping guidance. Not all parents

[5] The myth of invisible men safeguarding children under 1 from non-accidental injury caused by male carers. 2021 Para 6.20

[6] ICON I = infant crying is normal C- comforting methods can help O = It's ok to walk away N = never shake a baby.

choose to follow the advice given and this is an individual choice, but where parents feel unable to follow the advice, professionals should offer support and advice to enable parents to do so.

Linked recommendation 1:
For the Torbay Safeguarding Children Partnership to consider an expansion of the current 'prevent and protect' model to take in the 'additional needs' identified in the 'SUDI continuum of need' cited in the National Panel's Review, including learning about the particular demands of caring for twins.

Linked recommendation 2:
For the Torbay and South Devon NHS Trust to highlight the learning from this review to midwifery and health visiting staff to ensure that historical compliance with safer sleep advice is carried forward in any assessments regarding future pregnancies.

Linked recommendation 3:
For the Torbay Safeguarding Children Partnership to research best practice approaches to support parents to overcome barriers to following safer sleeping advice.

Linked recommendation 4:
For the ICON Steering Group to review the current way that ICON information is delivered to parents and co-parents, especially where there are additional vulnerabilities identified, including:

- when face to face discussions with parents and co-parents should happen
- when texts should be used to reinforce messages to parents and co-parents and
- a review of national best practice

10.27 Routine enquiries and responses to domestic abuse and controlling and coercive behaviour.

10.28 The team working with the family were not aware that the mother had experienced domestic abuse in her past. The mother did not disclose this information to professionals when routine enquiries were made around her pregnancy with C112, but did later disclose this in early 2022.

10.29 When the mother disclosed that she had commenced a new relationship in September 2022, the team around the family encouraged the mother to utilise Clare's Law and Sarah's Law. These laws enable parents to check with the police if there has been any history of domestic abuse or sexual offences against children by a new partner.

10.30 The expected routine domestic abuse enquiries which should be carried out by midwives and health visitors were not consistently asked in the mother's pregnancy with C110 and C111, even when she was seen alone. This appears to have been for a range of reasons. There was a gap in the mother being seen between July and September 2023 as the mother declined optional scans. There were also multiple missed midwife appointments leading up to the births.

10.31 The father of C110 and C111 was present at all of the visits undertaken by the health visitor following the birth of C110 and C111, which meant that the mother could not be spoken to alone.

10.32 There was no history of police involvement in the relationship between the mother and the father of C110 and C111. However, practitioners who contributed to this review did reflect that a wider approach to asking expectant mothers about domestic abuse may be beneficial and offer more opportunities for mothers to speak about their safety.

10.33 It was suggested that obstetricians, staff at delivery suites, day assessment units and GPs should also be alert to the risks of domestic abuse in pregnancy and provide the opportunity for expectant mothers to share concerns. If this approach were adopted locally, this would have created 28 opportunities to ask the mother if she had any concerns about domestic abuse or coercive control.

Linked recommendation 5:
For the NHS Devon Integrated Care Board to ensure that the Torbay and South Devon NHS Trust and Primary Care consider GPs, obstetricians, sonographers, staff in delivery suites and assessments units to also ask routine domestic abuse enquiries.

10.34 Missed appointments in pregnancy

10.35 There were 7 midwifery appointments missed in the mother's first pregnancy and 8 missed appointments in the second pregnancy.

10.36 NICE guidelines[7] require healthcare professionals to be vigilant about safeguarding concerns, including neglect, where children (including unborn children) are not brought to health appointments or expected screening. There is a 'Not Brought' policy[8] in place which stipulates the potential risks and required actions of healthcare staff. In this case, the policy was not triggered for two reasons. Firstly, not all of the missed appointments were consecutive, the local policy applies only to consecutively missed appointments. Secondly, in the first pregnancy midwifery appointments were carried out across two sites. The midwife did not have access to the family information on the site where she had appointments with the mother. She was therefore unable to detect the pattern of missed appointments.

Linked recommendation 6:
For the Torbay and South Devon NHS Trust to consider amending local recording systems to ensure that missed appointments are flagged, to enable practitioners to detect patterns of missed appointments, even when they are not consecutive.

10.37 Support for Care Experienced Parents

10.38 There have been multiple Safeguarding Practice Reviews that have shown that care experienced parents embark on parenting without the resources of their non care experienced counterparts and they can also lack access to a safe wider support system who can step in at times of need. This makes the support from their Corporate Parents all the more important.

10.39 The Torbay Corporate Parenting Strategy 2022 – 2025 states that children who have been cared for are a priority for the Council and they strive to "Support(ing) them to have all the opportunities that good parents afford their children"[9].

[7] Guidance for health care providers by the National Institute for Health and Care Excellence
[8] A policy for midwives and health visitors requiring a review after 3 consecutive missed appointments.
[9] Torbay Corporate Parenting Strategy 2022-2025

10.40 In line with the expectations of the Care Act 2000, the mother had an allocated personal advisor who continued to be her worker until the time of the death of C110. She received regular Pathway Planning and Reviews and received all of her entitlements such as council tax exemption, payment of water bills, setting up home allowance, and birthday allowances.

10.41 The mother received a period of good interagency support following the personal advisor's request for Early Help in February 2022. The personal advisor recognised the mother's needs. Namely, she had chosen to live with friends and had no secure housing, she was a care experienced parent who had separated from the father of her child and was to become a mother for the first time at the age of 19. The personal advisor made a referral for Early Help to support the mother. This referral was accepted, and it was agreed that a team around the family should support the mother and for her to move into a locally supported housing scheme.

10.42 The team around the family consisted of the health visitor, supported housing worker and the personal advisor. The supported housing worker was the appointed lead professional[10]. The team met regularly and were clear about what they were aiming to achieve with the mother. The support offered to the mother and C112 appeared to be successful. She was enabled to maintain her tenancy, had shown to be coping well with the care of C112 and had secured her own flat.

10.43 The early help support ceased in November 2022, which coincided with the mother moving out of the supported housing environment to live independently. She received a prompt 'settling in' visit from her personal advisor and her health visitor undertook C112's annual health review. She was also visited twice by her housing support worker. All support ceased in May 2023 at the mother's request. At this point, the mother appeared to be coping well and had just started a new relationship.

10.44 Early help support is offered on a voluntary basis, given that no safeguarding concerns were known at this point, it ceased. This reduced the support available to the mother to that of the personal advisor, who had infrequent face-to-face contact.

10.45 It is right that parents can exercise the right to decline services under early help, but it is also important that all professionals working with families are aware of what factors might require a re-referral for early help services and to consider who might be the most appropriate lead professional.

Linked recommendation 7:
For the Torbay Safeguarding Children Partnership to be given assurance that closures of early help plans include contingency planning, and clear pathways are in place for families that may need to be re-referred into early help services.

10.46 Despite the mother's and C112's planned move to independent accommodation there were delays in the mother receiving goods that she needed. The family moved into their accommodation on the 21st of April 2023. The mother was using her 'settling in'[11] grant to buy essential items for her home. Despite the planned nature of the move the mother did not have a washing machine, bed, or vacuum cleaner at the time that she moved.

10.47 The records also show that the mother quickly experienced difficulty in navigating the complex benefits system and the management of her bills. On occasion, she requested a

[10] This role includes being responsible for coordinating the plan for the family.
[11] A settling in grant is an allowance designed to support care experienced young people to help finance the start of a new home.

meeting with her personal advisor to help with her finances, but she was offered advice on the telephone instead. In the months leading up to C110's death, the family were experiencing acute financial difficulties.

10.48 It is important, where possible, that plans are made in advance to secure essential household items, to enable a smooth transition into independent living and that care experienced young people, where required, are offered active assistance in navigating the complex benefits system.

10.49 It may therefore be advisable for some focussed assurance activity to be undertaken, about how care experienced parents are supported and prepared for independence.

Linked recommendation 8:
For the Torbay Corporate Parenting Board to support audit activity testing out the effectiveness of support and preparation for care experienced parents moving into independence.

10.50 The Pathway plans and reviews focussed on the needs of the mother as a care experienced young person and did not explicitly identify those of a young woman aged 21, who was to be a mother of 3 children under 2. The current Pathway Planning proforma does not prompt any consideration of the wider needs of a care leaver as they plan to or become a parent. Supporting care experienced young people to have all the opportunities that good parents afford their children[12] should include considering their needs for support to be the best parents they can be.

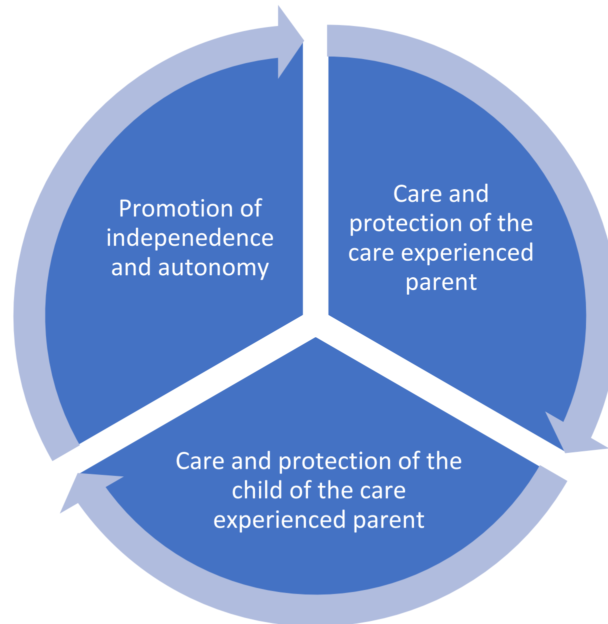
Linked recommendation 9:
For Torbay Children's Services to review the Pathway plan proforma used for expectant care experienced parents to ensure that the wider needs of parents are identified, and their support needs are responded to.

10.51 There is a dichotomy for personal advisors. On the one hand, workers are expected to promote young people's autonomy and respect them as adults. On the other hand, their role can and should include challenging conversations to help young adults shape their decisions, especially around relationships and pregnancies including when young people may be placing themselves under pressure or at risk. Personal advisors also have a responsibility to highlight if a young adult who has been in care is placing their own child at risk.

10.52 This is a complex balance where there are competing demands; to respect the autonomy of the young adult, to care for and protect the young adult and to care for and protect the child of care experienced parents where this is required, as shown in Figure 1.

Figure 1

[12] Torbay Corporate Parenting Strategy 2022-2025



10.53 By this time the mother and father of C110 and C111 had a two-year-old child and two premature babies to care for, were experiencing financial difficulties, living in damp housing conditions and had very limited wider family or support. These immediate presenting needs did not include the other known vulnerabilities such as:

- Lower socioeconomic status
- Poor or overcrowding accommodation
- Adverse childhood experiences by both parents of C110 and C111
- Poor uptake of antenatal and post-natal services
- Prematurity or other vulnerabilities to the infant
- The family were experiencing financial difficulties

10.54 It is not the primary role of the personal advisor to promote the care and protection of the children of care experienced parents. It is however part of the role to identify when other professional support and assistance may be required to help the care experienced parent to be the best parent they can be. In this case, there was a missed opportunity to call upon further support for the family from Early Help in December or January 2024, around the time of the birth of the twins.

10.55 The health visitor saw the twins 5 times before the death of C110. There was a potential opportunity for the health visitor to explore a referral to Early Help for the family following the twins' birth. The mother was reported to present as very 'able' and the father as 'hands on', but the following vulnerabilities for the family were known:

- The mother's age.
- The routine parenting demands of 3 children under the age of 2.
- The twins' prematurity.
- The mother's history of having been cared for.
- The family history of Early Help for C112.

10.56 The mother asked her midwife for support via Early Help in February 2024. At this time the twins had been discharged from the midwifery service. Midwifery services usually hand over the care of babies to health visiting services after 14 days. The mother's request for help was made some 6 weeks after this point. The midwife did try to return the mother's call, but the mother did not pick up. The midwife left a message advising the mother to contact her health visitor to seek support for Early Help.

10.57 This was a missed opportunity, however, it also points towards the quality of the relationship the mother had with her midwife, given that she reached out to her some 6 weeks after they had finished working together.

10.58 Referral pathways into Early Help have changed since the death of C110. Parents can now self-refer to Early Help and referrals do not necessarily need to go via Children's Services. Local data suggests that these changes have resulted in increased uptake of Early Help by parents.

10.59 This recent change is positive, however, it is important that the Partnership is assured that there is the opportunity not only for parents to proactively seek support but also for professionals to be able to identify potential risks and vulnerabilities and make appropriate referrals to Early Help when needed.

Linked recommendation 10:
For the Torbay Safeguarding Children's Partnership to ensure assurance is provided that personal advisor, health visitors, midwives and GPs are aware of the potential risks and vulnerabilities that could make the task of parenting even more challenging for care experienced parents and are aware of their roles and responsibilities in securing support where needed.

10.60 Understanding the risks and strengths of fathers and co-parents.

10.61 The mother's personal advisor met the father of C110 and C111 in April 2023. His name and date of birth were taken by the personal advisor and recorded on the mother's file. Consent was not sought for checks to be carried out about the father's background and no further action was taken. This was a missed opportunity to understand the history of the father of C110 and C111 who was care experienced and also had two children from a previous relationship about whom there were historical safeguarding concerns.

10.62 In October 2023 the personal advisor went to speak to the mother and father of C110 and C111 due to concerns that C112 was spending large amounts of time with his father. The father of C110 and C111 told the personal advisor that he had two children and he was care experienced. It is unclear why this did not prompt the personal advisor to clarify further details and carry out checks.

10.63 The final opportunity to establish information about the father of C110 and C112 came in January 2024 when the health visitor met the family. The health visitor's record of the assessment did reference the father of C110 and C111 but stated that he was 'not available' to discuss his childhood, although he was present at the time of the assessment being carried out. The health visitor was told that the father had no contact with his own wider family, this did not prompt any probing questions as to why this might be.

10.64 The absence of awareness of steps taken to secure details of the father and research his history, would indicate that there are enduring local practice issues about the assessment

of 'hidden males' and recent practice briefings delivered by the Partnership did not appear to have raised practitioner awareness or consistently improved practice.

10.65 Therefore, the Partnership was keen to elicit learning as quickly as possible to clarify local barriers to the engagement of and assessment of males and co-parents. The author was commissioned to carry out a specific reflective session with practitioners. An event took place in December 2024 which was attended by practitioners from:

- Children's services
- Health Visiting
- School nursing
- Health based mental health practitioners
- Early help practitioners

10.66 Practitioners fed back that they had limited awareness of the findings from local and national research on the importance of engaging and assessing the risks and strengths that male parents and co-parent bring to families.

10.67 Some existing good practice was identified. Health visiting professionals were able to describe cultural changes in their service, where expected practice involves taking details of males and enquiries made to build a picture of the strengths or risks they are brought to the family. In addition, the 'DadPad' app was being used to promote fathers' engagement and sense of inclusion.

10.68 When asked to consider what might act as barriers to the engagement and assessment of parents and co-parents, practitioners identified the following:

- The need for time to read notes and files to understand family histories
- The impact of the societal view of the mother as the 'carer' and how this frames the engagement and involvement of male parents and/or co-parents
- The safety of professionals working alone when visiting homes and how safe they feel to ask questions and engage males in this context
- Office hours are generally between 9am and 5pm which either excludes parents who work full time or necessitates visits out of hours – this is again linked to lone working and professional safety
- Professionals could feel 'stuck' when mothers refuse to disclose the identity of fathers
- The importance of management oversight and supervision to prompt consideration of male parents and co-parents in assessments

10.69 Practitioners felt that the following may promote learning from national and local reviews and promote improved engagement and assessment of male carers and co-parents:

- A 'welcome letter' for dads[13], giving a specific welcome to ensure that they do not feel pushed out or excluded from antenatal and postnatal services.
- The need for ongoing learning from research and reviews – giving this local relevance by linking this to local reviews and audits.

[13] Developed in Devon County Council

- The importance of training and development for frontline practitioners and managers.
- For organisations to consider how front-line practitioners can be made to feel safe to explore the risks and strengths of male parents and co-parents, within their day to day practice.

10.70 This review found evidence of some cultural changes in services and the Partnership showed an appetite to quickly elicit learning so that steps can be taken to change practice as soon as possible. However, feedback from practitioners indicated that further work is required to both embed the learning from national and local reviews in respect of the engagement and assessment of hidden males, as well as improve the overall engagement of fathers in the ante and post-natal stages of children's lives. The low number of fathers who completed the parental survey also points to the need to do more to include fathers and co-parents in ante and post-natal services.

Linked recommendation 11:
For the Torbay Safeguarding Children Partnership to support agencies to work together to consider the adoption of the reflections and ideas for practice improvement made by practitioners.

Linked recommendation 12:
For the Torbay Safeguarding Children Partnership to consider adding the engagement and assessment of 'hidden males' as a business priority or undertake specific scrutiny in the future, to ensure that actions taken to improve practice are embedded and making the required changes.

10.71 Finally, the mother of C110 wanted the review to highlight the importance of access to baby CPR and training for parents on how to manage choking in babies.

Linked recommendation 13:
For the NHS Devon Integrated Care Board to consider how baby CPR and first aid (including the response to choking) can be made available to parents and co-parents in Torbay.

11. Appendix 1

Local Child Safeguarding Practice Review
Terms of Reference
Children: C110/C111/C112

July 2024

1. Reason and Context for Review

1.1 This review relates a three month old baby, who sadly died on 22/04/2024, and her siblings. The baby who died has been given the pseudonym C110. C110 had a three month old twin sibling, C111, and a two year old half sibling, C112. C110 and her siblings were living with their mother and the father of C110 and C111 at the time of the incident under review. C112 also spent time with his father, including at times overnight contact.

1.2 On 22/04/2024 the police contacted Torbay MASH to report that C110 had been in cardiac arrest after being left asleep on the family sofa. The most likely cause of death is believed to be SUDI, linked to the parent's lack of compliance with safe sleeping advice. However, further medical examinations identified healing fractures to C110 and possible healing fractures to C111. Both parents were subsequently arrested by the police on 25/04/2024 and remain under investigation for grievous bodily harm.

1.3 C110 and C111 had not been subject to any prior contact with Children's Services in Torbay. C112 had been subject to early help intervention. The mother is a care experienced young adult. The father of C110 and C111 has two older children who reside in Devon, and he is linked to safeguarding concerns in that area under the categories of physical abuse and neglect. The concerning information about the father was not believed to be known by agencies in Torbay until after the death of C110.

2. Purpose

2.1 This review will be based on the key lines of enquiry recorded in section four below. However, during the review, if further learning opportunities are identified these will be added at the discretion of the TSCP C110-C112 Review Panel. The key purpose of the review is to prevent future similar harm and learn lessons where appropriate to further safeguard and promote the welfare of children. The review should aim to identify systematic learning, rather than holding individuals or organisations to account for their actions.

2.2 If concerns are identified within the review process that fall outside these terms of reference, such as those of a safeguarding or misconduct nature, the

Independent Reviewer will refer to the TSCP who will then consult with the relevant body to consider appropriate responses and processes.

3. Period Under Review

3.1 The period under review is from 15/02/2022 until 29/04/2024.

3.2 The Independent Reviewer may also request summary background and contextual information outside of this period and analyse as relevant.

4. Key Lines of Enquiry

4.1 The following key lines of enquiry have been established, based on the findings of the Rapid Review, and these have been noted by National Panel. Further questions may be agreed by the TSCP C110-C112 Review Panel and will be recorded under their linked line of enquiry if required.

1	**Analyse the effectiveness of communication and information sharing between agencies during the period under review and identify if this led to missed opportunities to support/safeguard the children.**
2	**Review the extent and consistency with which routine domestic abuse enquiries were applied by agencies working with the family.**
3	**Comment on the pattern of health DNA appointments which did not meet the reported criteria for enacting the DNA policy.** **Review whether the application of professional curiosity around DNA'd appointments in consideration of the mother's care experienced status, wider environmental and family factors would have improved support and safeguarding.**
4	**Comment on the quality and consistency of midwifery recording systems in respect of fathers accompanying mothers to appointments.**
5	**Review the 'invisibility' of the father and any lack of professional curiosity about his involvement with his older children and whether this could have improved safeguarding responses.**
6	**Review the missed opportunities across the Partnership to enquire about the nature of the parent's relationship and the mother's new relationship.**
7	**Review and comment on the impact of the lack of clarity and understanding of the role of Personal Advisor versus that of a Social Worker and what impact this had on planning.**
8	**Review the effectiveness of local safe sleeping guidance/procedures and partnership responses where there is evidence that this is not being followed by parents.**
9	**Review the effectiveness of the transition process when parent/s move out of the young parent's provision into their own accommodation.**

5. Methodology

5.1 This review will be carried out according to statutory guidance and using best practice to ensure appropriate learning opportunities are identified and analysed. The final report should identify recommendations that can be converted into SMART actions to assist learning. It is anticipated that the review will be conducted remotely, however if ‘face to face’ meetings are required the need for these will be evaluated in advance by the TSCP C110-C112 Review Panel.

5.2 The Independent Reviewer will feedback progress to the TSCP at regular planned intervals via the TSCP C110-C112 Review Panel. In situations where urgent/unplanned feedback is necessary, this will be undertaken via the TSCP Business Team.

5.3 The TSCP C110-C112 Review Panel will meet monthly, however meetings can be held more frequently if required at the discretion of the Chair.

5.4 The TSCP C110-C112 Review Panel will consist of:

- Divisional Director, Safeguarding (Chair)
- Children’s Social Care
- Police
- Designated Health Professionals (ICB and NHS Trust)
- Midwifery
- Independent Reviewer
- TSCP Business Team
- Additional members as deemed necessary

5.5 Legal advice will be provided by the Local Authority Legal Department.

5.6 Communications/PR support will be provided by the Local Authority communication lead for Children’s Services.

5.7 Final learning from the review will be presented by the Independent Reviewer in the form of a full CSPR report that will be completed to timescale as far as is practicable. The final draft report will be agreed by the TSCP C110-C112 Review Panel before being presented formally to TSCP Executive Group for review and sign off via partnership business channels. Any agreed amendments to the report will be required to be undertaken by the Independent Reviewer.

5.8 The timescale for completion and publication of final version of the CSPR report is six months from the date the TSCP made the decision to initiate the review. This decision was made on 17th May 2024. The last submission date to National Panel is therefore considered to be 6th November 2024, seven working days prior to publication.

6. Review of Existing Materials and Papers

6.1 The Independent Reviewer will identify the information they require to undertake the review with the support of the TSCP C110-C112 Review Panel. The information will be sourced and provided by the TSCP Business Team and partner agencies will be expected to comply with information requests (where legally permitted) in a timely manner.

7. Involvement of Practitioners and Staff

7.1 The Independent Reviewer will identify and engage with relevant practitioners, managers, and key workers to ensure any learning opportunities are fully incorporated into the reviewing process. It is anticipated that there will be at least one 'practitioner event', combined with the offer of 1:1 or small group sessions for workers to meet.

8. Involvement of Families/Other Parties

8.1 Parents, carers and family members of the siblings will be notified of the review by the TSCP and invited to participate at an appropriate time.

8.2 Involvement of other interested parties will be considered as appropriate by the TSCP C110-C112 Review Panel.