GREENWICH
Safeguarding
Children
PARTNERSHIP

Local Child Safeguarding Practice Review Child G

Commissioned by Greenwich Safeguarding Children Partnership following Rapid Review on 11th November 2022.

1. **Introduction**

1.1. This Local Child Safeguarding Practice Review was commissioned by Greenwich Safeguarding Children Partnership (GSCP) in response to the sad death of Child G.

1.2. Child G's death was notified to the Greenwich Safeguarding Children Partnership and a Rapid Review meeting was held on 11/11/22. The Rapid Review panel which consisted of strategic leads from across the partnership, identified learning through analysis of the known facts surrounding the case and, they agreed this warranted further exploration to consider potential improvements in practice. The National Child Safeguarding Practice Review Panel agreed with this decision.

1.3. To build on the learning identified in the Rapid Review, a practitioner event was held to consider the key lines of enquiry from a front-line practice perspective.

1.4. Child G's family were invited to participate in the review but, did not wish to engage. However, upon receiving a copy of the report, Child G's mother advised that she had no comment and the maternal Grandparents of Child G felt that they had important information to add and met with the report authors. They provided insight into the lived experience of Child G and the challenges they faced in trying to secure mental health support for their daughter, Child G's mother.

1.5. The methodology for this review was felt to be proportionate given that little information was held or known about the family as there was no previous involvement with services, other than universal services. The review greatly benefitted following a discussion with the maternal Grandparents without which the review could only hypothesise on the family's lived experiences and individual circumstances.

2. Principles underpinning the review

- To remember that the main purpose for undertaking a Local Child Safeguarding Practice Review is to learn and improve child safeguarding practice.

- Recognition that safeguarding children is complex.
- It is important to understand not only what, but why professionals did what they did, the underlying contextual reasons that led individuals and organisations to act as they did are equally important in obtaining a full understanding of what happened.
- The review will also seek to understand practice from the viewpoint of the practitioner and organisations and form a view based on what was known and what was knowable at the time rather than using hindsight.
- Relevant research and case evidence will inform findings and recommendations.
- To take a child-centred approach.

3. Overview of the Incident

3.1 The Police were called to the home address by the London Ambulance Service to an unresponsive 1 year old child who was in cardiac arrest. The child was subsequently pronounced dead at hospital following resuscitation efforts by both the London Ambulance Service and the hospital's Emergency Department.

3.2 Mother called the London Ambulance Service and upon their arrival told them that the child had been left unattended in the bath for 10-12 minutes in shoulder height water. Mother closed the bathroom door and proceeded to hoover (no one else was in the home). When the mother returned, Child G was submerged in the water and unconscious.

4. Background information prior to the review

4.1 Child G's mother is the 3rd of 4 children born in the UK to parents of Black African heritage. The family identify as middle class, Christian and part of a community. Her two older siblings have left the family home and have their own families, her younger brother (adult) remains at home. Child G's mother had a happy upbringing in a close family. Her parents first became concerned when she was at university about how she was coping, she dropped out of her initial course and re-enrolled at a different university from where she graduated.

4.2 Concerns about Child G's mother's mental health were first raised by the family in 2016. Police records state that in 2016, the Police were called to a family dispute between Child G's mother (26 years old at the time) and her parents. At this time, concerns relating to Child G's mother's mental health were raised by the parents however, a mental health assessment was refused and there was no diagnosis received from the G.P. The family's account differs to these records and the maternal grandparents of Child G advised that their daughter had been exhibiting paranoid thoughts relating to the Police following her for some time. Her mother (Child G's maternal grandmother) and brother (Child G's maternal uncle) took her to the Police station to try to reassure her that she wasn't being followed. The maternal Grandmother's account is that she was dealt with respectfully and the Police explained that they were not following her and they would have no reason to nor resource

to do so.

4.3 Child G's maternal grandparents and extended family continued to have concerns about their daughter's mental state in 2016. They sought advice through various channels including calling the ambulance to take her to A&E to undertake a mental health assessment. However, as Child G's mother was an adult no support nor assessment could be enforced and, her parents state she was able to eloquently refuse assistance, masking her challenges because she did not want intervention.

4.4 At the first maternity booking appointment, Child G's mother disclosed that she had a surgical termination the year prior.

4.5 Child G was of mixed heritage (mother is Black African and father is White British). Child G was born via caesarian section with no birth complications nor disability, during the Covid-19 Pandemic. Child G was discharged from hospital following her birth to routine community midwifery care and resided with her mother, in a single parent household. Child G and her mother had regular contact with the extended maternal family, when possible, outside of Covid-19 lockdown restrictions. During lockdown periods, Child G and her mother were unable to regularly see their family however, they maintained contact via telephone and video calls. There is limited information about Child G's father, he is a White man in his 40s, who is said not to live in London. He was not at Child G's birth, nor on her birth certificate and appears to have played little role in her life. Child G's maternal grandparents description of their granddaughter is of a bubbly, smiley, active little girl who enjoyed their visits and appeared to have a bond with her mother.

4.6 Child G and her mother were on a universal pathway with no statutory or specialist involvement from services and, did not access children's centre activities. Normal health visiting practice would have meant that at the 8-12 month developmental review would have included accident prevention advice however, Child G's mother declined the initial appointment.

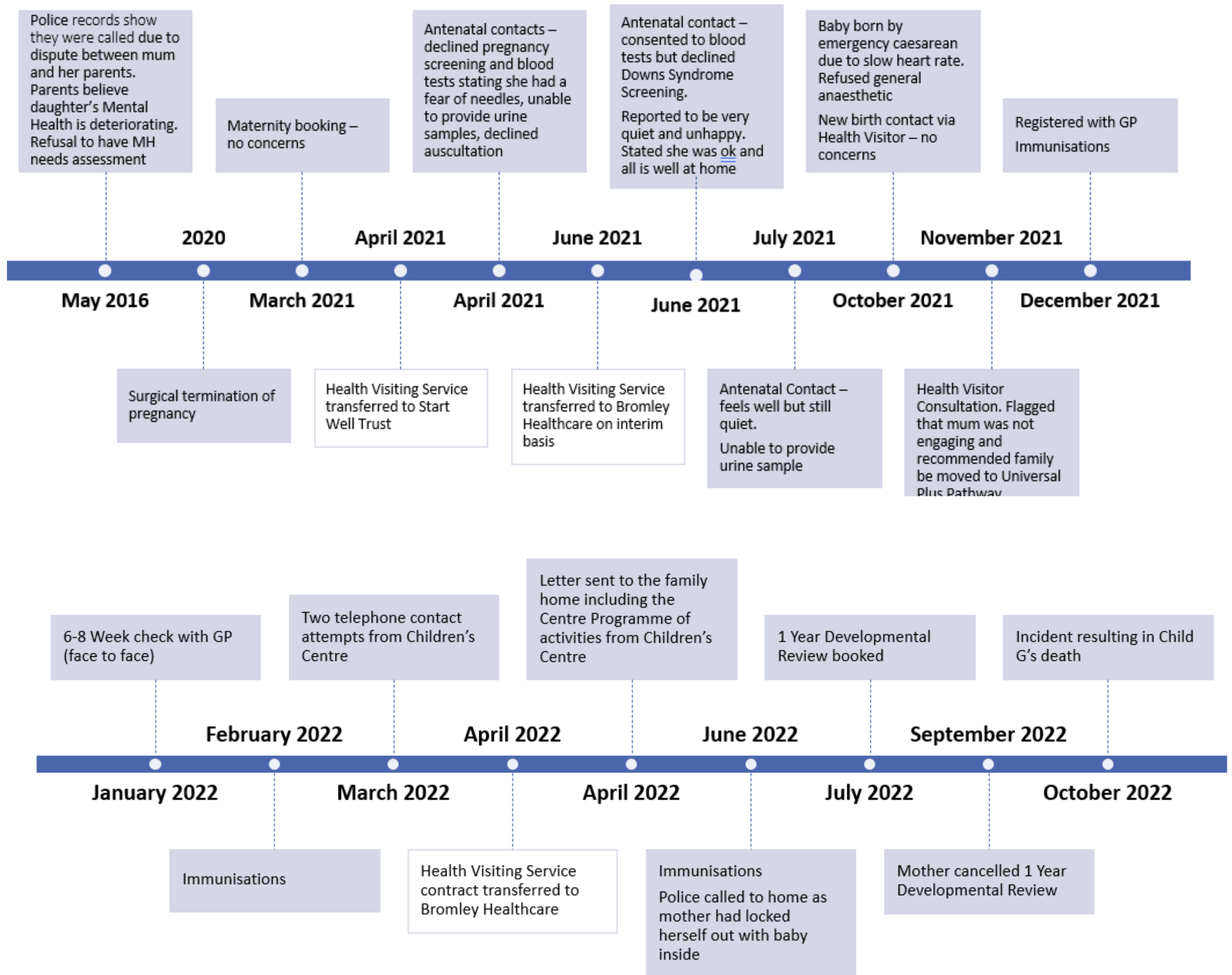
4.7 Child G's maternal Grandparents state that Child G would regularly visit the park with her mother and go outside often. The maternal Grandparents of Child G added that when Child G was born, they saw their daughter show emotion and that she engaged well with Child G which leads the review to understand Child G's lived experience as within a loving and stable extended family.

5. Key Lines of Enquiry

5.1 The Rapid Review Panel identified four key lines of enquiry following analysis of the known facts at that time:

i. Were there any missed opportunities to refer or signpost the mother to other agencies or services and are all staff across the partnership aware of what is available and how to refer/signpost?
ii. Are vulnerable babies being hidden from/ missed by services?
iii. What was the impact of covid-19 on mother?
iv. Is there anything further the Partnership can do to encourage engagement in universal services?

6. Timeline of Events



7. Key findings

7.1 Information available to the Rapid Review Panel suggested that mother and baby were isolated and there was an unwillingness to engage with professionals during ante-natal care with the refusal of routine screening tests. Whilst it is not unusual or necessarily cause for

concern for pregnant women to refuse vaccines or scans, as is their right, combined with the records detailing mother's low mood and quietness during appointments, it raises the question of whether there was sufficient professional curiosity and whether further assessments should have been undertaken with peri/post-natal depression considered especially taking into consideration the surgical termination one year prior. Post review, the maternal Grandparents of Child G stated that Child G and her mother were not completely isolated, once Covid-19 lockdown restrictions were ended Child G and her mother regularly visited the park and saw their family.

7.2 Child G's mother was pregnant during the peak of the Covid-19 pandemic, any potential feelings of isolation could have been exacerbated by the pandemic lockdowns which may have impacted on mother's mental health although, there is no way of evidencing this. Child G was born as lockdown restrictions were lifted, but it is possible that the effects of the pandemic impacted on Child G's mother wanting to engage with the Children's Centre activities.

7.3 Four months prior to Child G's death, the Police received a call from the mother stating that she had locked herself out of the home whilst Child G remained inside, alone. At this time, Child G would have been 8 months old. This was considered an unfortunate incident and, no safeguarding concerns were raised, nor details of the incident shared with Children's Safeguarding and Social Care. Police at the practitioner's event advised that this was a proportionate response to the incident and this has been discussed and explored with the Detective Chief Inspector of Public Protection SE BCU who has confirmed this was an appropriate response to an incident where no concerns, safeguarding or otherwise were flagged.

7.4 Child G's Mother had no mental health diagnosis, but the family had concerns about her mental state when she believed she was being followed by the Police in 2016. The family took Child G's mother to the local Police station in 2016 to reassure her that Police were not following her. The Police referred the case to Adult Social Care who made contact with Child G's mother to offer support but she declined. Child G's mother was within her rights to refuse consent for a mental health assessment. This behaviour which the family believed was paranoia continued and the family's concerns about her mental health led to them seeking support through multiple agencies. Their efforts to secure support for Child G's mother was unsuccessful despite their expressed concerns. At that time, Child G's mother was an adult and refused consent for a mental health assessment. Child G's Grandparents state that their daughter was able to speak eloquently and mask her mental health struggles passing off her mother's attempts to secure help as a mother/daughter disagreement.

7.5 Both pre and post-natal appointments included mental health screening assessments and, information relating to mental health support was shared as it is routinely with any new mother following an emergency caesarian. Child G's mother reported that she was 'ok' and 'fine' during all screening assessments some of which, were undertaken over the telephone due to Covid-19 restrictions. During a routine telephone call appointment for the 6-8-week baby check with Health Visiting Services, Child G's mother was described as not engaging. At this point, the Health Visiting Service recommended the family were placed onto a Universal Plus pathway which means the case should have been reallocated and more intense support offered. This recommendation was not followed up.

7.6 The review considered the culture of Child G's mother and whether this impacted on engagement or access to community resources as well as seeking mental health support. The review authors discussed this with the maternal grandparents who shared that their culture was not a barrier to seeking or accessing support for them and gave examples of how hard they had tried to access mental health support for their adult daughter.

8. Key Lines of Enquiry Findings

Were there any missed opportunities to refer or signpost the mother to other agencies or services and are all staff across the partnership aware of what is available and how to refer/signpost?

8.1 It is not clear why the recommendation that the family be placed on the Universal Plus pathway was not followed up. Feedback from the practitioner event was that there had been an unsettled period with high staff turnover, low capacity and morale along with a delayed migration of ICT systems following a change in provider. The timescales for the change in provider are included in the timeline. There was a 4-5 -month gap between the service transferring to Bromley Healthcare and the date of the recommendation which makes it difficult to link the change in provider to the lack of follow up however, the review acknowledges that it is possible it contributed. The 1-year check for Child G was cancelled by the mother and, because the family had not been moved to the Universal Plus pathway, the onus to rebook this appointment was on her.

8.2 Child G's mother was signposted to services available at the Children's Centre who contacted the family on three separate occasions but, Child G's mother chose not to engage which is within her rights.

8.3 Child G's mother declined post termination support following a termination one year prior to becoming pregnant with Child G. Declining support is within the parent's rights and, it is impossible to know whether further exploration within assessments could have led to an increased offer of support nor whether any additional support would have been accepted.

What was the impact of Covid-19 on the mother?

8.4 Any view on the impact of the pandemic on the mother's mental wellbeing would be an assumption however, the review acknowledges that the lockdown restrictions would have meant that Child G's mother was, at times very isolated. It is possible that Child G's mother did not wish to attend Children Centre activities due to the pandemic even once, restrictions were lifted.

8.5 The pandemic also led to a changed way of working which resulted in some appointments being undertaken over the telephone or by video call which does not always provide a true picture of the family's lived experiences.

Is there anything further the Partnership can do to encourage engagement in universal services?

8.6 Engagement with universal services is voluntary and, it is clear that information on how to access these services was shared with Child G's mother on multiple occasions.

8.7 As above, Child G's mother was signposted to services available at the Children's Centre who contacted the family on three separate occasions but, Child G's mother chose not to engage which is within her rights.

Are vulnerable babies being hidden from/ missed by services?

8.8 Child G and her mother attended routine appointments except for one cancelled appointment. Parental disengagement in child health-care services can adversely affect a child's health and may even have serious implications for their safety (Lewin and Herron, 2007; Powell, 2011). Over one in ten parents in England have not received any mandated health visiting checks, a report has found, which leaves them at 'significant risk' of not receiving a wide range of support. (Research in Practice 2022). Health visiting services are required to offer 5 mandated visits but, it is not mandatory for parents to accept the offer. The mother's unwillingness to engage with Children's Centres does not lend itself to suggest that Child G was being hidden by the mother.

8.9 On 23rd November 2021 at the 6-8 week telephone contact with the Health Visitor, the Health Visitor observed that mother was not engaging with the session and recommended a face to face follow up and that the family be moved to the Universal Plus Pathway which would have led to an increased offer of support. The review was unable to identify the detail of why the recommendation to move the family to the Universal Plus Pathway was not followed and concludes that this was an oversight.

9. Conclusion

9.1 There is no single point of failure nor any evidence to suggest that Child G's death could have been avoided. There is learning from this tragedy for the partnership which may require some strengthening of practice for agencies in relation to ensuring home safety and accident prevention information is discussed and shared with families at key contact points.

10. Recommendations:

10.1 The Royal Borough of Greenwich commissioned a review following the change in Health Visiting providers which has led to service improvements. The Greenwich Safeguarding Children Partnership should ensure that Commissioned Services are represented in its work to increase an understanding of safeguarding across the system and assure itself that providers (current and potentially new) and commissioners work closely together to ensure that case information is actioned during transition periods.

10.2 The Safeguarding Children's Partnership continue to promote information about home safety and water safety. Health Visiting Services to ensure home safety information is circulated when 1 year checks are cancelled or delayed.