Local Safeguarding Children Board

Serious Case Review
Overview Report

In respect of

Child X

Report Author:
Ghislaine Miller
BA MA CQSW AASW

Accredited Overview Author: Tavistock Consultancy Service, London Safeguarding Children Board and Department for Education

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OVERVIEW REPORT

1.0 INTRODUCTION

1.1 The Local Safeguarding Children Board (LSCB) commissioned this Serious Case Review (SCR) following the death of Child X in early September 2012, at 20 days of age. A few days earlier Child X and her twin had both been fed in bed in the early hours of the morning by their parents who had then fallen asleep with the twins still in bed with them. When Ms. U woke up later she could not find Child X, but after she had awoken her partner, Mr. V, she found the baby underneath him. They called an ambulance and the baby was taken to hospital and later transferred to a specialist children's hospital, where scans showed that there was significant brain trauma. A decision was made to turn off the ventilator to see if the baby could breathe unassisted, but the baby died shortly after this.

1.2 At the time of death, both twins were subject to interim supervision orders in ongoing care proceedings and child protection plans to the local authority. Following the death of Child X, the other twin, Child Y, was removed from the parents and accommodated under section 20, and placed in foster care. Care proceedings are now underway for this baby and the plan is adoption.

1.3 Ms. U has another child, Child W, who was removed from her care in the summer of 2011, following an anonymous telephone call to the police, Children's Social Care (CSC) and the RSPCA expressing concerns about conditions in the home. At that time, Ms. U was not in a relationship, and her mother was living with her, to help with the care of Child W, whilst Ms. U returned to work. Child W's grandmother had several cats that she had brought with her, and when the RSPCA visited the house, they removed the cats and deemed the house unfit for habitation. They contacted CSC Intake and Assessment Service that day and reported their concerns about Child W living in those conditions.

1.4 There was a delay of 9 days before someone from CSC visited the house at the end of July 2011 but when they did, their visit coincided with a visit from the police, who removed Child W under police protection powers. Ms. U agreed to Child W being accommodated under section 20 and she was placed in foster care. Ms. U was arrested for child neglect (she was cautioned for this offence) and the local authority initiated care proceedings on Child W.

1.5 There was an acknowledged concern by the CSC and the LSCB about the delay in responding to concerns about Child W, and the LSCB commissioned a management review from all the agencies involved with Child W at that time. Although information was gathered from agencies, this review was not concluded, and there were no conclusions drawn from it, and so part of the remit of this SCR is to draw together any information from that review that might have a bearing

on practice in relation to this SCR. It is to be stressed that Child W is not
1.6 the subject of this SCR.

By February 2012 the care proceedings on Child W had been underway for some months, and the two main threads of the proceedings were a) a psychological assessment of Ms. U by a Chartered Psychologist (to include observation of the interaction between Ms. U and Child W) and b) a parenting assessment of Ms. U (to include assessment of the relationship and attachment between her and Child W) by an independent Family Centre.

1.7 At the end of February 2012, Ms. U admitted to a member of staff at the family centre that she was pregnant. This Serious Case Review will focus on events from that time onwards, until the death of Child X in September 2012.

1.8 Since the death of Child X and the removal of Child Y from the family home, care proceedings on Child Y have been initiated and are on-going. The plan is to place her for adoption. The possibility of placing her and Child W with the same adopters is being explored.

Serious Case Review Process

1.9 The case was referred to the Standing Serious Case Review Panel (SCRP) and was discussed at the meeting on 13 September 2012. It was decided that the criteria for conducting a Serious Case Review (SCR) were met in accordance with paragraph 8.12 of Working Together 2010 and that a recommendation should be made to the LSCB Chair that a serious case review be conducted. The LSCB Chair endorsed the recommendation of the SCRP on 28 September 2012 and the Department for Education was notified on the same day.

Terms of Reference

1.10 The terms of reference are those outlined in Working Together 2010, with additional specific questions to be addressed, namely:

1.10.1 Are any issues raised in the management review on Child W, or actions emanating from that review, relevant to this SCR and practice in relation to Child X?

1.10.2 What was known about Ms. U's key relationships and what was the presence or absence of male figures in her life?

1.10.3 What was known about the parenting capacity of Ms. U and Mr. V from the time of Child W's birth? What did the management review on Child W indicate about Ms. U's parenting capacity?

1.10.4 Two weeks before the death of Child X the local authority had applied for, and been denied, care orders in respect of Child X and Child Y. Can we better understand the thinking and process that contributed to the court making the decision that it did?

1.10.5 Was the information and assessment provided by CSC complete and robust, including appropriate information from partners, and did it appropriately reflect the risks and concerns in this case?

1.10.6 Was legal services representation, including Cafcass and the Children's Guardian input, complete and robust, providing clarity about any risks identified and the potential consequences for the children?

1.10.7 What was the quality of the court's decision making?

1.10.8 Did the delay in identifying Ms. U's pregnancy have any effect on the outcomes in this case?

1.11 **Independent Overview Author**: Ghislaine Miller, Independent Consultant was appointed as Overview Author and attended all SCRP meetings with a remit to question, understand and challenge.

1.12 The Overview Author qualified as a social worker in 1976 and has an MA in Social Work and an Advanced Award in Social Work. She has significant experience in the work of Local Safeguarding Children Boards and Serious Case Reviews and is an accredited Overview Author, accredited in October 2010 by the Tavistock Consultancy, London Safeguarding Children Board and Department for Education. The author is also a trained Lead Reviewer for the Social Care Institute for Excellence (SCIE) Learning Together model of systems based case reviews. The author is independent, with no prior knowledge of or involvement in this case.

1.13 **Independent SCRP Chair:** Laura Eades, Independent Consultant, was appointed as Independent Chair of the SCRP**.**

1.14 Laura Eades is an independent consultant in children's services with a background of senior management positions in local and central government and the voluntary sector. She has been independent chair of 5 different LSCBs and has chaired, project managed and authored numerous SCRs. She has no connection with the Local Authority's services or with this case.

1.15 **Panel Membership**

Laura Eades, Independent Chair
Police Representative: CAIT
Head of Safeguarding, CSC
Representative, The Local Authority's Health Services
Representative, NHS Local Borough Team
Representative, CAMHS
Representative, Cafcass
CSCB Business Manager
CSCB Administrator

1.16 IMR. reports were commissioned from the following organisations:

- Children's Schools and Families; Children's Social Care and Legal Services from the Local Authority
- Local Council: Early Years Service
- Metropolitan Police (MPS)
- Cafcass
- CAMHS
- The Local Health Services (A&E, school nursing, health visiting and community and acute services)
- NHS in the Local Authority and Independent Contractor Services (GP)
- The Local Ambulance Service (LAS) (letter)
- Local Authority Housing (letter)

1.17 The SCRP met on five occasions from 17 October 2012 onwards. The agreed date for submission of the final overview report and health overview report was 3l May 2013.

1.18 There has been an emphasis on learning lessons from this Serious Case Review, as well as quality assurance. This has been built into the process through:

- A briefing for IMR authors on 12 November 2012, to go through the SCR process, including the terms of reference and the standard expected from an IMR report, to enable the overview author to produce a good quality overview report.
- IMR authors presenting their reports to members of the SCRP on 15 January 2013. All IMR authors stayed for the duration of the meeting and this not only enabled panel members to ask questions regarding omissions, discrepancies in information but also provided an opportunity for issues emerging from the various reports to be discussed. This discussion provided an early opportunity to identify lessons for learning that could be used to improve practice, with an emphasis on early implementation of that learning.
- The IMR reports have been quality assured by the SCRP. Further work (for example clarification, further exploration of particular issues, ensuring that the recommendations flowed from the analysis were SMART) was requested by the SCRP on some reports. This additional work was completed within the requested deadlines.

Parallel Processes

1.19 **Criminal Proceedings:** Ms. U was initially charged with neglect in relation to Child W, but these charges were dropped. There have been no charges in relation to Ms. U or Mr. V in relation to the death of Child X. The police view is that the co-sleeping arrangement that resulted in the death of Child X did not equate to child neglect.

1.20 **Post Mortem and Coroner's Enquiry:** the post mortem took place on 12

September 2012. The Coroner's Report received on 12 December 2012 stated that: *"Despite a thorough post mortem examination including appropriate ancillary investigations, no definite cause of death can be determined. There are no features of unnatural death. The case is therefore best regarded as sudden unexpected death in infancy; this being a co-sleeping associated death. There is a recognised risk of infant death when co-sleeping in bed with an adult, although the precise mechanism of such deaths remains uncertain"*.

Involving the Family

1.21 Ms. U and Mr. V have been notified by letter of the SCR that is underway and have been invited twice by letter to meet the overview author. A visit was recently made to the family home by the SCRP Chair and the overview author. The couple had been notified by letter about the visit, but there was no one at home.

2.0 FAMILY AND PROFESSIONAL CONTEXT

2.1 Family Context

2.1.1 **Ms. U:** 2 referrals had been made to CSC prior to the removal of Child W in July 2011: one from the midwife in 2008 when Ms. U was pregnant with Child W that resulted in an Initial Assessment, and another from the nursery Child W attended with concerns about neglect, that resulted in "no further action" (see paragraphs 2.7. and 2.8). What we now know about Ms. U and her family history has been gathered from her during various assessments, including those commissioned by the court during the care proceedings on Child W (see paragraph 1.6 above). Ms. U's own mother has not been seen or involved in any of these assessments, so Ms. U's account of her own upbringing has not been triangulated or verified.

2.1.2 Ms. U is now 40 years old, is White British, and was born in the Local Authority. She has an older brother. According to Ms. U her father left the family home when she was young after he discovered that his wife was having an affair. He took his son with him, and left Ms. U with her mother, although she did see him at weekends.

2.1.3 Her mother later re-married, and the new husband brought 2 of his own 4 children to the new family arrangement. It seems that from this point on her life became miserable: she described sexual abuse by the step-father from the age of 10; extreme bullying by her step-siblings (the Chartered Psychologist who assessed her described it as a "horribly real life Cinderella story"); and neglect, both physical and emotional on the part of her mother, including not taking seriously the alleged abuse of her daughter by her new husband. Ms. U described her mother as "A nasty drinker who drank a bottle of sherry each day". Ms. U's stepfather died of a heart attack in 2005.

2.1.4 Ms. U was also bullied at school because she was "fat". Despite this, she did relatively well at school and left school with several GCSE's. She

then went on to college and did a City and Guilds Certificate in Community Care. At the age of 18 she went to work as a learning support assistant in a school and remained in that job until she was 24. After this she went to work in a cattery and remained in that job until she was 31. She then went to work as a Care Assistant for adults. Throughout these years Ms. U was still living at home with her mother.

2.1.5 Ms. U was still working as a Care Assistant for adults when she discovered, at the age of 36, that she was pregnant with Child W. She had met the father of the baby on an internet dating site, but he ended the relationship when Ms. U made it clear that she intended to go through with the pregnancy. Not only did she have to cope with the end of this relationship, but there were two other incidents with males that had a negative impact on her: she had been sexually assaulted by a male colleague whilst working at the cattery some years earlier, and later disclosed (during the Family Centre Assessment for the care proceedings about Child W) that around the time she had met Child W's father she had been brutally raped and horsewhipped by another male she had also met on an internet dating site. She did not report this incident to the police at the time, or when she subsequently made a disclosure to a member of staff at the Family Centre, despite being encouraged to do so. This left Ms. U not knowing whether Child W was the result of her relationship with her "boyfriend" or was the result of the rape.

2.1.6 Ms. U concealed her pregnancy from her mother until she was 8 months pregnant and did not tell her mother when she went into hospital to be induced.

2.1.7 Ms. U did receive ante-natal care and in October 2008 the midwife made a referral to CSC expressing concern about her vulnerability. An initial assessment was completed by a student social worker who supported Ms. U in a housing application. The case was closed to CSC in January 2009, after Ms. U was found accommodation.

2.1.8 Child W was born in March 2009, and Ms. U and the baby were initially placed in temporary accommodation by the council, and then provided with a 2 bedroom terraced house in the Local Authority in April 2010. Child W started to attend a local nursery in July 2010 (she was then aged 16 months) and Ms. U returned to her job as a Care Assistant for adults. By October 2010 staff at the nursery had some concerns about Child W and signs of possible neglect: she came to nursery with a dirty nappy and often had scratches on her body. On 4 October 2010 a member of staff from the nursery made a referral to CSC, expressing these concerns. There was no formal response from CSC and the nursery were advised to talk to Ms. U about it, keep a note of any further concerns and report back on these.

2.1.9 By June 2011 Child W had moved to the toddler class at the nursery and there were on-going concerns about neglect, including scratches on her body. They were about to refer the matter to CSC again, but this

was pre-empted by the removal of Child W from home by the police in the incident described in paragraph 1.4 above.

2.1.10 **Ms. U's mother:** was already known to the Local Housing Team because of the poor conditions in her home. When she moved to her daughter's house following the birth of Child W, she had taken her many cats with her. A Housing Officer visited the house at the time Child W was removed and stated, *"The property was in a filthy and unwholesome state. All officers present entered the property and within minutes we were covered in fleas. It was very difficult to move whilst inside the property due to the clutter and the rubbish. The smell was also very bad. I noted a child's quilt placed on the sofa in the living room and I was advised by the police officer that that was where the tenant's 2 year-old child slept. After a few minutes the smell was so overwhelming I had to leave the property. Once outside I realised that both my feet and legs were covered in fleas: approximately 30 on each leg".* The cost of cleaning the house, which Ms. U paid for, was £3,000.

2.1.11 **Mr. V:** little is known about Mr. V and his family background. Ms. U first had a relationship with him in 2009 when Child W was about 9 months old. She had known him for several years as they both drank and played darts at the local pub. They had a relationship for about 5 months at this time (during which she had not introduced him to Child W) but their relationship broke down in January 2011 after she discovered on Facebook that he was already in a relationship with another woman and that he had told her his mother was dead, which was a lie. In fact both parents are alive and he was living with them in another part of the County. According to Ms. U it was her distress following the breakdown in this relationship that led to the deterioration in the state of the house and her ability to look after Child W. At the time Ms. U discovered she was pregnant in February 2012, she and Mr. V were not in a relationship (although they had had sexual encounters) but later resumed one with the intention of parenting the twins together.

2.2 Professional Context

2.2.1 Children's Services:

An Ofsted inspection of safeguarding and looked after children services took place in May 2012. The overall effectiveness of safeguarding services was deemed to be adequate, with the capacity for improvement deemed to be good, *"The partnership is highly ambitious for children and young people, and has developed clear priorities based on analysis of need and listening to staff and young people"*.

2.2.2 Cafcass

2.2.2.1 The Children and Family Court Advisory and Support Service (Cafcass) was established in 2001 as an independent non-departmental public body, one of whose core functions is to safeguard and promote the welfare of children and young people in a range of family court proceedings. Cafcass employs qualified and experienced social workers as Family Court Advisors (FCAs) who undertake a variety of roles

within public and private law proceedings.

2.2.2.2 In this case, the specific role was that of Children's Guardian, the core elements of this being to provide the court with an independent overview of the child's situation, and of options available to the court and to make recommendations to safeguard and promote the welfare if the child. *"It is not the role of the Guardian to repeat the assessments of the local authority"*. (CAFCASS IMR.)

2.2.2.3 Cafcass involvement with this family began on 8 September 2011 when an application for an Interim Care Order was made in relation to Child W. She had been removed from her mother's home in July 2011 under emergency police powers as described in paragraph 1.3 above. Children's Guardian 1 was appointed to review the papers for the court hearing the following day. The issues noted in relation to Child W were poor physical care due to extreme conditions in the home; the possible learning difficulties of the mother, Ms. U, and possible concerns about Child W's development.

2.2.2.4 At the court hearing the following day, no order was made as Ms. U agreed to Child W remaining in foster care under section 20. Two expert assessments were commissioned: one from a psychologist, and the other from the Family Centre. However, Children's Guardian 1 continued to have a role in relation to Child W and court matters.

Appointment of Children's Guardian for the Twins

2.2.2.5 "The principal functions of Cafcass are set out within s12 of the Criminal Justice and Court Services Act. The children's guardian is appointed by the court in accordance with the Family Procedures Rules 2010 rule 16.3 or rule 16.4, and the powers and duties of the children's guardian are set out in rule 16.20, the further duties are set out in Practice Direction 16A. The key point, for the purpose of the Overview Report (5.2.1) is that the children's guardian had no locus *(a source of activity or power*) in respect of the twins until the local authority placed a care application before the court and the court appointed her as guardian on 23.812.[1]

2.2.2.6 This means that although Children's Guardian 1 was appointed as guardian to Child W, she had no responsibility towards the twins. Although she had expected to be appointed Children's Guardian to the twins at the point when the local authority made the application, she was in fact on leave that day (23 August 202) so the guardian on duty in the courtroom that day was asked to provide advice as requested.

Joining the Twins to the Existing Proceedings for Child W

2.2.2.7 Although there were existing proceedings regarding Child W, it would be for the Judge to decide whether the proceedings in relation to the

[1] Cafcass: note from Regional Manager and Legal Department

twins could have been joined to these.

3.0 THE HISTORY OF PROFESSIONAL INVOLVEMENT (January 2012 to 10 September 2012)

3.1 By January 2012 the two strands of assessment were underway in connection with the care proceedings on Child W: the psychological assessment of Ms. U had been completed (based on a 3 hour 20 minute interview, and no observation of Ms. U and Child W together) and the parenting assessment had started on 3 January 2012 and was taking place at the Family Centre where Ms. U was having contact with Child W 5 times a week.

3.2 Ms. U had been referred to Adult Services (for an assessment about whether she had a learning difficulty) but she did not meet their criteria for provision of a service.

3.3 Mr. U started to attend counselling, which she arranged herself via her GP. (It was a recommendation of the psychological report that she would need counselling).

3.4 On 23 February 2012 Ms. U told a worker at the Family Centre that she was pregnant. The Family Centre worker notified the allocated social worker that same day. On the following day, 24 February 2012, she attended the booking clinic at the Local Hospital and subsequently received regular and frequent antenatal care.

3.5 On 9 March the social worker visited Ms. U at home to discuss the pregnancy. Ms. U told her that she was pleased about the pregnancy, as was the father, Mr. V.

3.6 On 23 March 2012 the social worker had supervision with her team leader. It was noted that Ms. U was pregnant and that "*the plan to return Child W home had changed because of this"*. The social worker was instructed to carry out a "pre-birth assessment".

3.7 On 16 April 2012 the Parenting Assessment was completed by the Family Centre and was made available and uploaded on to the electronic system in CSC. In general it attributed the poor home conditions to both Ms. U's stubbornness (she said it was her mother who had caused the mess and so she was not going to clean it up) and laziness. The assessment concluded that Ms. U's pregnancy had changed the outcome: that there might have been a chance of Child W returning home but this had been jeopardised, because *"the view was that mother would not be able to parent two children"* (CSC IMR. report). **The report emphasised the need to assess Mr. V: his parenting capacity, his background, relationship with Ms. U and Child W**.

3.8 On 28 April 2012 the social worker had supervision with her team leader. Further questions for the Family Centre were agreed, and it was noted that one of the two people (friends/relatives of Ms. U) being assessed as

carers/special guardians for Child W had withdrawn.

3.9 The social worker had supervision with her team leader again on 1 May 2012 and it was noted that Ms. U was expecting twins. It was also noted that the Care Plan for Child W needed to be submitted to court by 15 May 2012, and **that Mr. V was to be included in the parenting assessment.**

3.10 On 4 May 2012, the social worker met with Ms. U to discuss the pregnancy. Ms. U said she felt she would cope and did not think there would be a problem. The social worker met with Mr. V the following day, 5 May 2012. His view was that he had been having an "on-off relationship with Ms. U for the past 5 years, and would move in with her once the twins were born.

3.11 On 17 May 2012 the social worker had supervision again with her team leader. The supervision records noted doubts about Ms. U's ability sustain change (to look after twins) and the plan of Special Guardianship for Child W was being pursued. There was no mention of the parenting assessment on Mr. V.

3.12 On 21 May 2012 the date of the final hearing in relation to Child W was announced as August 2012. Also on 21 May 2012, a perinatal report from Community Services noted that Ms. U had been offered therapy and had been given anti-depressants. Ms. U was seen on three occasions by the peri-natal community mental health team. The original referral by the health visitor had been turned down as it was felt her mental health was stable and she did not therefore meet the criteria. However, Ms. U re-referred herself and was then provided with a service.

3.13 On 18 June 2012, Ms. U told the social worker that the twins were due on 18 September 2012 although she had been told that they would be induced in August 2012.

3.14 On 26 June 2012 the social worker had supervision with her team leader, and the due date of the twins was noted. **It was also noted that the social worker still needed to undertake a pre-birth assessment, to include Ms. U and Mr. V.**

3.15 On 29 June 2012 Ms. U told the social worker that she wanted to have a residential assessment in connection with the care proceedings about Child W.

3.16 The social worker made two appointments to see Mr. V as part of the pre-birth assessment, on 9 and 12 July 2012, but he did not attend either. His explanation for missing the first was that he was working. He offered no explanation for missing the second.

3.17 On 18 July 2012 the social worker started to undertake a Pre-

Conference Core Assessment. It was completed by the following day and was submitted for the Child Protection Conference on 20 July 2012.

3.18 On 20 July 2012 the social worker had supervision with her team leader. They discussed Ms. U's request for a residential placement for an assessment of her relationship with Child W and their view was that there should be no more assessments in relation to Child W's care proceedings. They discussed plans for the unborn twins and were of the view that there would either be a residential assessment or removal of the twins at birth, and that this was to be discussed with "senior management".

3.19 On 25 July 2012 an initial child protection conference took place on the unborn twins. Both Ms. U and Mr. V attended and said that they wanted to look after the twins together. There was no mention in the minutes of the meeting of the need for a pre-birth assessment to be completed, to include both parents.

3.20 Health Visitor 1 attended the conference and recorded the following information in the electronic records: *"the twins are due in September but Ms. U may be induced late August; Ms. U's first child was removed by the Police and is now in foster care; Ms. U was cautioned for Neglect; Ms. U has been referred to the Perinatal mental health team; Ms. U has been diagnosed as having moderate depression and is on prescribed medication; Ms. U's Cognitive assessment was satisfactory; Ms. U has counselling through MIND and has an advocate; the father of the unborn twins was identified as Mr. V and he was reported to live in East London; Mr. V is a possible carer for his father who has severe Mental Health Issues; Mr. V had not yet engaged with Social worker but attended the conference."*

3.21 Health Visitor 1 made the following comments regarding a child protection plan for the unborn children (Child X and Child Y): "*Ms. U loves her children very much but the concern is that "she has to address issues in relation to her own childhood and past, which are very entrenched. Add twins to the situation and it will be very stressful for Ms. U. The support package would have to be very tight and require a lot of supervision to support Ms. U and ensure the twins would be well cared for.*" She agreed to a Child Protection plan for both babies under the category of neglect.

3.22 No-one from the midwifery services attended the conference, and they did not provide a report.

3.23 On 3 August 2012 the Family Centre who had carried out the assessment on Child W for the court sent an addendum report to CSC, suggesting that a further assessment should be undertaken on Ms. U in relation to looking after the twins. The report stated, **"This is a new situation and may also involve a father who is willing to be assessed alongside Mr. U or independently should Ms. U fail this further period of assessment."**

3.24 On the 07 August 2012 a core group meeting took place. Both parents attended this meeting.

3.25 On 15 August 2012 a legal planning meeting took place, involving the social worker, the team leader, the new interim service manager and the local authority solicitor. The solicitor stated that the threshold of significant harm relating to the twins had been met, and also advised that the suggestion of the Family Centre to undertake a further parenting assessment involving Ms. U and Mr. V should be taken into consideration. The minutes of the meeting, stating agreed actions, were circulated that same day and stated:

1. The local authority will carry out a parenting assessment of the mother and father of the children on the basis only that they are putting themselves forward as a couple to care for the children.
2. It has been agreed that this will be done as a residential parenting assessment.
3. The cost of the residential placement should be met by as tripartite funding between the parties.

3.26 The solicitor concluded: "in the meantime I will draft a position statement based on the information you sent to me yesterday to respond to the other parties".

3.27 By the time the solicitor had circulated these minutes, along with another e-mail asking for clarification about who would be paying for the residential assessment, the social worker's team leader had finished for the day and was now on annual leave.

3.28 The next day, 16 August 2012, the interim service manager replied to the e-mail from the solicitor: *"There is nothing in the Family Centre assessment that leads me to believe that mum can care for her twins. If she cannot cope with one child then I am not sure how she could cope with two. I am aware that it is a new dad, but we need to test his commitment before agreeing to a residential assessment. It is not fair to set mum up to fail. Removal at birth, assessment of father, especially his commitment, and assess supervised contact".*

3.29 There is no evidence that the social worker replied to the e-mail from the solicitor. There were no further e-mail exchanges between the solicitor, the social worker and the interim service team leader.

3.30 The solicitor then sent out a position statement (based on the expressed view of the interim service team leader) that they did not support any further assessment of Ms. U in relation to the twins (sic: as the assessment undertaken in relation to Child W had already provided sufficient evidence that she was unable to look after Child W and would not therefore be able to look after twins either). The local authority's position about Mr. V was that he had failed to turn up for 2 appointments with the social worker and that the relationship

between him and Ms. U *"was not clear"*.

3.31 On 17 August 2012 the Chartered Psychologist submitted an addendum to his report to court in relation to the care proceedings on Child W. He had seen Ms. U once more, and noted some positive changes, in that she had distanced herself from her mother and that her mental health had not deteriorated further. However, he did note that she had not been able to reflect on how she would cope with three children to look after, and his view was that if her relationship with Mr. V broke down, then it would be unlikely that she would be able to manage.

3.32 Also on 17 August 2012, 3 days before the twins were due to be induced, the social worker visited Ms. U and Mr. V and asked if they would agree to the twins remaining in hospital for 5 days after the delivery to enable the local authority to take the matter to court (seeking consent rather than "removing" the children legally). The parents would not agree to this and said they were seeking legal advice.

3.33 On 21 August 2012 the twins were born following an induced delivery. Mr. V was not present at the birth. A discharge meeting was arranged for 24 August 2012. The midwife was informed of the local authority's plan to seek interim care orders on the twins.

3.34 On the same day, 21 August 2012 the social worker's statement to court was finalised. It recommended that the twins be placed in foster care on Care Orders, that the parents would have contact with them five times a week, and twice a week contact between the twins and Child W. This was a holding plan until the relationship between the parents, and in particular, Mr. V's ability to support Ms. U and the twins could be assessed.

3.35 On Friday 24 August 2012 a contested court hearing took place. The local authority wanted to remove the twins on interim care orders and place them in foster care. Mr. V's solicitor vigorously argued against this, stating that there was no evidence to support the plan for removal. The court accepted that the threshold for significant harm had been met, but the local authority's argument that the twins should be removed was not accepted on the grounds that there was "no imminent risk". (Case law RE v LA 2009, which stated that separation is only ordered if the child's safety is at risk to the extent that immediate removal is necessary). The court did not accept the evidence from the social worker that Mr. V had failed to co-operate on the basis of two missed appointments and accepted the view that Mr. V and Ms. U were a couple who were intending to live with each other.

3.36 Interim supervision orders were made on the twins.

3.37 It is of note that the social worker was not supported in court by her team leader or the interim service manager or the local authority solicitor. It is also of note that the Children's Guardian who was involved in the care proceedings on Child W (and was likely to be appointed as children's

guardian to the twins) was on annual leave, and a duty guardian was in court that day. She did not support the local authority's application to remove the twins as there was no "imminent risk".

3.38 Also on 24 August 2012, whilst the court hearing was taking place, a duty social worker visited the hospital and spoke to the midwife, explained that the court hearing was taking place and requested that the twins be kept in hospital until the Tuesday 28 August 2012. Ms. U agreed to this.

3.39 On 28 August 2012 a further legal planning meeting took place to discuss the outcome of the court hearing. The meeting was attended by the social worker, the team leader and the interim service manager. They were unhappy with the outcome in court and attributed it to the barrister acting for local authority not putting forward a robust enough case.

3.40 During the meeting the solicitor pointed out that despite the interim care orders not being granted, that the local authority still had a responsibility to safeguard the children and needed a plan in place to do so. The solicitor also suggested that the local authority could still give consideration to a residential assessment that would include both parents and the twins. The interim service manager refused this suggestion, stating that: *"the court had made their decision and if the courts think that the parents are able to look after them, then so be it". She also stated that there was now no need to leave Child W in foster care "given that the twins were back home with mother".'* The solicitor asked how the safety of the twins would be monitored and the interim service manager said that the social worker would do weekly visits.

3.41 On 29 August 2012 a discharge planning meeting took place at the hospital. Mr. V had moved into Ms. U's house by this point. Visiting arrangements of professionals was agreed and the twins were to be discharged the following day, 30 August 2012.

3.42 That same day, 29 August 2012, the parents were given a written agreement to sign. It was signed by the social worker, but not by the parents, who said they wanted to seek legal advice before signing.

3.43 On 31 August 2012 the social worker did a home visit. Child X was asleep throughout the visit, but was noted by the mother to be feeding well. Child Y was awake intermittently during the visit and Ms. U said there were some feeding problems with her. The midwife had not yet made a home visit and the social worker telephoned her to make sure that a visit was planned (community midwifery took over the care of Ms. U and the twins and five visits were made to them at home between their discharge from hospital at the end of August and the death of Child X). During the visit, the social worker spoke at length to Mr. V about his family history, but there is no recorded evidence that the social worker observed and assessed how the parents were managing and coping with the care of the twins and what the quality of the "bonding' was with them (CSC IMR.).

3.44 The social worker had supervision with her team leader that day. There was no recorded discussion about the fact that the twins were at home, what the risks were and how this was to be managed. There was a note to say that the plan for Child W had been special guardianship with a relative, but that now needed to be reviewed in the light of the decision of the court in relation to the twins, and that this needed to be discussed with the interim service manager. There was also a note that the review child protection conference for the twins was due shortly, but no discussion of what the child protection plan was for the twins as they were at home with the parents, which was not the plan that had been anticipated.

3.45 On 6 September 2012 the social worker made her second home visit. Both twins were asleep on Ms. U's chest. The social worker spoke to Mr. V again about his family history, challenging him that he had not mentioned that he had been previously married to an American citizen. Again, there was no record of any observation of how the parents were coping with the twins, how well they were doing looking after them, and what the emotional bond was with them, and with each other.

3.46 On the following day, 7 September 2012, CSC were contacted by University College Hospital, and informed that Child X had been admitted after Mr. V had rolled on top of her whilst asleep during the night. Both twins were at the hospital. A strategy meeting took place at the hospital that day. The police and CSC were in agreement that Child Y should be removed from the parents but the consultant paediatrician was not initially in agreement. However, agreement was reached during the meeting that Child Y should be removed under police protection powers and be placed in foster care. It was also agreed that an application should be made for interim care orders on both twins. Child X was transferred to a specialist hospital and Mr. V went with her. Ms. U remained at UCHC with Child Y.

Child X died three days later.

3.47

ANALYSIS OF PRACTICE

4.0

4.1 What was known about Ms. U's key relationships and what was the presence or absence of male figures in her life? What was known about the parenting capacity of Ms. U and Mr. V from the time of Child W's birth? What did the management review on Child W indicate about Ms. U's parenting capacity?

4.1.1 What has emerged from information provided by Ms. U herself during the various assessments that have taken place in relation to the care proceedings on Child W is that she has had an awful childhood: with her father leaving the marriage when she was young, being brought up by a controlling and neglectful mother, having a stepfather who sexually abused her and step-siblings who taunted and bullied her. There are indicators that her mother failed to take her seriously and protect her from sexual abuse by

her step-father. She was also bullied at school for being "fat". It is also significant that she later alleged she was sexually assaulted by a colleague at the cattery and later brutally raped by a man she had met on an internet dating website. All of this points to a vulnerable woman who has been taken advantage of throughout her life

4.1.2 The abusive and controlling nature of the relationship between her and her mother seems, from the evidence available, to have continued into her adulthood and it is hugely significant that she did not leave home until she was 34 and then because she was pregnant: a pregnancy she concealed from her mother.

4.1.3 *"Concealed pregnancies are by no means a new phenomenon. In the past concealment may have had significant links to the stigma and shame attached to giving birth to an "illegitimate" baby and the culture of women and girls being sent away to a mother and baby home for their confinement and subsequently placing their baby for adoption. Although societal attitudes and practice have changed greatly over the years, concealed pregnancies still occur. There is limited research into the phenomenon and the links between concealed pregnancy and child abuse. A pregnancy may be concealed for a variety of reasons, many based on fear or denial. In some cases the fear is because the pregnancy was a result of sexual abuse, either within or outside the family, and/or a woman is fearful of revealing a pregnancy for fear that it will provoke or increase incidents of domestic violence. "The reason for the concealment will be a key factor in determining the risk to the child and that reason will not be known until there has been active professional exploration and assessment".*[2]

4.1.4 All of the above has been self reported by Ms. U to professionals and yet what seems to be lacking is any professional curiosity or in depth exploration of what this has all meant to Ms. U and the impact it has had on her own emotional development, her capacity to recognise her own needs and look after and protect herself, and the extent to which she might then be able to look after her own child/children.

4.1.5 It is concerning that none of the assessments that took place included her own parents to explore the family dynamics further, not only in relation to the past, but her own mother's involvement in the recent present: why her mother moved in with her, what the quality of the relationship between them was, to what degree her mother was responsible for the deteriorating home conditions, that resulted in removal of Child W, and what her relationship was with her granddaughter.

4.1.6 There is evidence that Ms. U has remained in contact with her father (she was quoted as visiting him after Child W was removed from home). Again, there appears to have been no contact made with him by the social worker and a lack of professional curiosity about the nature of her relationship with her father.

4.1.7

[2] Lewisham Safeguarding Children Board, Concealed Pregnancy and Birth Protocol, page 5.

Whilst there are indicators of Ms. U's vulnerability, and she is also described variously by professionals, somewhat judgementally, as being "lazy" and "stubborn" there is also another side of Ms. U that does not seem to get much mention and that has not been assessed and explored sufficiently: that is the fact that despite her terrible upbringing, she did leave school with several GSCE's and then went on to get a City and Guilds Certificate in Community Care. Over the next 20 years she only had three different jobs, all with a focus on caring for others (children as a learning school assistant; animals at the cattery; adults with mental health problems).

4.1.8 Professional curiosity about what led her into these roles, and how successful she was in carrying out her caring duties could have provided a useful insight into her capacity to parent. It is quite remarkable that she stayed in these jobs so long. She was a Learning Support Assistant for 6 years; at the cattery for 7 years and had been a carer for several years when she became pregnant with Child W, and even returned to work there after Child W was born. It would have been useful to know and understand how well she did her job, and how those she cared for and those she worked with regarded her.

4.1.9 What is not known is whether Ms. U has had any positive experiences of having a relationship with an adult male, or whether they have all been abusive and controlling in nature. And little seems to be known about her current relationship with Mr. V. Again, there seems to have been little professional curiosity about exploring this, in order to understand the dynamics that underpin it, and the extent to which they would have been able to work together in looking after their children, both physically and emotionally. There is evidence of the relationship breaking down previously, because Ms. U discovered Mr. V was in a relationship with another woman at the same time and had not been honest with her.

4.1.10 Something that warranted further exploration was the level at which both Ms. U and Mr. V function, intellectually and emotionally. It was thought Ms. U might have a learning difficulty and she was referred to adult social care, but did not meet their threshold. That in itself does not rule out the fact that she might have special needs or even be considered a "vulnerable adult" because of her past abuse and her apparent inability to protect herself. The same applies to Mr. V: very little is known about his functioning capacity.

4.1.11 What was known about Ms. U's parenting capacity at the time of Child W's birth was very limited. A pre-birth assessment was completed in relation to Child W late in the pregnancy following a referral by the midwife who had concerns about Ms. U's vulnerability. The pre-birth assessment was completed by a student social worker in late 2008/early 2009,and no concerns about parenting were raised at that time and support was focussed on assisting with the provision of accommodation as Ms. U was still living with her mother at that time. The case was closed in January 2009.

4.1.12 At the time of Child W's removal in July 2011little was known about Ms. U parenting skills and capacity, and she was not in a relationship with Mr. V at this time. One of the two assessments commissioned by the court as part of

the care proceedings on Child W was a community based parenting assessment, that took place over several months and was based on observations of Ms. U and her interaction with Child W during the 5 times a week contact sessions at the Family Centre. One of the key issues that have emerged from the parenting assessment was Ms. U's "*inability to provide guidance and boundaries for Child W. She would buy and hoard items for Child W, which left her house and garage full of things.*" Ms. U was described as using food and TV as a way of bribing Child W to do certain things and that she struggled to set boundaries for her.

4.1.13 In the early stages of the Family Centre assessment there was evidence that Ms. U was improving in this area of parenting, but was unable to sustain that improvement, and later would ignore advice given by Family Centre staff. The deterioration in her being able to maintain improvements was attributed by her assessors to the fact that she was pregnant and because she was pregnant had stopped taking her anti-depressants.

4.1.14 Nothing was known about Mr. V's parenting capacity at this time. He only came into the picture in late February 2012 when Ms. U announced her pregnancy. He was not invited to become part of the Family Centre assessment (although this had been suggested by a member of staff from the Family Centre) and was first seen by the social worker in May 2012.

4.1.15 Although the social worker was asked to undertake a pre-birth assessment on Mr. V and Ms. U, the first time he was offered an appointment for this was in July 2012, and he failed to attend this and another appointment the following week, so there was no assessment of him in the Core Assessment completed for the Pre-Birth Conference.

4.2

Assessments

There were several assessments mentioned that took place in relation to this case:

4.2.1 **Assessments Commissioned by the Court in Relation to Child W**

As outlined in paragraph 3.1, two assessments were commissioned by the court in relation to the care proceedings on Child W and were already on-going before the timeline for the beginning of the case review, but did continue throughout the time covered by the review and remained unresolved at the time of Child X's death. These assessments became enmeshed with decision making in relation to the twins, although this could not be formalised by the court because of the locus issue for the Children's Guardian and joining of cases issue outlined in paragraphs 2.2.2.5-2.2.2.7.

4.2.2 There was a psychological assessment undertaken by a Chartered Psychologist and the Parenting Assessment undertaken by a Family Centre. Both assessments were commissioned by the court at the first hearing for an interim care order application in respect of Child W on 9 September 2011.

4.2.3 The psychological assessment report was completed earlier than expected, in November 2011, rather than in December. The parenting assessment did not start until 3 January 2012 and was completed on 24 April 2012, so took

nearly 4 months to complete. Addenda to both reports were later submitted to court. Although commissioned to look at Ms. U and her parenting capacity, both assessments later included discussion about how Ms. U might be able to parent the twins, and a pivotal issue in this matter was the role of Mr. V and what part he might be able to play in looking after the twins and supporting Ms. U. Interestingly however, he was not invited to join in either assessment.

4.2.4 On 30 July 2012 a hearing had taken place at the London Family Proceedings Court, to consider an application made by Ms. U for a residential assessment in relation to Child W. The application had been opposed by Children's Guardian 1, and the case was not heard because Ms. U had failed to file certain papers.

4.2.5 However, the court ordered that both the Chartered Psychologist and the Family Centre provide addendum reports. The addendum report from the Family Centre was received by Children's Guardian 1 on 6 August 2012, and the addendum report from the psychologist on 20 August 2012. This was just a few days before the contested hearing for interim care orders on the twins. The Children's Guardian 1 was on leave and the report was sent to her home address, so her colleagues were unable to access it (this is discussed further elsewhere in the report).

4.2.6 What is striking is the fact that Mr. V was not invited to be included in the Family Centre Assessment. If it had been made explicit that this assessment was being used to assess parenting capacity of both parents in relation to the twins, then the terms of reference for the assessment could have been revised to ensure they included the relevant matters, and included Mr. V.

4.2.7 **Pre-Birth Assessment by the Social Worker**

Ms. U disclosed her pregnancy to a member of staff at the Family Centre on 23 February 2012. The social worker was asked to complete a pre-birth assessment by her manager in March 2012, and reminded at the following supervision that Mr. U was to be included in that assessment. It appears that there is not a stand alone pre-birth assessment tool and so what she did complete was a core assessment for the Pre-birth Child Protection Conference on 25 July 2012. This assessment is outlined above and was completed in one day, whereas, at that time the time allowed to complete such an assessment was 35 days, to enable a comprehensive assessment to be completed in conjunction with other agencies involved.

4.2.8 This assessment was scant and did not include an assessment of Mr. V and his relationship with Ms. U. The reason given was that Mr. V had failed to keep two appointments with the social worker at the beginning of July, the week before she completed the assessment. What is significant is that the social worker had been asked in March to undertake an assessment, but had left it until July. There may be contributing factors to this, such as the court proceedings in relation to Child W, and other cases on her case-load that were also in court proceedings.

4.2.9 The London Child Protection Procedures state: *"Pre-birth conferences should*

always be convened when there is a need to consider if an inter-agency child protection plan is required. This decision will usually follow a pre-birth assessment."[3] In relation to pre-birth assessments, the procedures state:

"A referral should be made at the earliest opportunity in order to:

- *Provide sufficient time to make adequate plans for the baby's protection;*
- ***Provides sufficient time for a full and informed assessment;***
- ***Avoid initial approaches to parents in the last stages, at what is already an emotionally charged time;***
- ***Enable parents to have more time to contribute their own ideas and solutions to concerns and increase the likelihood of a positive outcome to assessments;***
- ***Enable the early provision of support services so as to facilitate optimum home circumstances prior to the birth".***

4.2.10 There is little doubt that the pre-birth assessment was started far too late, and that the Core Assessment format that was used does not lend itself to such a specific assessment, in that the headings refer to a child already born rather than an unborn.

The Social Workers Statement to Court in Relation to the Care Order Application for the Twins on 23 August 2012

4.2.11 This was completed after the change of decision following the Legal Planning Meeting on 15 August 2012.

4.2.12 Although the Core Assessment completed by the social worker was scant, by contrast the statement she submitted to court, dated 21 August 2012, clearly articulates the involvement of CSC with Ms. U and, the concerns about her ability and capacity to parent the twins that had emerged from the Family Centre assessment. This was based on observation of her interaction with Child W at the Family Centre. What had also become clear was that Ms. U still did not understand about her neglectful care of Child W and the impact that it had had on her development:

4.2.13 "*Although Ms. U accepts the concerns of the Local Authority and is working towards change, it is evident in discussion that she does not fully understand them. It is of concern that Ms. U does not recognise the neglect that Child W suffered and that she continues to state that she does not anticipate that she would have any difficulties parenting in the future. This unrealistic and naïve expectation concerns the Local Authority that should Ms. U's care of the twins decline, she would not recognise when it became neglectful"*.[4]

4.2.14 The report went on to say that the Family Centre had concluded in their assessment that *"Sadly, in my opinion, Ms. U is unable to meet the demands as a mother to three children and will be unlikely to manage the demands of*

[3] London Child Protection Procedures, London Safeguarding Children Board, 2010, paragraph 8.14.2

[4] Social worker statement to court, dated 21 August 2012

two, based on my observations. She is not equipped with the knowledge to manage the care of babies and lacked foresight when demands were discussed. Regrettably, due to her history and inability to care for Child W I am not optimistic about her capacity to provide appropriate care for two babies as ***sole carer*** *in the short or long term."*[5]

4.2.15 The statement argues that Mr. V's role in parenting the twins and supporting Ms. U was a pivotal issue, but that because of his lack of engagement (in attending the two appointments in July 2012) this had not been assessed. On the basis of this, the local authority recommended that the twins be removed at birth on an interim care order and be placed in foster care. However, the possibility of a residential assessment had not been ruled out and would depend on Mr. V demonstrating his commitment in the contact sessions with the twins (5 times a week): *"The Local Authority is of the opinion that a residential parenting assessment could be considered in respect of Ms. U, Mr. V and the twins in the future once Mr. V has demonstrated his commitment to Ms. U and the twins."*[6]

4.2.16 The social worker's statement does represent a clear analysis of the issues, and at that point in time, so near to the birth of the twins, and without any evidence of Mr. V's commitment, this appears to have been a reasonable proposal to the court.

4.2.17 However, the issue of Mr. V's commitment does come with some value judgements that are open to challenge. It is a fact that he failed to attend two appointments with the social worker, however, months had passed since it was known that Ms. U was pregnant, and there was opportunity to engage Mr. V much earlier in both the Family Centre and the social worker's assessments. The weight placed on two missed appointments seems disproportionate. He had in fact attended the pre-birth Child Protection Conference and the Core Group meetings. On the other hand he had failed to attend the birth of the twins, and there was evidence from Ms. U that he had lied to her in the past.

4.2.18. The issue of his commitment was expressed clearly by the Psychologist in his addendum report in August 2012:

"Mr. V represents a crucial but almost entirely unknown factor. If the relationship is functional and supportive; if it were to continue, if he were to play an active part in the lives of Ms. U and any children in her care, one might suppose that the dynamic would be very different and that her psychological state and her parenting competency might be improved. However, there is good reason to be concerned about the relationship. It has faltered in the past and, according to Ms. U, problems in their relationship contributed to the deterioration in her functioning in 2011. Ms. U claims that they are to live together but they have never done so and Mr. V remains living with his mother despite Ms. U being in the last stage of her pregnancy. One must wonder about their ability to build and maintain a

[5] Quote from Family Centre Assessment in Social worker statement to court, dated 21 August 2012
[6] Social worker statement to court, dated 21 August 2012

relationship whilst living together, especially with the demands of caring for two new-born babies. The quality and future of this relationship is very uncertain"

Health Assessments

4.2.19 The Health Overview Report (HOR) has identified a failure by some agencies to undertake required assessments (ante-natal services/Brearley Risk Assessment: health visiting services/Family Health Needs Assessment) and in general noted, *"Despite the numerous opportunities available, there is no documented evidence to indicate that practitioners discussed the impact of the neglect and removal of Child W had on her, how she felt about having the twins and how she would be able to develop her parenting skills sufficiently to manage their care".*

4.2.20 The HOR also identifies a lack of professional curiosity by various health professionals:

- **The GP** (Practice 1): who was aware of the removal of Child W and the related circumstances of neglect. *"However, there is no indication given that consideration was given during consultations (regarding the pregnancy) as to how this may impact on her ability to care for the twins both emotionally and physically".*
- **Health Visiting***:* HV1 visited Ms. U during her pregnancy, and also visited Child W in the foster placement, *"and would have been aware of the extreme level of neglect that had manifested itself historically. However, there does not appear to have been any professional curiosity as to what lay beneath this or any exploration of any potential relationship between this and Ms. U's own experience of growing up."*
- **Midwifery:** there were a significant number of midwives involved with Ms. U during her pregnancy: **a total of 40** (this includes inpatient and out patient). And yet, none of them visited her at home. She was, however, visited at home by the community midwifery service on 5 occasions following the birth of the twins.
- **Perinatal Community Services:** Ms U was seen on three occasions and her mental state was assessed as "mild to moderate". However, the IMR author identified that the practitioners who saw her were relatively inexperienced and did not receive supervision. Although Ms U expressed her distress about not getting Child W back and losing the twins, the impact of this on her mental health was not considered as part of the assessment.

4.3 The Use of Child Protection Planning and Decision Making to Safeguard and Protect the Twins

4.3.1. The initial child protection conference took place on 25 July 2012, just under 4 weeks before the twins were due to be induced. Both parents attended the meeting, which concluded that the children would become subject to child protection plans at birth, under the category of neglect. Health Visitor 1 attended but did not comply with Pan London procedures by submitting a

written report. The GP (Practice 1) was not invited to the meeting by CSC and did not receive minutes of the meeting. No one from midwifery services or peri-natal mental health services attended the meeting. The latter did, however, submit a report.

4.3.2 A core group meeting took place on 6 August, just two weeks before the babies were due. Both parents attended, the social worker and the health visitor. The following information was recorded by Health Visitor 1 in the electronic records: "the social worker explained the legal planning process; Ms. U disclosed she sees the perinatal mental health team 6 weekly and has counselling from them; Mr. V wishes to be part of the assessment process and is aware of expectations if it is to be residential; Ms. U brought up her concerns regarding Child W's foster carer". The plan for the core group is recorded as:

- A discharge planning meeting to be arranged once the twins have been delivered.
- The social worker will investigate Ms. U's concerns about Child W's foster carer.

4.3.3 The Croydon Health Services IMR author noted *"This meeting was held 14 days prior to the date of induction. There appears to be a lack of clarity regarding the parenting assessment to be undertaken. It's not clear how the action plan discussed at the core group meeting was to address the risks and concerns discussed at conference. There appears to be an assumption made that Child X and Child Y would be removed at birth, but there is no evidence of how Ms. U and Mr. V would be supported through this process. There also appears to be no contingency plan, other than a discharge planning meeting once the twins have been delivered."*

4.3.4 There is evidence from the HOR that the discharge planning meeting was not effective: "*It is apparent from the CHS IMR that the discharge planning meeting was not carried out in a manner that allowed for adequate assessment of the circumstances at that time and robust decision making regarding professional support following discharge. Key health professionals were not in attendance(GP Practice 1, peri-natal mental health) and documentary evidence suggests that health staff present were not all fully aware of pertinent information including the outcome of the parenting assessment, the unsuccessful application for interim care orders or the subsequent supervision orders. Although health staff should have had access to the case conference minutes and child protection plan, there is no indication that the discussion included these. It is not clear how robust assessment of risk and suitable discharge planning could be made in the absence of this information".* (HOR. paragraph 6.4.19)

4.3.5 The purpose of the CP planning system is to provide a robust framework for panning and decision-making around children who need safeguarding, but the system was not rigorous in planning for these twins, and supporting the parents. Decisions appear to have been made by CSC in isolation.

There are several examples where decisions by CSC seem to have been

4.3.6 made spontaneously and were not underpinned by assessment and evidence to support that decision:

- It is recorded in the CSC IMR. that the social worker and team leader had supervision in early March 2012, when it had been discovered that Ms. U was pregnant. The pregnancy was noted and "the original plan to rehabilitate Child W had changed due to the pregnancy".
- Following the legal planning meeting on 15 August 2012 the interim service team leader changed the plan that had been agreed in the meeting. This change of plan appears to have been based on a limited knowledge of the case and the issues involved and may have been influenced by the resource implications of funding an expensive residential placement.
- At the second legal planning meeting on 28 August 2012 the local authority solicitor pointed out to the social worker, team leader and interim Service Manager that the local authority was still responsible for safeguarding the twins even though an interim care order had not been granted and that a residential placement could still be considered. The response of the interim Service Manager is concerning (see paragraph 3.33).

4.4 The Unsuccessful Application for Interim Care Orders on Child X and Child: Y. Setting the Scene for the Court Hearing on 24 August 2012

CSC and LA Legal services

4.4.1 Although it had been known that Ms. U was pregnant since the end of February 2012, the first legal planning meeting to discuss what approach was to be taken in managing the twins case and what the plan was for them, was not held until Wednesday 15 August 2012. This seems to be very late in the day, given that the twins were due to be induced at the end of August and that final evidence for the care proceedings on Child W was to be submitted in August. There is no reason given for the lateness of this meeting, but it may be that the needs of the unborn twins had been over shadowed by the court proceedings in relation to Child W. It is the author's view that leaving this meeting so late did have an impact on what subsequently happened in court.

4.4.2 Prior to the legal planning meeting, the social worker and her team leader had met regularly in supervision to discuss this case, but the supervision notes do not indicate that they had formulated a plan about what might be in the best interests of the twins. Indeed, much of the supervision appears t have been taken up discussing what was going on in court with Child W. It would have been difficult to formulate a plan, as no assessment had taken place of Ms. U and Mr. V's relationship and their capacity to look after the twins. Such an assessment, undertaken early enough, would have enabled the local authority to work in partnership with the parents and hopefully agree on a suggested way forward to be offered to the court, such as a residential assessment placement that would include both parents, or a community based assessment combined with the children living at home

(on interim care orders) with an intensive package of daily support by professionals from CSC and health.

4.4.3 As it was, the legal planning meeting on 15 August 2012 was the first time the plan for the twins was discussed, and it is of significance that as well as the social worker and team leader attending, the meeting was also attended by a new interim Service Manager. The meeting agreed that the parents should be given the opportunity to be assessed as they had put themselves forward as a couple, and that the proposal to the court would be the offer of a residential parenting assessment.
The solicitor confirmed this in writing to the social worker, team leader and Interim service manager that same day.

4.4.4 The following day the interim service manager sent the solicitor an e-mail which effectively overturned the plan that had been agreed the previous day: her plan was that a residential assessment would not take place until Mr. V had "proved himself" and that the twins were to be removed at birth. The solicitor took this as his instruction and sent out a position statement to that effect to all parties. At this point the social worker was unaware of the change of plan as she had not been told by the interim service manager and the team leader was also unaware as she had gone on annual leave the previous evening after the legal planning meeting.

4.4.5 It is now known(following interview of the interim service manager by the CSC IMR author) that she had overturned the decision based on incomplete and inaccurate information about the case, given to her by the social worker. She was of the view that Mr. V had only just put himself forward as a carer and that he had failed to turn up for appointments. It is the author's view that the social worker may have had a somewhat fixed and judgemental view of Mr. V (that he was not trustworthy and reliable and did not have Ms. U or the twins interests at heart) that had not been tested out through an assessment, had not been challenged in supervision and that she conveyed this to the interim service manager and this may have contributed to the decision being overturned.

4.4.6 Neither the team leader or the social worker had replied to the e-mail from the solicitor on 15 August 2012, neither were aware of the change of plan prompted by the reply from the interim service manager to the solicitor. The team leader had gone on annual leave after the legal planning meeting, and the social worker was not told.

4.4.7 The position statement from the local authority solicitor may well have been perceived by the family and their legal representative as unhelpful and adversarial: stating that the local authority proposed to remove the twins at birth and that Mr. V would have to prove himself first if he wanted to be assessed.

Cafcass

4.4.8 Children's Guardian 1 discussed the case in supervision with the service manager on 31 May 2012. In interview she recalled that at that time *"she was forming a view that Ms. U would struggle to care for Child W.*

and at that point she was considering the fact that, as Child W had been in foster care for almost a year, timescales for her did not fit in with the birth of the twins and therefore it was likely that her needs would not be met in the care of Ms. U". It is not clear what her view was about any plans for the twins at this point, and the Cafcass view is that this was not relevant as she *"was not appointed as Children's Guardian at this point in time and this has no locus in respect of the twins"*.

4.4.9 On 2 August 2012 Children's Guardian 1 received an e-mail from the Children's Solicitor confirming that Ms. U's labour would be induced on 20 August 2012. She had annual leave booked for the period 9 August until 28 August 2012. When Interviewed by the Cafcass IMR. author Children's Guardian 1stated that she "expected the twins to be born at the end of August, followed by a hearing for an Interim Care Order Application and that she would be appointed as the Children's Guardian. This contradicts the fact that she had received an e-mail to say they would be induced on 20 August (whilst she was on leave).

4.4.10 On 6 August Children's Guardian 1 had received the addendum report from the psychologist. A hard copy of the report had been sent to her home address but it was not loaded on to the electronic case file system (ECF) to enable access by the service manager to access it.

4.4.11 The twins were born on 21 August 2012 and the applications for Interim Care Orders were received at the Cafcass office on 23 August 2012. The service manager e-mailed Children's Guardian 2 who was due to be on duty in court the following day, to ask her to "attend the hearing and give 'suitable advice' to the judge or magistrates". The e-mail contained only the application and no supporting files. Children's Guardian 2 would have been able to access the electronic files of Children's Guardian 1, and intended to do so that evening, but in the event, did not. The IMR. author stated, *"In the event, CG2 did not access the case files but had she done so it is doubtful to what extent these would have assisted her in understanding the key issues. Copies of the expert reports were at the home of Children's Guardian 1 (sic: who was away on holiday)."* There is evidence that she did review the "bundle" at court on the day.

4.4.12 Children's Guardian 2 did have supervision with the service manager at 10 am on 23 August and this would have been an opportunity to discuss the case but they did not.

Events in Court on 24 August 2012

4.4.13 There are a variety of perspectives about what happened and why in court that day, outlined in the agency IMR.s. The fact of the matter was that the application for removal and Interim Care Orders was rejected, with the robust use of case law and legal argument by Mr. V's legal representative about whether or not the twins were at "imminent risk" and the social worker agreed, under rigorous questioning that they were not.

The twins were made subject of Supervision Orders to the local authority. The local authority position of removal at birth and no consideration of a

residential assessment until Mr. V had "proved himself" would have already been known to Mr. V's legal representatives (see paragraph 4.4.5 above),

4.4.14 and it would not be unreasonable to assume that this was seen as an entrenched position that needed robust challenge in court, which is indeed what happened.

It is concerning that the social worker was not supported in court by a manager, although she said in interview that this is 'normal' practice**.** The local authority solicitor was not in court either. A legal planning meeting took place on 28 August 2012 and at this meeting the social worker

4.4.15 expressed the view that the barrister representing the local authority was not robust enough in court, and that Mr. V should have been put on the stand.

The Cafcass IMR. author asserts that Children's Guardian 2 was of the view that she was not in favour generally of babies being separated from their parents. Case law on this "played a part in her thinking". However, her views were not sought by the court and it is not clear why, although she did inform

4.4.16 the local authority, via her legal representative, that her preferred option would have been for Ms. U to be placed in a residential setting with the twins.

It is the view of the Cafcass IMR. author that Children's Guardian 2 played a somewhat "passive" role in the courtroom. If she had expressed her view to the court that a residential placement with the twins was her preferred

4.4.17 option, then perhaps this might have cut through the entrenched positions of removal/not of the twins and provided a way a way forward that could have been agreed by all parties.

Did the Delay in Identifying Ms. U's Pregnancy have any Effect on the Outcomes in this Case?

4.5 Agencies became aware of Ms. U's pregnancy at the end of February 2012**,** so there was no delay. What did have an impact though was agencies' responses to this news. It is the author's view that good practice would have ensured that the social worker undertook a through pre-birth

4.5.1 assessment involving both parents at the earliest opportunity, and that those professionals involved in the care proceedings for Child W would have benefitted from some discussion and "joined up thinking" in relation to both cases, and how to take this forward through the courts. There is little sense of professionals working in partnership with these parents and it is hard to imagine what they understood of the various legal proceedings, assessments a other interventions that were on-going. The opportunity to engage with both parents through doing a pre-birth assessment was present, but the opportunity was lost as the assessment was started far too late.

Information Sharing, Record Keeping and Communication (inter and intra agency)

Generally: there is evidence that the level of information sharing at the

4.6 initial child protection conference in relation to the twins did not meet the expected standard. Although Health Visitor 1 had not completed a report

4.6.1 for the conference as required and requested, she did give a verbal report to the meeting. However, it is of concern that no representative from midwifery services attended the meeting or provided a report. It is also concerning that the minutes of the meeting were sent to the midwifery service and were filed in a "confidential file". The HOR notes, *"It is unclear how other midwives involved in the care of Ms. U would have been made aware that the minutes were available and how they would be able to gain access to them".*

4.6.2 There is evidence that the quality of communication and information sharing in relation to the court proceedings and the court commissioned assessments **could** have been better. There is no evidence that information was sought from health agencies by the local authority in gathering information for court (HOR).

4.6.3 Although reports were shared amongst parties, and there is evidence that the Children's Guardian and the social worker did speak on occasions, there is little sense that they were working together to produce the best possible outcomes for Child W. There would have been opportunity to discuss the best possible strategy for resolving matters in relation to Child W whilst dealing with the conundrum of Ms. U being pregnant with twins, when they had been unaware that she was in a relationship with Mr. V, and knew nothing about him.

4.6.4 **Cafcass:** there is evidence that the case recording of Children's Guardian 1 fell below the standard expected by the agencies own procedures. Many notes were hand written and were not legible, when they should have been recorded electronically. In addition, vital information was not uploaded on to the electronic system, and so could not be accessed by colleagues in her absence. It is also of concern that reports were posted to the Guardian's home address and that one report in particular was delivered to the wrong address. All of these issues have been identified in the IMR. report and have triggered appropriate recommendations for action.

4.6.5 There is still no explanation for Children's Guardian 1 going on annual leave without making contingency plans for the Interim Care Order Application that would in all probability be made whilst she was away and enabling other guardians to have access to the information she had gathered. There is a disconnect between the fact that she received an e-mail about the twins being induced on 20 August 2012 and her understanding that they would not be born until after she was back from leave at the end of August. Despite the issue of locus raised earlier in the report (see paragraph 2.2.2.5) whilst CG 1 had not been appointed as CG to the twins, she had indicated that it was likely that she would be when the local authority made the application to court.

4.6.6 There is also no explanation for the case not being discussed in supervision between Children's Guardian 1 and the service manager on 7 August 2012, or between Children's Guardian 2 on 23 August 2012. These all point to ineffective communication and information sharing that falls below the

expected standard. Again, these have been addressed in the IMR. report and recommendations for action.

4.6.7 **CSC:** there is evidence that communication between legal services, the social worker, team leader and interim service manager was not effective, in that the interim service manager was the only person to respond to his notes of the legal planning meeting on 15 August 2012, and it is of concern that the interim service manager did not inform the social worker of the change of plan.

Supervision

4.7 **CSC:** There is evidence that the Social Worker had regular supervision with her Team Leader, but there is evidence that it was process and task driven, and lacked challenge to the social worker by the manager. For example,

4.7.1 the social worker was asked in supervision on 23 March 2012 to undertake a pre-birth assessment and to include both Ms. U and Mr. V in this. There is no evidence that this was completed and there is no evidence that the request was followed up in subsequent supervision sessions. There is also no evidence that supervision was used as a reflective process: to consider issues such as how to engage Mr. V, the direction this case was to take, how to consider the needs of the twins whilst at the same time take into consideration information from the assessments on Child W; what the court commissioned assessments actually meant, etc.

Health Visitor: on 9 July 2012 Health Visitor 1 had a Safeguarding Children Supervision session with Clinical Service Lead 1 and this family was discussed. The plan of action for Health Visitor 1 was recorded as follows:

4.7.2
- To attend the pre-birth case conference scheduled for 25.07.2012
- To provide a case conference report for 25.07.2012.
- To update Ms. U's epex records with relevant information.
- To complete a Brearley risk assessment by the date of the next conference on the 25.07.2012.

4.7.3 The IMR. stated *"These are very specific actions with deadlines attached to most. A Brearley Risk Assessment is completed when a practitioner is concerned that a child is at risk of actual or likely significant harm. This model of risk assessment looks at the potential risk factors to a child or unborn baby under specific headings; potential risks, background factors, current factors and strengths within the family. By analysing the information, practitioners should be clear about the needs of the child /unborn baby and the potential and level of risk to which the child/unborn baby is exposed. The analysis should then trigger an appropriate plan or action. There is no documentary evidence within the records reviewed by the author to show that Health Visitor 1 completed a Case Conference report or a Brearley Risk Assessment as agreed with Clinical Service Lead 1. There is also no documentary evidence to show that this was brought to the attention of Clinical Service Lead 1".*

Cafcass/ Children's Guardians: there is evidence that there was

4.7.4 insufficient rigour and challenge in the supervision between both Children's Guardian I and Children's Guardian 2 in supervision with their service manager in relation to this case. The former went on annual leave without discussing contingency arrangements, and the latter had the opportunity to discuss the case the day before the court hearing (when she was to act as duty manager in court) with her manager, but the case was not discussed, which is of concern.

KEY LEARNING POINTS AND EMERGING ISSUES

5.0 **Timing and Drift**

5.1 Given the removal of Child W in July 20111 and the on-going court proceedings and assessments commissioned by the court, once

5.1.1 professionals became aware of Ms. U's pregnancy at the end of February, there was no reason to delay in making sure that a comprehensive pre-birth assessment took place, involving both parents. However, this was not started until 18 July 2012.

5.1.2 Also, given the ongoing proceedings with Child W, it would have been good practice for discussions between CSC and their Legal Services to take place at the earliest opportunity, to maximise the potential for working in partnership with these parents. However, the first Legal Planning Meeting did not take place until 15 August 2012, the week before the twins were due.

5.1.3 Moreover, the pre-birth child protection conference was not held until 25 July, with the Core Group meeting on 7 August 2012. This must have been very stressful for the parents, with the Family Centre assessment still going on, court matters in relation to Child W still unresolved, and the fact that she had had a move of foster placement because she had been inappropriately physically chastised by one of the foster carers.

5.2 Pre-Birth assessments: need to be seen as an iterative process involving the development of a social work relationship with the parent(s) over a period of time, rather than a process driven task to be completed on the basis of one or two meetings. They also need to incorporate knowledge and information from all agencies involved.

5.2.1 The opportunity was there to engage Ms. U and Mr. V in a pre-birth Assessment from the end February 2012 when the pregnancy was disclosed, and yet Mr. V was not offered an appointment to meet the social worker about this until the beginning of July 2012, when emotions were likely to be running high with the various court assessments and the care proceedings on Child W on-going, and the birth of the twins imminent. Mr. V was said by the social worker to be difficult to engage as he failed to turn up for two appointments, and yet there is evidence that he attended the initial child protection conference on 25 July 2012 and the core group meetings on 7 August 2012.

It would have been better if the pre-birth assessment had been started

much earlier, so that the strength of the couple's relationship could have been explored as well as their parenting capacity, both individually and as a couple, as this has become a pivotal issue as the Family Centre assessment had raised serious concerns about Ms. U being the sole carer to the twins.

5.2.2

Making the Best Use of the Child Protection Conference System

5.3

An initial child protection conference had taken place on the unborn twins on 25 July 2012. A decision was made that the children would become subject to child protection plans at birth: under the category of neglect. Both parents attended the meeting and subsequent core group meetings. The review child protection conference was due on 11 September 2012. Given that the application for interim care orders had been unsuccessful and the twins were discharged home from hospital on 30 August 2012 it was imperative that there was a robust protection plan in place that outlined the support to be offered by various professionals and what was to be expected of the parents.

5.3.1

With the benefit of hindsight it would have been good practice to have brought forward the review conference meeting as a matter of urgency to formulate a clear protection plan in partnership with the parents, as even though the local authority had not been successful in obtaining interim care orders they still retained their safeguarding duty in relation to the twins and this was not diminished through the making of Supervision Orders.

5.3.2

The core group meeting provided an opportunity to make practical plans for the twins, but there is no evidence that this was done.

5.3.3

Assessments: where there are already on-going assessments/care proceedings in relation to another sibling, there needs to be clarity, about what information is shared, for what purpose. The impact of the "locus" of the Children's Guardian

5.4

There was a significant investment of time and resources in commissioning expert assessments on Ms. U in relation to the care proceedings on Child W, and this spilled over into being a means of information gathering and assessment in relation to planning for the twins. However, this was not explicit. CSC were able to use information from the assessments commissioned by the court in relation to Child W and these were included in the social worker's statement to court in relation to the twins.

5.4.1

With hindsight, it might been beneficial if discussions had taken place between the social worker, her manager, the Children's Guardian and the IRO for Child W to reflect and analyse what exactly the assessments were indicating about Ms. U's parenting capacity and her capacity to change, and what support Mr. V could provide, and what his capacity was to parent the twins.

5.4.2

Better and more Timely Use of and Improved Communication with Legal Services

5.5 The legal planning meeting that took place on 15 August 2012 should have been held much sooner, so that there was a robust plan in place, based on a solid pre-birth assessment. In reality it appears that the meeting took place at the last minute so that something could be agreed before the twins were born.

5.5.1

5.5.2 As there had been no pre-birth assessment undertaken as agreed, the plan for a residential risk assessment seemed a reasonable but expensive response, and it may be that the change of plan the next day may have been resource driven. The key learning emerging here is that planning for unborn babies who may be at risk of significant harm should not be left until the birth is imminent, but should out of fairness to all, including the parents, be done sooner to allow enough time for assessments to be carried out and for legal services to be consulted and be involved in a meaningful way.

5.5.3 The legal planning meetings appear to have been process driven and the first one took place the week before the birth of the twins. It is difficult to imagine that a robust relationship between the solicitor and the CSC professionals could be built under such circumstances, and yet the legal advice underpinning this court case was pivotal. It is concerning that a decisions made in a legal planning meeting was overturned by one person after the meeting, without further discussion or challenge taking place.

5.5.4 It is also concerning that the local authority solicitor was not present in court to support the social worker. There was robust challenge to the social worker about the issue of "imminent risk" to the twins. Perhaps if there had been more discussion in legal planning meetings this issue might have been identified as a possible challenge by the parents' legal advisers and could have been addressed in the social worker's statement. Alternatively, the local authority solicitor could have briefed the social worker how to respond to such a challenge in court.

More Effective Management Oversight and Supervision

CSC

5.6 There is learning from this case about the need for rigorous management oversight and supervision. The social worker had several cases undergoing care proceedings, and this is a difficult task. This case alone was complex, with ultimately 2 sets of care proceedings taking place. Proceedings and assessments on Child W had their own pace and momentum, and there is a sense that this may have had an impact on activity in relation to the twins: resulting in insufficient focus and a lack of sense of urgency. The social worker had been asked early on in the pregnancy on several occasions in supervision to undertake a pre-birth assessment on Ms. U and Mr. V, but this was not done. This was not followed up by the manager and the assessment was not started until 18 July 2012, and was completed the following day. The assessment on ICS has not been signed off by a manager. It may be that it was not signed off, but if it was, that is also concerning, because it was scant.

5.6.1

5.6.2 Robust management oversight and supervision could have ensured that a robust assessment was undertaken over a period of weeks during the pregnancy, involving both parents. CSC would have then been better placed to form a judgement on the relationship between the couple and the capacity of Mr. V to co-parent the twins. This could have made a critical difference to the way the case progressed and the outcome of the care proceedings.

Cafcass

5.6.3 CG 1 had supervision with her manager before going on leave, but did not discuss the case. The duty CG (CG2 once appointed) had been asked to provide advice to the court on the day. She had supervision with her manager the day before the hearing, but did not discuss the case. Both represent missed opportunities for discussion and reflection on the case.

Health

5.6.4 Managers within Health Services 1 were actively involved in discussions regarding the twins. The case was also discussed within GP practice 1, but there is no consideration given to the needs of the unborn twins and no referral was made by the GP to CSC despite Ms. U's history and the removal of Child W. There is no evidence that the case was discussed in supervision in maternity services. (HOR, paragraph 6.9.4). It was good practice that the midwife made the initial referral to CSC in February 2012.

5.6.5 **Perinatal Community Service:** the SLaM IMR. points to a lack of management oversight and supervision in this case. This is in relation to;

- Declining a referral but later offering a service. Ms U was referred to the service in February 2012 (when she had disclosed her pregnancy) but the referral was declined as a report from the Health Visitor said that Ms U's mental state was stable, and it was deemed that she did not meet the threshold for services. However, Ms U was seen for an assessment in May 2012 and was seen on a total of three occasions. There is no record explaining this change of decision, although the Team Manager reported that it was as a consequence of a telephone call from Ms U self-referring.
- The SLaM IMR. indicates that the practitioners who saw Ms U were "relatively inexperienced" and would have needed support in assessment and decision making through multi-disciplinary case discussion and supervision. There is no evidence that either took place.

5.7 Neglect: how to manage these cases better and gather the evidence needed for PLO

5.7.1 *"Put very simply, the puzzle is this. Professionals agree that neglect as an aspect of child abuse is not at present satisfactorily handled by British child protection services; many also know that there is quite strong evidence that the longer term effects of neglect on children may be even more serious than sporadic physical injury as a result of abuse. Yet, somehow, the nettle has not been grasped. Assessment and protection plans have been less effective than for physical abuse. It is widely acknowledged that*

professionals may feel a sense of relief when there is an '"incident" or a "happening" in a particular family, which is seen to legitimate action'.[7]

5.7.2 Although written some years ago, this quote still resonates today, and still presents practitioners and managers with a quandary about how to handle and manage cases of neglect, at what point to intervene legally, and what the chances are of being successful in court.

5.7.3 In this case CSC did appear to understand what evidence they had to present to court to demonstrate the impact of physical and emotional neglect on the development of Child W. They also used the evidence about this from both the Family Centre and psychologist's assessments to demonstrate that despite therapeutic help, and support and guidance from the Family Centre, that Ms. U's capacity to change was limited and was probably insufficient to enable her to parent the twins alone.

"The assessment role of the social worker, working with other professionals is thus to assess the ability of the parent(s) and their willingness to engage in therapeutic work to achieve and sustain the changes required of them. Each parent is an individual with different motivation and capacity to change. It is therefore, important that this is taken into account during the assessment. Capacity has two elements: ability and motivation. If either one or the other of these is missing then the parent will be unable to respond appropriately to the child's needs."[8]

5.7.4 What both the Family Centre and the Psychologist pointed out was that Ms. U did have the motivation to change, but not the ability to do so. It was therefore crucial to assess what role Mr. V might have in co-parenting the twins: whether he had the ability and the motivation. Sadly, this was not assessed or tested out during the months of the pregnancy and left the local authority in a vulnerable position in court. By the time they went to court they were of the view, based on two missed appointments, that he lacked the willingness. The fact that this view was presented to court, but not underpinned by an assessment, exposed the local authority to challenge, and that is what appears to have happened in the courtroom that day and resulted in the twins returning home with the parents on Supervision Orders.

5.7.5 There is also evidence that the local authority did not seek information from health agencies involved with Ms. U and Mr. V, to contribute to the statement in court. The HOR indicated, *"There is no evidence to suggest any health agency involved in this review was contacted with regard to information relating to the court application".*

Improving Working Relationships between Cafcass and Children's Social Care.

[7] Professor Olive Stevenson, Neglected Children: issues and dilemas, Blackwell Science, 1998.
[8] Jan Horwath and Tony Morrison, Assessment of Parental Motivation to Change, from The Child's World, Jessica Kingsley Publishers, 2004.

5.8 Both Children's Guardian 1 and the social worker were heavily involved in the care proceedings in relation to Child W. Information from the assessments commissioned by the court in relation to Child W was used to inform the social worker's statement to court in relation to the care order application for the twins. It would have been beneficial if discussions had taken place between the social worker and the Children's Guardian 1 in those intervening months about the case and outcomes for all three children. Cafcass have highlighted the issue of Locus: defined as a centre or source of activity or power. Cafcass have stated that such dialogue would not be possible, as Children's Guardian 1 had no locus (legal jurisdiction) in relation to the twins until the date of the initial hearing. Although there are resourcing issues (only 2 managers covering the County area) it would be helpful if discussions could take place between Cafcass and CSC to develop a better understanding of safeguarding issues and opportunities for pre-proceedings communication.

5.8.1

6.0 CONCLUSIONS

6.1 The key issues for learning outlined above point to conclusion that professionals need to place greater importance on undertaking pre-birth assessments early enough on in the pregnancy to enable them to thoroughly assess parents' ability and motivation to change. Furthermore a bespoke pre-birth assessment tool is needed. Out of this can come evidence based judgements about their capacity to parent, and whether/not this is sufficient to meet the needs of the child/ren in question.

6.2 The HOR concluded: *"There is no indication from this review of this case that the specific cause of Child X's death could have been predicted. Professionals appeared to operate under a sense of optimism and did not take into account the significant presence of risk factors or Ms. U's capacity to change. Ms. U was a vulnerable woman who needed support from the agencies working with her. It is apparent throughout this review that (health) practitioners did not contextualise significant and concerning information or take into account the severity of the current and historical issues. Had health processes been followed in a more robust manner, including in-depth holistic assessments with management oversight, the sharing of relevant information and robust contribution to the child protection process, the safeguarding framework around Child X and Child Y may have been developed in a more rounded and informed manner".*

6.3 An issue that needs further consideration is what approach the local authority will take if/when Ms. U becomes pregnant again. Given that she has effectively lost three children already, thought needs to be given to careful handling and early engagement in any future pregnancies.

7.0 OVERVIEW RECOMMENDATIONS

7.1 That the LSCB is re-assured that there are clear procedures in place that are understood by staff in relation to pre-birth assessments, that are timely and inclusive of fathers, and that practice is consistent with these. In addition that there is a suitable tool/format for undertaking and recording these

assessments.

7.2 That the LSCB is re-assured that early intervention and monitoring takes place with families following a referral, making use of the CAF and Team Around the Child meetings.

7.3 That the LSCB Chair writes to the local court to outline learning from this case and to address the issue that when applications for Care Orders are refused is the court clear that the local authority will be unable to ensure that the children are adequately safeguarded. What is the expectation of the court in such circumstances?

7.4 That the LSCB is re-assured by partner agencies that the Child Protection Conference process is understood and used as the paramount planning forum for formulating and driving forward plans.

7.5 That the LSCB is re-assured by CSC that information is sought from all agencies involved, including health, when gathering information for assessments and reports for court.

7.6 That the LSCB is re-assured by all partner agencies that robust supervision is taking place that includes challenge, and reflection on practice and the effectiveness of interventions.

7.7 That the LSCB is re-assured that steps are taken to improve the working relationship between CSC and legal services and that decisions made at a Legal Planning Meeting cannot be overturned without another meeting taking place to ratify this.

7.8 That the LSCB is re-assured that discussions will take place between managers from Cafcass and CSC to develop a better understanding of safeguarding issues and opportunities for pre-proceedings communication.

7.9 That the LSCB is re-assured that if/when Ms U becomes pregnant again that there will be prompt input from CSC and other agencies in undertaking a comprehensive pre-birth assessment and appropriate therapeutic input.

8.0 HEALTH OVERVIEW REPORT RECOMMENDATIONS

8.1 All providers are to ensure that the lessons learned are incorporated into training, policies, procedures and guidance.

8.2 All providers to report on the Progress of their Individual Management Review Action Plan to the local CCG.

8.3 All organisations will ensure that staff contribute to the child protection case conference process by submitting written reports in a timely manner and attending conferences as required.

i. All practitioners working with families must consider the ecological

8.4 perspective, taking into account family history when completing assessments.

ii. Practitioners must have understanding of attachment theories in order to appropriately identify any concerns relating to the development of relationships between the child and their carer.

iii. Practitioners must consider the emotional needs of children in all their assessments.

8.5 All assessments must 'think family' and not only take into account the Father's history and parenting capacity but also include his relationship within the family dynamics.

8.6 Maternity services must consider and implement a model for multi professional discussions and planning which will allow for all cases with safeguarding concerns to be considered and robustly managed appropriately in order to support pregnant women and safeguard babies and children.

8.7 The value and significance of safeguarding children supervision/case reflection must be understood by all staff, endorsed by managers and embedded in practice.

9.0 SINGLE AGENCY (IMR.) RECOMMENDATIONS

9.1 Cafcass

9.1.1 That the Head of Service commission an audit of the quality of case recording of home workers in the service area in order to establish the level of compliance with current policy: the robustness of plans made for the extended absence of practitioners.

9.1.2 The Head of service for A15 should establish whether the Cafcass Supervision Policy 2012 is being effectively implemented and that requirements for the recording of situational supervision is understood by both managers and practitioners. This is to be achieved by dip sampling of case files, observations of supervision and commissioned audits.

9.1.3 Service Managers and Children's Guardians should be reminded of the practice note of April 2011 "Cafcass and the work of the Independent Reviewing Officer" by adding it to the agenda for team meetings, alongside other learning currently being implemented in order to improve working relationships between Independent Reviewing Officers and Cafcass Guardians.

9.2 Children's Social Care

9.2.1 Clear guidance on the completion of pre-birth assessments that are thorough, systemic, inclusive of fathers and timely, to be included in the

update of procedures.

9.2.2 Consideration should be given formally at operational management level on all cases on whether to convene a child protection case conference when a child has been accommodated either under section 20 CA 89 or through an Interim Care Order.

9.2.3 Specific development of the professional relationship between solicitors, managers and social workers in order to manage court proceedings; ensure knowledge of case law is up to date and discussed as part of the overall management of the case and closer collaboration. Understanding case law, challenging intelligently and robustly in the best interests of children.

9.2.4 Discussion of completed "expert assessments and their outcomes: findings must be discussed and consideration of actions to be taken as part of the supervision process.

9.2.5 Decisions made in legal planning meetings must not be changed unless there is a formal opportunity to discuss the reasons and consider the evidence once again.

9.3 Health Services 1

9.3.1 Staff need to convene a Team Around the Family meeting; when there are safeguarding concerns, a number of professionals across a multitude of agencies are involved and there does not appear to be a comprehensive and co-ordinated plan of action to address those concerns.

9.3.2 Staff need to keep concise and up to date records: including records of what has been observed or discussed in relation to parenting capacity and interaction between child and parent; particularly where there are existing concerns about parenting capacity / parenting ability / parental health.

9.3.3 An overview of the specific risks and concerns within such complex and vulnerable families must be maintained.

9.3.4 All relevant and pertinent information must be included in the transfer from the hospital to the Community Maternity Services - in order to provide continuity of service and more robust communication.

9.3.5 The Maternity Services need to adhere to Health Service 1s records Management Policy and file paper records in date order, attaching documents to be filed to existing records.

9.3.6 There needs to be more robust communication between Health Service 1 staff and the Community Mental Health Service; particularly where there are concerns and risks associated with parenting capacity and mental health.

9.3.7 If the lead or named health professional has not received Looked After Child Review minutes or Health Care Plans, they too have a responsibility to

escalate this to the Key Worker within Children's Social Care 1, the relevant Independent Reviewing Officer or the Quality Assurance Unit.

9.3.8 Looked After Child Review minutes and action plans, agreed at Looked After Child Review or following a Looked After Child health assessment, should be routinely reviewed as part of the safeguarding children supervision session.

9.3.9 Child protection supervision within the Children's Universal Service needs to be more robust and in accordance with the current Safeguarding Children Supervision Policy:

9.3.10 There needs to be a more robust process in place in relation to action plans agreed at supervision.

9.3.11 All midwives should be accessing child protection supervision in accordance with Health Services 1child protection policy.

9.3.12 Health Services 1 staff must be informed of the findings from this Internal Management Review in order that good practice can be shared, lessons may be learnt and more robust safeguarding practice is developed. Particularly with the key aim of enabling staff in relation to robust assessments / observation of parent / child interaction and good record keeping practices.

9.3.13 Individual health professionals involved in this Internal Management review must be de-briefed

9.3.14 Staff within Health Service 1s need to develop a greater understanding of attachment theory and how this links in to contacts with families, observations made and the importance of recording this information.

9.4 NHS - GP's, Independent Contracted Services

9.4.1 Key findings from this review to be incorporated into safeguarding children training. This includes:-

i. The need to consider historical information (including parent's experiences from childhood) when completing assessments and how this may impact on current concerns and risks.

ii. The need to 'think family' and include all relevant members when completing assessments.

iii. The need to consult with relevant procedures when considering safeguarding children issues.

iv. The need to have a broad understanding of all neglect issues (physical and emotional) and how this impacts on outcomes for babies and children.

9.4.2 There was a failure of communication between agencies.

There is a need for Practice 1 to reflective on practice during case discussion.

9.4.3 Staff involved in this review must be de-briefed regarding its findings and supported through the process of learning.

9.5 CAMHS

9.5.1 Perinatal Team to implement a clear and consistent system to ensure multidisciplinary discussion and oversight and direct supervision of all cases seen by junior or locum staff.

9.5.2 The Trust Supervision policy should be adhered to and supervision provided and evidenced for all staff including locums.

9.5.3 All staff need to be able to complete the Child Need and Risk Screen to a satisfactory standard to ensure that potential risks to children are identified as much as possible.

9.5.4 The Perinatal Service need to re-familiarise themselves with the current Trust Child Protection Policy to ensure that safeguarding practice is compliant with this policy, local and national guidance.

9.5.5 All practitioners need to be able to critically analyse information and thus risk assess regarding the impact of neglect on the welfare of children.

9.5.6 All clinical staff to participate in Child Protection conferences as per the Trust Child Protection Policy, pan-London and national policy/guidance.

9.5.7 The team to improve awareness of racial, cultural, linguistic or religious identity within the mental health assessment.

9.5.8 Perinatal staff to be able to demonstrate awareness of safeguarding adult issues and how to appropriately respond to these.

9.5.9 All staff, including CT1 and locums will be trained to the appropriate level in child protection.