Briefing – CSPR Infant Safety in the Most Densely Populated Place in the Country

Review Summary

The CSPR centres around the deaths of 2 children, Salman and Nyema. These are not the real names of the children which have been changed to protect their identities.

Salman and the family lived in an overcrowded one-bedroomed flat and at the time of death, the baby was sleeping in the mother's bed alongside an older infant sibling.

Nyema was one of several children in the family and was part of a multiple pregnancy. The infant had been in the hospital with a sibling due to concerns about the overcrowding and reported mould in the home and died during the admission. Following Nyema's death, an infection was discovered.

Themes from the review

1. **Overcrowding:** In both cases, the children were in accommodation that was insufficient to meet the needs of the family. Salman's mother had been on the priority housing list since 2011 due to severe overcrowding but was not proactive in bidding. Nyema's family lived in a one-bedroomed, privately rented flat that was only accessible by several flights of stairs. The review highlighted the need for agencies to have a greater awareness of housing issues, and how these might impact on risks within the family.

2. **Neglect:** There were several professional concerns around Salman's older siblings, who had previously been on Child in Need (CiN) plans, and concerns were raised regarding the family's engagement with antenatal care. There was no evidence of concerns regarding Nyema's family before the infants' admission to the hospital, however, while in the hospital there were concerns about the parents practicing safe sleep with their infants and taking professional advice. These factors raised questions about the sharing of records and information to Social Care.

3. **Think Family:** There was some indication that agencies did not fully account for the history of the family when building a picture of the needs of the children.

4. **Working together to make decisions regarding the welfare of children:** In Salman's case, the review identified a lack of professional curiosity to build a full picture of the experiences of the sibling group, and the CiN plans did not explore several crucial issues impacting the family, including housing. Several of Salman's siblings had hospital attendances with dental issues, and non-attendance at medical appointments. It is noted the hospital policy has now changed, and if a child is not brought in for a follow-up, this would lead to safeguarding concerns being raised. For Nyema, the hospital's decision to extend the infant's stay in the hospital, as well as the police decision to arrest the parents, both of which CSC disagreed with, were identified as missed opportunities to use the Multi-Agency Escalation policy. The review concluded that CiN plans should not be closed without corroborated evidence that the risks to the children had been resolved, and the THSCP should work to strengthen constructive challenges of CiN meetings.

5. **Unsafe sleep:** Unsafe co-sleeping happened in both families. In Salman's home, there was insufficient room for all the children to sleep separately. In Nyema's case, the hospital reported that the decision to co-sleep was challenged by hospital staff. It is noted that both of Nyema's parents said that they had not been fully informed of the risks around co-sleeping and were keen to keep a close eye on Nyema given that the infant was unwell and in hospital. Infant safety has featured in all Rapid Reviews and CSPRs in Tower Hamlets, in the past year.

Recommendations: There are 25 recommendations from the review which include, but are not limited to, strengthening information sharing, further consideration of housing in the context of safeguarding, improvement of multi-agency working in the context of individual family histories and to undertake a multi-agency audit of sleeping arrangements for infants.

Tower Hamlets Safeguarding Children Partnership

Thematic Review: Infant Safety in the Most Densely Populated Place in the Country

Recommendations relating to housing:

1. It is crucial that Child Protection Conferences have the up-to-date housing information about all members of the family to enable decision making to take account of overcrowding issues. This should include an assessment of those with parental responsibility for each child, to consider how they are able to advocate for their children.

2. Social Care assessments must include housing issues and how these impact on the risks within the family.

3. The THSCP should highlight to the Council Leadership, and nationally, the significant risks to the health, welfare, and education of children due to overcrowding and insufficient suitable housing in the borough. There needs to be a multi-agency strategy that mitigates the effects of overcrowding e.g. safer outdoor spaces, homework clubs, to ensure that no child misses out due to their living space.

4. When families are on the priority housing list, and there are children in the home, then housing officers in the relevant social housing association should consider whether there needs to be a safeguarding referral.

5. The THSCP should consider whether overcrowding should trigger an automatic safeguarding alert to enable a social care assessment in relation to the children. This could provide greater opportunities to consider how the housing space can be used to the benefit of the children.

6. When schools identify additional needs for a child, the housing arrangements should be included in the special education assessments to support effective planning for the child to achieve their full potential.

Recommendations relating to neglect:

7. Schools must prioritise timely transfer of records and proactively sharing information about any concerns about a child's welfare. This should be part of a work programme to strengthen how schools identify early signs of neglect and respond appropriately.

8. There needs to be a focus on how professionals raise concerns or disagreements in regard to Child in Need (CiN) plans.

9. Child Protection (CP) or CiN plans should include the requirement to seek to understand the reason for neglect to enable parents, carers and professionals to be clear on exactly what needs to change.

10. The THSCP should ask partners and relevant agencies:
    - How are professionals supported to identify neglect?
    - How do professionals explore the reasons for neglect with families?

***NOTE: RECOMMENDATIONS 11, 12, 24 AND 25 HAVE BEEN REDACTED FROM THE PUBLIC DOMAIN DUE TO PRIVACY AND SAFETY CONCERNS FOR THE FAMILIES INVOLVED IN THIS REVIEW.**

- Do professionals have the knowledge, the resources, and the supervision to give them the tools to effectively support families where there is potential cumulative child neglect?

Recommendations relating to Thinking Family:

11. RECOMMENDATION REDACTED*

12. RECOMMENDATION REDACTED*

13. All agencies should review their safeguarding policies to ensure that staff are clearly guided in how to access historical information when there is a child protection conference.

14. Health and education should review how midwives, health visitors and Designated Safeguarding Leads within schools are provided with safeguarding supervision that helps the practitioners to develop, feel supported and to practice safely.

15. The strategic partners should seek assurance that frontline staff are receiving, and acting on learning that is disseminated.

Recommendations relating to working together to make decisions regarding the welfare of children:

16. When there is significant overcrowding of the family accommodation, child protection conferences must include a housing officer from the relevant provider, i.e., Council or Housing Association.

17. CiN plans should not be closed without corroborated evidence that the risks to the children have been resolved. Professionals' meetings need to be held, with the family updated afterwards, to enable effective information regarding low level concerns.

18. Practitioners from any agency attending a child in need meeting must be confident, and given permission, to challenge a Children's Social Care decision to step down a case if they do not agree. In the same way as those who attend child protection conferences feel able to do.

19. The THSCP should consider how to create ways to strengthen the opportunities for the professional network to meet to constructively challenge each other to inform joint decision making, e.g., shared reflective supervision with an independent supervisor.

Recommendations relating to unsafe sleep:

20. Recognise the need for ongoing risk assessments for safe sleeping infants, particularly when common risk factors are present, for example in known overcrowding situations, when parents smoke, and when an infant is born prematurely.

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21. All agencies need to commit to disseminate the Lullaby Trust guidance to staff working with families.

22. Undertake a multi-agency audit of the sleeping arrangements for families meeting the criteria for unsafe sleep. This should assess what practitioners have recorded about the families and what plans have been developed to address the needs of the children. This should include what involvement the father/male carer has had in the assessments.

23. In hospital, when parents are not following the professional advice, there should be a contract made with the parents regarding the expectations for keeping the child safe from harm and what action the staff will take if the guidance is not followed.

24. RECOMMENDATION REDACTED*

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