Sandwell Safeguarding Children Board

Serious Case Review

Child HS

Lead Reviewer: Stephen Ashley

Executive Summary

Introduction

Sandwell Local Safeguarding Board agreed this case met the criteria laid down in Working Together 2015 for a serious case review to be conducted. The lead reviewer is independent and the terms of reference meet the criteria laid down in Working Together 2015.

Case Summary

Baby HS has been known to primary care services since birth and was subject to a pre-birth child protection plan. Their mother (referred to as F1) has been known to services at an early age and had received 'early help'. HS's mother has had a long history of low mood and self-harm and was known to Child and Adolescent Mental Health Services. Their father (referred to as F2), had a significant criminal history and had served a custodial sentence for robberies.

HS's parents began their relationship in 2015 and F1 reported she was pregnant later in 2015. At an antenatal appointment F1 disclosed that F2 had engaged in domestic violence against her (this allegation was later withdrawn) and as a result a referral was made to Sandwell Children's Social Care. Child protection procedures were undertaken and F1 was placed on a child in need plan until HS was viable, when it was agreed they would be subject to a child protection plan. Upon birth HS was accommodated with parents in supported lodgings and after two weeks the family unit moved to a self-contained flat in supervised accommodation.

In August 2016 HS was brought to the accident and emergency department as parents noticed that HS had a swollen right arm. HS also had a small bruise on their left cheek and a small red lesion on the medial aspect of their left wrist. X-Rays showed a fracture of the right upper arm. In view of this HS was admitted to a paediatric ward and a full skeletal survey, CT head scan, blood tests and medical photography were arranged. Overall results showed further fractures to both lower legs and a fracture of the right humerus. The injuries sustained were treated as non-accidental injuries.

An investigation commenced and F1 and F2 were arrested. Criminal proceedings are now concluded.

Key Themes

Information sharing between professionals

- Professionals were aware of the history of F1 and F2 and shared information about them,
- professionals worked well together to develop a post birth plan,
- National Probation Service and the General Practitioner failed to fully engage with conferences or core groups and this left an information gap,
- there are confused systems in use to record medical records,
- the GP and the Family Nurse Partnership should have shared more information with each other,
- Health and Children's Social Care should improve their information sharing protocols,
- F2 was subject to MAPPA but information about him was not shared with all professionals and his case was not taken to a MAPPA Panel,

- the supported housing scheme did not receive a detailed briefing on the histories of F1 and F2 and a lack of training in safeguarding by staff at the scheme meant that they did not forward information that may have been useful to other professionals.

The use of child protection procedures

- Statutory meetings took place in reasonable timeframes,
- thresholds were correctly applied,
- referrals were made in a timely way,
- attendance by the Probation Service and GP at key meetings was lacking,
- legal meetings were held in a timely way and they were a proportionate response,
- the Public Law Outline was proportionate,
- the closing of the Public Law Outline was reasonable in the circumstances,
- the majority of child protection guidance and protocols were followed in this case.

The quality of assessments

- The initial single assessment was of good and detailed quality,
- pre-birth assessments did not take place,
- post birth assessments were not completed until the day HS was injured,
- Sandwell Safeguarding Children Board procedures were not followed regarding pre- and post birth assessments,
- a failure to complete assessments contributed to over optimism by professionals.

Professional curiosity and disguised compliance

- F2 was particularly skilled at engaging in disguised compliance,
- efforts were made by some professionals to triangulate their views to ensure they were not over optimistic in their approach,
- Children's Social Care were realistic about F1 and F2's capabilities,
- there was evidence of over optimism by some professionals,
- some professionals considered presentation factors without considering the facts around a failure by F1 and F2 to be compliant,
- a more robust assessment process may have reduced this over optimism.

Leadership and decision making

- Children's Social Care showed strong leadership and some good decision making,
- conferences did not resolve the different views of professionals,
- the decision to accommodate the family back at the supported housing scheme was controversial, but taken knowing the risks and ensuring that as far as possible they were mitigated,
- the Independent Reviewing Officer and conference Chair could have shown stronger leadership in resolving issues between professionals.

Key Findings

The key findings are:

- the initial referral and strategy meeting was timely and correct; it represented good practice,
- information sharing was at times poor and resulted in some professionals being unaware of key issues,
- with the exception of the initial single assessment, pre-birth and post birth assessment protocols were not followed,
- some professionals were over optimistic about the parenting ability of F1 and F2,
- F1 and F2 were capable of disguised compliance,
- some professionals lacked professional curiosity when dealing with F1 and F2,
- child protection meeting procedures were adhered to,
- Children's Social Care demonstrated good decision making and positive leadership,
- child protection conferences failed to resolve differences between professionals,
- over optimism and sympathy for F1 and F2 by some professionals, including the conference chair, caused confusion about the long-term plan for the family and resulted in less understanding of the risk posed by F1 and F2,
- the legal planning meetings and Public Law Outline were proportionate in their actions and conclusions,
- the decisions around accommodation of the family were reasonable and pragmatic in the circumstances,
- throughout the pre-birth and post birth period F1, F2 and HS were well supported by professionals,
- regular and appropriate contact was maintained with the family throughout the review period.

The overall finding of this review is that:

> **Professionals identified at a very early stage the risk posed to HS by their parents. They acted quickly to put a plan in place to protect HS when born. While better information sharing and less optimism about the parenting capabilities of F1 and F2 would have potentially improved decision making; the level of protection and support provided to HS was reasonable and proportionate in the circumstances. The prospect of legal proceedings was considered but would have been unlikely to succeed; this was the only additional protective factor that may have been afforded to HS.**

Recommendations

1. Sandwell Safeguarding Children Board should hold a post event learning work shop for professionals. This review should be used as a case study for professionals to understand their responsibilities and improve understanding of;
    a. pre and post birth assessments,
    b. child protection conferences and core groups,
    c. information sharing,
    d. disguised compliance,
    e. conflict resolution.

2. The local authority should review the protocols in place with those accommodation providers who are engaged with vulnerable adults and children. Specifically, they must

ensure that training standards for staff and information recording and sharing practices are in place and understood.

3. Sandwell Safeguarding Children Board should facilitate a meeting of senior officers to agree a protocol for attendance and participation at key meetings. In particular, child protection conferences and core groups. This should include; the National Probation Service, Police and General Practitioners.

4. The Sandwell Safeguarding Children Board should seek assurance from the MAPPA Panel that it is reviewing its role in cases involving offenders that are playing a key role in child protection. In particular it should seek assurance about the role of the National Probation Service in child protection cases.

Conclusion

F1 had been regarded as a vulnerable person for most of her life and had been subjected to and perpetrated violence. F2 had a significant criminal past and a history of violent crime, robbery and domestic abuse. This was a toxic mix and their baby was always going to be at high risk. An early referral by F1's midwife ensured that agencies became engaged with the couple at an early stage in F1's pregnancy. A strategy meeting took place and F1 was placed on a child in need plan. Sandwell Children's Social Care undertook a detailed assessment that ensured that professionals understood the risks. Children's Social Care showed strong leadership and good decision making when agreeing that, at the earliest possible opportunity, the unborn HS would be the subject of a child protection plan. A legal planning process would provide a contingency, and be in place upon the birth of HS.

Throughout the pre-birth phase professionals were heavily engaged with the couple. F1 was offered support with mental health issues and parenting skills. F2 was offered significant help and support with his drug, domestic violence and parenting issues. Whilst the couple demonstrated to professionals that they were engaging and F2 was able to convince some professionals of the progress that he was making, the couple were continually missing appointments. Some professionals were over optimistic and F1 and F2 were able to present themselves in a positive way; this was 'disguised compliance'. Pre-birth assessments did not take place and a post birth assessment was not completed until HS had been injured. These assessments may have prevented some over optimism by professionals and presented the couple in a more realistic light.

A series of legal planning meetings were held and a Public Law Outline was in place. This could have provided a legal solution if professionals believed that the risk to HS remained so high as to make it dangerous to reside with parents. Given the support supplied to F1 and F2 and the more positive view of many of the professionals, the requirements of the Public Law Outline were met; it is highly unlikely that any form of legal application to separate HS from parents would have been successful.

Professionals did work well together but there were gaps in the information they were sharing and both F1's GP and F2's probation officer were unable to attend key meetings. While reports were provided to child protection meetings, the attendance of key professionals at conferences and core groups is an essential part of the safeguarding process.

When HS was born they were placed, along with parents, in supported lodgings with 24-hour support. Unfortunately, circumstances changed when that accommodation became unavailable and the family moved back into previous supported accommodation. This was not an ideal solution but was unavoidable. Considerable and well-planned support was in

place to mitigate any risk to HS. The relationship between F1 and F2 deteriorated following the birth of HS.

Professionals did not at any stage reduce the almost daily support offered to the family. There are areas that can see some improvement by professionals, but ultimately they acted throughout in the best interests of HS. Despite the support in place and the best efforts of professionals, HS received serious non-accidental injuries while alone in the care of their parents. They must take full responsibility for those injuries.

Section One – Introduction

1.1 What this review is about

This serious case review concerns a child known, for the purpose of this review, as HS.

Sandwell Safeguarding Children Board (SSCB) agreed this case met the criteria laid down in Working Together 2015 for a serious case review to be conducted.

The brief circumstances of this case are as follows; HS has been known to primary care services since birth and was subject to a pre-birth child protection plan. Their mother (referred to as F1) has been known to services at an early age and had received 'early help'. HS's mother has had a long history of low mood and self-harm and was known to Child and Adolescent Mental Health Services (CAMHS). Their father (referred to as F2), had a significant criminal history and had served a custodial sentence for robberies.

HS's parents began their relationship in 2015 and F1 reported she was pregnant later in 2015. Whilst at an antenatal appointment F1 disclosed that F2 had engaged in domestic violence against her (this allegation was later withdrawn) and as a result a referral was made to Sandwell Children's Social Care (SCSC). Child protection procedures were undertaken and F1 was placed on a child in need (CiN)[1] plan until HS was viable when it was agreed they would be subject to a child protection plan[2]. Upon birth, HS was accommodated with parents in supported lodgings and after two weeks the family unit moved to a self-contained flat in supervised accommodation.

In August 2016 HS was brought to the accident and emergency department as parents noticed that they had a swollen right arm. HS also had a small bruise on their left cheek and a small red lesion on the medial aspect of their left wrist. X-Rays showed a fracture of the right upper arm. In view of this HS was admitted to a paediatric ward and a full skeletal survey, CT head scan, blood tests and medical photography were arranged. Overall results showed further fractures to both lower legs and a fracture of the right humerus. The injuries sustained were treated as non-accidental injuries.
An investigation commenced and F1 and F2 were arrested. Criminal proceedings are now concluded.

[1] **Child in need plan** – A multi-agency plan agreed by professionals under provisions of the **Children** Act 1989 which provides a **definition** of a **Child In Need**… "Section 17 - A **child** shall be in **need** if: a) He is unlikely to achieve or maintain or to have the opportunity of achieving or maintaining a reasonable standard of health or development without the provision for him of services by a local authority".

[2] **Child protection plan** – where a child protection conference determines that a child is at continuing risk of significant harm a multi-agency child protection plan is formulated to protect the child. A core group of professionals are responsible for keeping the child protection plan up to date and co-ordinating inter-agency activities within it.

1.2 Why this review was conducted

The Independent Chair of the SSCB agreed with a recommendation of the Serious Case Review Panel that this case should be the subject of a serious case review; under the requirements of the Local Safeguarding Boards Regulations 2006, section 5(1) (e) and (2).

The statutory basis for conducting a serious case review (SCR) and the role and function of a Local Safeguarding Children Board is set out in law by: *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*.

Regulation 5 requires the Local Safeguarding Children Board(LSCB) to undertake a review where –

(a) abuse or neglect of a child is known or suspected; and
(b) either –

(i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Guidance for Local Safeguarding Children Boards (LSCBs) conducting a serious case review (SCR) is contained in Chapter 4 of *Working Together 2015*. This version of Working Together was used when deciding upon the serious case review process, as it was the most current at the time decisions were taken around the review process (published in March 2015).

The purpose of this serious case review is to establish the role of services and their effectiveness in the care of HS, whether information was fully shared by the professionals involved and child protection procedures were appropriately followed. This process ensures that any deficiencies in services can be identified and lessons learned, to minimise the risk to other children or young people.

1.3 How this review was conducted

1.3.1 The Review Panel

The lead reviewer/author was Stephen Ashley who has extensive experience in the compilation of high-level reports into child protection issues, having been a senior police officer for thirty years and worked for Her Majesty's Inspectorate of Constabulary. He has conducted several serious case reviews and is the independent chair of two safeguarding children boards.

The lead reviewer is independent of Sandwell Safeguarding Children Board in accordance with *Working Together 2015* chapter 4 (10*).*

In addition, a review panel was established. Meetings were held at regular intervals and the panel was consulted about the progress of the review and provided further information where appropriate. The panel included a senior manager from each of the key agencies.

The Sandwell Safeguarding Children Board (SSCB) business unit supported the panel.

1.3.2 The Terms of Reference

This SCR has been conducted using a methodology adapted to suit the circumstances of this review and is described in more detail in the next section. The methodology established how well systems have worked, and where they can be improved. It is not a criminal or disciplinary review designed to attach blame to individuals.

The review covers the period from May 2015, the point at which HS's parents began their relationship, to August 2016 when HS was taken to hospital with significant injuries. This period was selected following a Serious Case Review Panel meeting and is of a sufficient range to include all engagement that HS had with agencies in Sandwell (both pre and post birth). Whilst this period was the basis for the review, contextual and relevant information falling outside of this period was also included.

The review was conducted in a way which:

- recognised the complex circumstances in which professionals work together to safeguard children,
- sought to understand precisely who did what, and the underlying reasons that led individuals and organisations to act as they did,
- sought to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight,
- was transparent in the way data is collected and analysed,
- made use of relevant research and case evidence to inform the findings.

Agencies that are involved in child safeguarding are required to follow the statutory guidance laid down by government. The guidance is called *Working Together*. It contains all the processes that agencies are required to follow. Working Together has been through several iterations. This review benchmarks against the statutory guidance contained in *Working Together 2015*[3]. This is the version that professionals would be working to during the timeframe of this case.

The review worked to terms of reference agreed with the Chair of the SSCB. The author took full cognisance of the third annual report of the national panel of independent experts on serious case reviews that was published in November 2016.

1.4 Methodology

The methodology agreed by the Sandwell Safeguarding Children Board (SSCB) review panel is based on a model consistent with the requirements of *Working Together 2015*. It ensures that:

- a proportionate approach is taken to the SCR,
- it is independently led,
- professionals who were directly involved with the case are fully engaged with the review process,
- families are invited to contribute.

[3] ***Working Together March 2015*** - https://www.gov.uk/government/.../working-together-to-safeguard-children--2

1.4.1 Chronologies and Management Reports

Agencies were asked to compile a report detailing their contacts with the individual involved in this case, resulting in a combined chronology of events. In addition, each agency was asked to highlight areas of concern and good practice. Where appropriate, an action plan, detailing those areas for improvement and the work being undertaken to address those issues, was included. All the agencies that were asked for a report provided the information requested. These reports are referred to as Individual Management Reviews (IMRs). In cases where further clarification was required agencies responded in an open and honest way.

In some cases, where contact with the subjects was minimal, agencies were only asked to provide a chronology and a covering report. In addition, interviews with front line staff and managers took place.

1.4.2 Learning Event

The learning event with front line practitioners is an essential part of the process. In the learning event, front line staff and managers that had had contact with HS were brought together for discussions around themes that had been identified from the chronologies and reports. This engagement provided a view of their engagement with HS that enriched the information provided by agencies and ensured that all the relevant facts were recorded. It was the most effective way of triangulating the evidence and ensuring that an accurate picture of HS and the traumatic events they suffered were obtained.

This review seeks to determine **why** events occurred and not just record the facts of **what** happened. The front-line view is invaluable in achieving this.

Whilst the details of discussions that took place were recorded, the comments made by the staff involved were non-attributable and their comments are not quoted directly in this report. For many front-line practitioners, this was the first opportunity for them to discuss with other professionals their engagement with HS and their family; it was pivotal to the learning from these traumatic events.

1.4.3 Family Engagement

F1 and F2 and their direct relatives have been offered an opportunity to discuss this review.

1.4.4 Parallel investigations

Throughout the period covering this review a criminal investigation was being conducted by West Midlands Police.

1.5 How this report has been structured

Following the introduction, section two provides a history of the subjects involved in this review and is the story of what happened to HS over the timeframe agreed within the terms of reference. It provides a synopsis, and tries to paint a picture of the world into which HS was born and the circumstances in which they lived during this period. Where an event or issue has proved to be significant, it is highlighted and any pertinent questions are raised at that point. These areas of significance are analysed in greater depth in section three.

Section three analyses the significant issues exposed in section two and explains **WHAT** happened and **WHY**. From this analysis, the key themes are discussed in section four and

the voice of the child in section five. Section six contains the key findings. The recommendations in section seven have been developed from these findings taking account of the work carried out by agencies since these events occurred.

The conclusion is, in effect, a summary. It is an evidence-based view of the case.

There is an executive summary at the beginning of the report containing the key issues.

This report has been written so that it can be read by the public without redaction. As a result, the names of the main subjects are not used and there are no dates that might readily identify HS or their family.

Section Two – The Story of Baby HS

2.1 Introduction

This section follows the story of HS over the review period. Those events that are of significance are highlighted and examined in greater depth in section three. This section begins with a pen picture of the world that HS was born into. It is intended to provide a degree of context around the circumstances in which HS and parents were living and how that might have affected what happened.

The second part of this section looks at the background of HS's parents and how their upbringing and pre-birth behaviour may have influenced the outcomes for HS and the way in which agencies viewed HS's circumstances.

Finally, this section contains a chronological story of the events affecting HS that are divided into two phases:

- Phase One – Pre-birth period
- Phase Two – Post birth period

2.2 What was the world like for HS?

HS was born in the summer of 2016. At the time of their birth, HS was already the subject of a child protection plan that highlighted the risk professionals believed they were at from their parents. Initially HS along with parents resided in supported lodgings. In these circumstances, the family unit lived together but had 24-hour support available to them. After two weeks, the family moved in to a small flat contained in a supported residential unit. There was significant support provided for HS and parents. The family had coordinated support from midwives, the Family Nurse Partnership and social workers, as well as the 24-hour support available in the residential unit.

HS was regarded as a normal child and the accommodation they were in provided for all their basic needs. Professionals commented that the family accommodation was clean and tidy and that HS had all the clothing they needed and parents had all the equipment they required to sustain a newborn child.

Professionals were of the view that HS's parents were doing well as new parents and both F1 and F2 were fully engaged with their baby. There was also some engagement with grandparents but it is unclear how positive this relationship was.

Whilst both parents were of concern to agencies, there was a general feeling that HS was being properly cared for and that there was every chance that HS would remain with parents.

At the time HS received their injuries a post birth assessment was being completed by Sandwell Children's Social Care (SCSC) that would have highlighted the positive improvements made by F1 and F2.

2.3 The background of HS's parents

There is no doubt that the parents of HS were the biggest determining factor in HS's life. There is also little doubt that HS's mother (F1) was a vulnerable individual who was relatively young and lacked family support. HS's father (F2) had a significant criminal record and a history of perpetrating domestic abuse. This was a toxic combination for a newborn child.

This family was always going to provide a challenge to agencies especially once they became aware that F1 was pregnant. There is further detail below of the relevant history of HS's parents.

2.3.1 HS's Mother

F1 was vulnerable and this was recognised by agencies at an early stage. F1 had been identified as at risk of CSE at the age of 11 following disclosures made to professionals. Her vulnerability continued over the next four years and it seems that no additional safeguarding measures were put in place. There were reports of self-harm and reports of violence in the home. Throughout her early teens, F1's life seems to have become more unsettled. She was excluded from school for assaulting other students and informed the school nurse that she wanted to have a baby and would not accept sexual health advice. The family were also evicted from their home and there were reports that other family members subjected F1 to violence.

F1 was placed on a CSE risk register and a CSE screening tool completed. She also attended CAMHS, reporting depressive symptoms and suicidal ideation.

2.3.2 HS's Father

F2 seems to have had a troubled childhood judging by the comments he makes to professionals about his *"messed up childhood".* Both F2's parents had died by the time HS was born.

F2's criminality is the most relevant factor in his history. That is because it should have afforded him the opportunity to receive support. F2 had 8 convictions for offences of robbery, harassment and breach of a non-molestation order. F2 was MAPPA, category 2 level 1[4] because of his pattern of domestic abuse with several partners and he had a child safeguarding marker because one of his robbery victims was under 16 years old. F2 committed robberies against vulnerable females, stealing their mobile phones. At the time HS

[4] **MAPPA Category 2 level 1** - **Category 2** – An offender who has been convicted of an offence under Schedule 15 of the Criminal Justice Act and who has been sentenced to 12 months or more in custody. **Level 1 cases -** Ordinary agency management level 1 is where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a level 2 or 3 MAPP meeting. It is essential that information-sharing takes place, disclosure is considered, and there are discussions between agencies as necessary. The Responsible Authority agencies must have arrangements in place to review cases managed at level 1 in line with their own policies and procedures. Please see the guidance document MAPPA Level 1 Ordinary Agency Management Best Practice, issued by the Offender Management and Public Protection Group in March 2011 and available on EPIC at http://npsintranet.probation.gsi.gov.uk/document_library/Documents/mappa_level_1_best_practice- _march_2011.doc.

was injured, F2 was on licence from prison. F2 was released from prison in 2015. His licence expired in January 2017.
F2 was seen in more positive light by many front-line professionals. He was described as: *"charming"* and *"open and honest".* F2 was articulate and presented well to professionals. F2's probation officer said that he: *"had changed significantly for the better".* F2 had drug issues and admitted to cannabis use.

F2 had two older children and has no contact with these children.

Significant Issue One

F1 was a vulnerable person who had been identified with significant needs. F2 was an individual with a history of violence and abuse. Agencies were aware of these issues.

- Did agencies do enough to support this couple?
- What more could have been done to support them?

2.4 HS's Story

2.4.1 Phase one- pre-birth

F1 and F2 began a relationship at some point in 2015. F1 had been considered as at risk from child sexual exploitation (CSE) and as a result was assessed at a Risk and Vulnerability meeting. At this time, it was established that she was pregnant and the father was F2.

In autumn 2015 F1 attended an antenatal appointment at her General Practitioner's (GP) surgery. F1 disclosed to the midwife that she had been subjected to domestic violence by F2, suffered from mental health issues and had previously self-harmed. The midwife made a referral using the standard multi-agency referral form (MARF) and completed a 'cause for concern' form shared with other health professionals. The form was submitted through the multi-agency safeguarding hub (MASH). Following discussions at the MASH a decision was made, in a formal meeting, to undertake a section 47 child protection enquiry[5]. A single assessment[6] was requested as a result.

Whilst the assessment was being completed midwives and the Family Nurse Partnership became more closely engaged with F1. F1's GP also made referrals to CAMHS. Over the six-week period that the assessment was completed numerous contacts were made with F1.

[5] **Section 47 enquiry** - Under Section 47 of the Children Act 1989, if there are reasonable grounds to suspect that a child is suffering or is likely to suffer significant harm a Section 47 enquiry is initiated. This is to enable the local authority to decide whether they need to take any further action to safeguard and promote the child's welfare. This normally occurs after a strategy discussion. Section 47 enquiries are usually conducted by a social worker, jointly with the Police, and must be completed within 15 days of a Strategy Discussion.

[6] **Single assessment** - Assessments are undertaken of the needs of individual children to determine what services to provide and action to take. They may be carried out: to gather important information about a child and family; to analyse their needs and/or the nature and level of any risk and harm being suffered by the child; to decide whether the child is a **Child in Need** (**Section 17**) and/or is suffering or likely to suffer **Significant Harm** (**Section 47**); and to provide support to address those needs to improve the child's outcomes to make them safe. Assessments should be conducted in accordance with Chapter 1 of Working Together 2015, and the Local Protocol for Assessment.

It was apparent that she often made herself difficult to contact and failed to attend several appointments.
Following completion of the assessment it was agreed by agencies that F1 would be the subject of a child in need (CiN) plan. The clear intention was to provide F1 with a *"safe, stable home environment".*

At this point F1 and F2 were living with F1's grandmother. This was clearly causing some stress. In addition, F1's grandmother refused access to many services; including social workers.

As part of the CiN plan F1 and F2 were placed on the Family Nurse Partnership programme. On a number of occasions both F1 and F2 stated they no longer wanted to be on the programme and it was the persistent approach of the family nurse practitioner they ensured they remained engaged. This pattern of declining help, missing appointments and being non-contactable continued throughout F1's pregnancy.

There was considerable discussion between agencies and sharing of information about both F1 and F2. By January 2016 agencies were aware that the couple were finding it difficult living with F1's family; F2 was still using cannabis, but was *"weaning himself off it"*; they were reluctant to engage with agencies; missed appointments; were struggling financially and F1 was considered a *"Walter Mitty"* character by some professionals.

In mid-January a social worker was allocated to the couple and the team leader recorded that: *"there are significant concerns regarding each parent which are increased if they care for the unborn jointly*. [There is] *nothing in either parent's history which would indicate they can provide this* [level of care] *for the unborn".*

At the end of January, a joint CiN meeting took place. Concerns were expressed by all agencies at the meeting. It was agreed that an initial child protection conference[7] (ICPC) should take place when F1 was 24/26 weeks pregnant.

Significant Issue Two

Agencies identified at an early stage that HS would be vulnerable and at risk. An early referral followed by an assessment took place and F1 was subject to a child in need plan. The period from autumn 2015 to spring 2016 was a critical period in the application of child protection procedures.

- Did agencies follow statutory guidance in an efficient and effective way?
- Was the application of procedures proportionate?

As part of the work agreed within the plan, F1 and F2 were asked to undertake a parenting programme. F2 was asked to participate in the Brighter Futures programme (BFP), which was designed for the perpetrators of domestic violence. F2 was also asked to participate in the IRIS drug programme and a 'young fathers' programme. In fact, attendance at any of these programmes was at best sporadic and in the case of the Brighter Futures programme

[7] **Initial child protection conference** - An initial child protection conference is normally convened at the end of a **Section 47 enquiry** when the child is assessed as either having suffered **significant harm** or to be at risk of suffering ongoing significant harm.

F2 refused to attend, stating he had been on a far more intensive domestic violence course whilst in prison. There is in fact little recorded around the role of the National Probation Service in this case although some liaison did take place.

It is unclear how much engagement the National Probation Service provided but one professional could say that in a conversation with the probation officer allocated to F2 she had commented that F2 had undertaken a *"complete turnaround".*

Work had also been conducted around the accommodation issues and F1 and F2 were to be housed at a supported housing scheme.

F1 remained on a child in need plan and was subject to at least one core group[8] meeting. At this meeting agreement was reached between professionals as to the support both F1 and F2 would receive and to coordinate their work. Whilst Women's Aid and the Family Nurse Partnership had arranged support there was further evidence that both F1 and F2 were missing appointments.

It was agreed that F1 and F2 would live at the housing scheme until the birth of HS and they would move there at the beginning of April.

Significant Issue Three

Significant work was conducted by agencies at the pre-birth phase. To be effective, the pre-birth work needed to ensure that sharing of information and engagement took place between key front line staff.

- Was this the case?
- Were there gaps in the intelligence profile of the family unit?

In March 2016, the ICPC took place. The only agencies represented were SCSC, the family nurse and community midwife. The meeting was thorough and considered reports from Probation, Police and Women's Aid; in addition to those present. SCSC were clear that they would also be undertaking a legal planning meeting.

Whilst credit was given to the parents for their honesty, it was unanimously agreed that unborn HS would be made subject of a child protection plan under the category of neglect. The meeting agreed that a legal planning meeting would take place. Following the meeting, the team leader from SCSC was concerned that the meeting was not quorate but a core group meeting was arranged.

In April 2016 a review child protection conference[9] (RCPC) took place. The meeting was not attended by the National Probation Service or GP but was otherwise well attended. It was in effect a continuation of the initial meeting rather than a review conference.

[8] **Core group** - is normally used in relation to children subject to a multi-agency child protection plan Core Groups are made up of professionals from differing agencies who are responsible for implementing and monitoring the Child Protection Plan.

[9]**Review child protection conference** - Child Protection Review Conferences are convened in relation to children who are already subject to a child protection plan. The first review conference is normally convened three months after a child protection plan is first drawn up, then at intervals of not more than six months. The purpose of the review conference is to review the safety, health and development of the child in view of the child protection plan, to ensure that the child continues to be adequately safeguarded and to consider whether the child protection plan should continue or change or whether it can be discontinued.

It was confirmed and agreed at the meeting that unborn HS would be made subject of a child protection plan under the category of neglect.

It is also clear from the comments made by front line professionals who were present at the conference that SCSC were firmly of the view that a contingency plan was required and they would be pursuing legal proceedings at the appropriate time. This is reflected in the minutes of this meeting. Whilst there was no dissent from the view that HS should be subject of a child protection plan, several members requested that a review should take place of the legal position.

This meeting confirmed the actions from the first meeting and laid out a significant number of actions for the agencies to complete. Plans were further developed at core group meetings over the next three months.

Two Public Law Outline[10] (PLO) meetings subsequently took place. It was clear from these meetings that the legal advice supported the view that HS would meet the threshold for care proceedings to take place. The PLO actions were clear and supported the work conducted under the CiN process and ICPC. One action was that a parenting assessment should be conducted over a two-month period following the birth of HS.

Regular planned and unplanned visits were conducted in a coordinated way by several professionals throughout the period up to HS's birth. A birth plan was developed.

Significant Issue Four

The assessment process, initial child protection conference and subsequent core group meetings and public law outline meetings are statutory child protection procedures designed to protect a child at risk.

- Were those procedures correctly followed and proportionate?
- Were they effective?

2.4.2 Phase two – post birth

HS was born in the summer of 2016. The hospital reported that F1 was struggling to cope and it was identified that F1 would need close support when leaving hospital. HS was a healthy baby and observations by several frontline professionals reported that HS was alert and developing well.

F1 and F2 had been placed in supported lodgings following the birth of HS. This was a placement that ensured that an experienced carer was available 24 hours a day to support and monitor the family unit. It was clear from discussions with professionals that several options were considered. This included placing HS in foster care or placing F1 and HS in foster care together. One of the key factors was the relationship between F1 and F2. Professionals felt that F1 relied very much on F2 and was not likely to be compliant if she was

[10] **Public Law Outline** - Guide to Case Management in Public Law Proceedings came into force on the 6th April 2010 and an updated version came into effect on 22nd April 2014. The Public Law Outline sets out streamlined case management procedures for dealing with public law children's cases. The aim is to identify and focus on the key issues for the child, with the aim of making the best decisions for the child within the timetable set by the Court, and avoiding the need for unnecessary evidence or hearings.

split from F2. In addition, some professionals were impressed with the way that F2 was developing as a father.

Unfortunately, after 2 weeks the placement was temporarily unavailable (the foster carer was on holiday) and it was agreed that the family unit would return to the housing scheme where a place had been kept open. A co-ordinated response by agencies ensured that high levels of supervision and support were available to the family.

Significant Issue five

Professionals discussed several options for safely accommodating HS and their parents. Safe and stable accommodation for the family was required.

- Were sufficient accommodation options available?
- Was the accommodation provided suitable in the circumstances?

Over the summer period professionals intensively monitored the family. At this time, the parenting assessment was being conducted.

There appears to have been a downturn in the relationship between F1 and F2. F1 complained that F2 often smelt of cannabis and at one point F2 asked a social worker if he would be able to have custody of HS if he split from F1.

In mid-July the midwife noted some marks on HS's chest and was unsure if it may have been a rash. The midwife told F1 to take HS to the GP. In fact, this appointment had to be made by a social worker when F1 failed to make the appointment. It transpired that the marks were indeterminate in nature and the GP mistakenly wrote *"pressure mark"* in HS's record. On reflection, the GP is confident they were not any form of non-accidental injury.

At the end of July, a further core group meeting had taken place. At this meeting F1 had bruising to her face and had reported her mobile phone *"stolen".* The Woman's Aid support worker felt that the relationship between F1 and F2 had further deteriorated and professionals stated at the learning event they understood the risks posed by F2 to F1 and jointly to HS.

However, reports reflect the fact that F2 was complying with requests and was witnessed showing affection and helping with HS. Reports do reflect the concerns around F2 and his *"controlling"* nature but this is balanced by the perceived improvements he had made to his lifestyle and the open and honest way he talked to professionals about his past problems.

At the end of July, the PLO was reviewed. It was agreed at this meeting that this was the end of legal proceedings and care proceedings were no longer considered necessary. The child protection plan would remain in place.

There were still concerns regarding the state of F1's mental health and the relationship between parents. The parenting assessment was nearing completion.

In late August, F1 contacted her social worker to say that HS appeared to be hurt. F1 was told to take HS to hospital, which she did.

Following examination, it was determined that: HS had a swollen right arm; a small bruise on the left cheek and a small red lesion on the medial aspect of their left wrist; X-Rays showed a fracture of the right upper arm. In view of this HS was admitted to a paediatric ward and a full skeletal survey, CT head scan, blood tests and medical photography were arranged. Overall

results showed further fractures to both lower legs and a fracture of the right humerus. The injuries sustained were treated as non-accidental injuries.

F2 threated the social worker with violence whilst at the hospital and was escorted out.

A child protection strategy meeting took place and as a result HS was placed in foster care and F1 and F2 were arrested.

Section Three – Analysis of Significant Issues

3.1 Introduction

This section provides further depth and analysis to the significant issues that have been identified in section two.

3.2 Significant Issues

Below are the significant issues in this case. The analysis of these issues provides the evidence for the key themes and findings.

3.2.1 Significant issue one

F1 was a vulnerable person who had been identified with significant needs. F2 was an individual with a history of violence and abuse. Agencies were aware of these issues.

- **Did agencies do enough to support this couple?**
- **What more could have been done to support them?**

It is clear that F2's offending history and the vulnerability of F1 made this relationship high risk and professionals certainly recognised this at an early stage. F1 was on the CSE 'radar' and F2 was on licence and under the supervision of the National Probation Service.

As detailed in 2.3.1, F1 had been known to agencies from an early age. F1 had also been cautioned for theft and assault.

SCSC completed a two formal assessment in her early teenage years. These did not result in initial child protection conferences being held.

As a result of the referrals to SCSC, F1 was subject to the Early Help programme and both she and her family were referred to a number of organisations to support them. These included Barnardo's; Women's Aid and Connexions. The family and F1 refused to engage.

In 2014, a Barnardo's CSE project worker reported F1 was subject to violence in the home. An assessment was completed and F1 was regarded as at risk of CSE and as a consequence her case was regularly reviewed at CSE Risk and Vulnerability meetings. It is unclear what actions arose from these meetings but F1 did receive support from CSE project workers.
F1 had engaged with her General Practitioner both as a child and adult. The mental health issues she had were well documented and she had received several referrals to CAMHS. F1 did not attend appointments and eventually the GP prescribed medication to help her with her issues around depression.

This period falls outside of the terms of reference for this review but the events of her early teenage years are relevant to her behaviour after she began her relationship with F2. In

particular, refusing or avoiding any help or support offered to her and her continuing mental health issues.

Apart from the 'early help' that engaged with F1, no other formal child protection measures were put in place around F1; despite clear indications this may have been appropriate.

In summary, F1 and her family were offered considerable support but this was refused or avoided. Two assessments were conducted but did not suggest invoking child protection procedures. Professionals identified the risk posed to F1 and put in place early help measures. F1 and her family failed to fully engage and this raises a question as to whether F1 should have been placed in more formal child protection procedures and made the subject of an initial child protection conference.

The position regarding F2 is described in section 2.3.2. F2 had a troubled childhood and a significant criminal history. F2 had been arrested on at least 17 occasions and had 8 convictions from 14 offences, including robbery and domestic violence.

At the time he started his relationship with F1 through to the period when HS received non-accidental injuries, F2 was on licence from prison. This meant that the National Probation Service was monitoring him. Whilst in prison the Probation Service records show that he was not subject to any offence specific work. Upon release the Probation Service assessed F2, using the Offender Assessment System known as OASys.

The OASys assessment is an integral part of the work probation officers do in assessing offenders; identifying the risks they pose; deciding how to minimise those risks; and how to tackle their offending behaviour effectively. OASys is designed to help practitioners to make sound and defensible decisions. It has not been possible to establish the exact content of the OASys. F2 attended on 26 occasions to see his probation officer. The probation officer did not attend any of the formal child protection meetings but did submit a report and described F2's progress as: *"a complete turnaround".*

When F1 and F2 moved into the housing scheme a support worker contacted F2's probation officer and asked for a view about him. The probation officer stated that F2 was not intimidating towards others, did not use class A drugs and that his domestic abuse related to incidents in 2010. The officer concluded by stating that F2 had changed *"significantly for the better"*.

F2 was also subject to Multi-Agency Public Protection Arrangements (MAPPA)[11] at category 2 level 1. MAPPA was introduced in the Criminal Justice Act 2003. This means that F2 was subject to a process that should ensure information about the risks he posed are shared and there is mitigation in place to reduce any risk. F2 was graded at MAPPA level 1. This is described in the following terms:

*"**Level 1** - Ordinary agency management is for offenders who can be managed by one or two agencies (e.g. Police and/or Probation). It will involve sharing information about the offender with other agencies if necessary and appropriate."*

No evidence has been provided of the work conducted under these arrangements. If convicted of an offence in this case a MAPPA serious case review should be conducted.

[11] **MAPPA** - MAPPA is not a statutory body in itself but is a mechanism through which agencies can better discharge their statutory responsibilities and protect the public in a co-ordinated manner. MAPPA allows agencies to assess and manage offenders on a multi-agency basis by working together, sharing information and meeting to ensure that effective plans are put in place. Agencies retain their full statutory responsibilities and obligations at all times. All MAPPA offenders are assessed to establish the level of risk of harm they pose to the public. Risk management plans are then worked out for each offender to manage those risks. These set out the action that needs to be taken to minimise the risk.

The best opportunity to engage with F2 was whilst he was in prison and following his release on licence. Much of this period falls outside the scope of this review. There is little evidence that any significant work took place with F2 either whilst he was in prison or upon his release. It is of concern that there is little evidence of the MAPPA process being effective.

As part of the work planned under child protection procedures F2 was asked to complete the Brighter Futures programme. F2 declined and avoided attending, stating he had completed a better programme whilst in prison. F2 was also asked to engage in a drug programme, which he failed to attend. Considerable effort was made to engage F2 on a programme for 'young dads', which he accepted but did not attend.

F2 was offered considerable support that he avoided or declined and the frustration felt by professionals at the learning event who highlighted how difficult it was to get compliance from either F1 or F2.

In summary: a huge amount of support was available to F1 and F2. Despite repeated encouragement both F1 and F2 either declined help or avoided it with a string of missed appointments. F2 was often able to provide plausible reasons for his failure to attend. Whilst questions remain around the level of support provided under MAPPA, agencies provided the couple with numerous offers of support and did all they could to encourage their engagement. F1 and F2 actively avoided the good level of support being offered.

3.2.2 Significant issue two

Agencies identified at an early stage that HS would be vulnerable and at risk. An early referral followed by an assessment took place and F1 was subject to a child in need plan. The period from autumn 2015 to spring 2016 was a critical period in the application of child protection procedures.

- **Did agencies follow statutory guidance in an efficient and effective way?**
- **Was the application of procedures proportionate?**

The risk posed by F2 and the vulnerability of F1 meant that HS was at risk. This was identified as soon as F1 declared her pregnancy.

The first referral occurred when a midwife conducting an ante-natal appointment, in autumn 2015, established that F1 had been the subject of a domestic violence incident by F2. The midwife immediately made a referral to SCSC. Very quickly agencies responded. A section 47 single assessment was initiated and a multi-agency safeguarding hub (MASH) meeting convened. A 'cause for concern' form was also completed. The Family Nurse Partnership became engaged and placed F1 on the Family Nurse Partnership (FNP) programme.

A good quality assessment was completed within the correct and appropriate timescales. A multi-agency meeting was held and F1 was placed on a child in need plan. At the learning event practitioners agreed that they had identified the risk to the unborn child and were clear that the plan they developed had to be comprehensive and well-coordinated. The evidence suggests that this was the case.

The team leader from SCSC stated that she was of the view that the history of the parents dictated the actions that would need to follow. Her view was that F1 would remain on a CiN until HS was 'viable' when a pre-birth child protection conference would be held. This was agreed by all the agencies involved and this conference could not take place, under the guidance, until F1 was 24/26 weeks pregnant.

These early stages of pregnancy gave the agencies the opportunity to plan and put in place the support HS would need. All the safeguarding agencies used this time well in terms of a strong plan and coordinated work.

All the agencies understood the risks to F1 and the unborn HS. These risks were well documented and entirely proportionate based on the previous history of the parents. The referral was correctly made and treated seriously. Meetings were carried out in a timely manner; an assessment was conducted that was detailed and timely. The decision to place F1 on a CiN plan was correct and the view that an ICPC should be held when F1 was 24/26 weeks pregnant was reasonable and proportionate. The view of SCSC that they should consider legal proceedings as a contingency plan was also a proportionate and correct course of action. In summary, the risk to the unborn HS was understood; there was a good plan and agencies were working together in the best interests of the family unit and the unborn child.

3.2.3 Significant issue three

Significant work was conducted by agencies at the pre-birth phase. To be effective, the pre-birth work needed to ensure that sharing of information and engagement took place between key front line staff.

- **Was this the case?**
- **Were there gaps in the intelligence profile of the family unit?**

This report has documented much of the work put in place to support F1 and F2 prior to the birth of HS. There is evidence that agencies worked together to coordinate their support. This did not include a pre-birth assessment.

There were gaps however in the information sharing process. Child protection meetings were well attended by SCSC and most health professionals. There were some agencies and professionals that did not attend these meetings.

The National Probation Service did not attend meetings. Given the danger posed by F2 this was unacceptable. The National Probation Service were in the best position to ensure that F2 engaged with professionals and to provide an accurate picture of his offender history and any work he had already undertaken. F2 was on licence and consequently the National Probation Service could dictate to F2 the work he should undertake whereas other agencies could only advise and persuade him to engage. The probation officer did engage with other professionals and submitted a report to the first RCPC. Professionals were able to quote F2's probation officer in terms of comments made by her about him. These comments were generalisations and it is not clear whether the evidence supported these comments. Unfortunately, professionals treated comments made by the probation officer as important and they added to a general sense that F2 had made significant improvements that reduced the risk he posed to F1 and HS. The National Probation Service have not been able to provide any further detail around their engagement and did not attend the learning event.

The General Practitioner (GP) also agreed that there were problems over sharing some information. The GP did not attend child protection meetings. The professionals at the learning event were clear that GPs did not routinely attend these meetings. The GP explained that GPs did not have time to attend these long meetings and were not compensated if they were to find a replacement to cover their surgery while at a meeting. Professionals and GPs at the learning event agreed that this was a situation that needs to be resolved. GPs can offer an important and unique view of a family and their view needs to be considered when deciding on the future of children and families. It is clear that there needs to be a clear understanding

of how the GP can engage with conferences and core groups. The GP dealing with F1 described how the information about her was available on System One. This is an IT system that is used by many GPs, but by no means all. There are other IT systems available and in some cases GPs do not record information on any shared IT. This is a huge blockage to information sharing. In this case it also seems that the Family Nurse Partnership did not flag HS and their family to the GP and place the correct flags on the system. This meant that the information flow failed in both directions.

In addition to the issue around the use of System One, is a question around what information is held and shared. F2 was not registered with a GP until he moved into the housing scheme, where it was a requirement of residency. F2 registered with a different GP than that of F1. He also registered HS with this new GP. The new GP was unaware that HS was on a child protection plan or the history of F2. This was because all the safeguarding records were linked through a safeguarding node to F1. By the time HS's record reached the second GP (approximately 2 weeks), they had been injured. Whilst this issue did not affect the outcome for HS, it raises a question around where safeguarding issues are recorded. It seems that safeguarding records are held routinely on the mother's health records and there is often nothing recorded on a father's record. This is dangerous as health professionals are left without an understanding of the potential dangers posed by an individual. Health professionals should review the information sharing systems.

At the learning event, there was concern that some professionals were unaware of the referrals made between the GP and CAMHS. This is of concern given the long history of mental health issues suffered by F1. F1 attended at least one CAMHS appointment but declined help, avoided appointments or failed to attend. Given the importance of this issue a failure to share information between professionals resulted in a failure to plan alternatives to deal with these problems. These issues could have been resolved if the GP had been able to attend child protection meetings and CAMHS had been invited and attended.

The lack of a pre-birth assessment is discussed at greater length in the next section but the lack of a pre-birth assessment was a lost opportunity to share information.

There is sufficient evidence to justify the view that information sharing between professionals in this case could have been better. Ultimately, there were some failures in information sharing but it is unlikely to have impacted on the outcome for HS.

3.2.4 Significant issue four

The assessment process, initial child protection conference and subsequent core group meetings and Public Law Outline meetings are statutory child protection procedures designed to protect a child at risk.

- **Were those procedures correctly followed and proportionate?**
- **Were they effective?**

Following the initial referral by a midwife in autumn 2015 a single assessment was completed in respect of F1 and F2. It was a thorough and accurate assessment of the risks that would be posed to the newborn baby. It clearly stated that: *"the prognosis for the baby very poor and almost unachievable"*. It provided an excellent point of reference for agencies as the pregnancy progressed and child protection procedures were considered.

The ICPC took place in March 2016. These were the pre-birth conferences that professionals had agreed should take place at earlier meetings. These meetings were critical in determining the way in which HS would be treated when they were born. Attendance at this meeting was

poor and no explanation has been given as to why several agencies did not attend. This included the Police and National Probation Service.

The first meeting agreed that HS was at significant risk of harm and required a child protection plan in the category of neglect. Parents were present at the meeting. The plan put forward by SCSC aimed to reduce risks to HS by *"close monitoring and a robust support plan".* Discussions took place around residential status of the family. The plan provided showed that child protection visits would be two weekly. Parents were required to engage with the services offered and attend all medical appointments. A legal planning meeting was to be convened to consider a contingency plan for the baby. The plan also included a requirement that assessments should be: *"be prioritised and concluded prior to the baby's birth".* This complied with Sandwell Safeguarding Children Board procedures.

An initial core group meeting took place later in March. This group developed the outline plan agreed at the ICPC. Support from the Family Nurse Partnership, Brighter Futures programme and Sandwell Women's Aid. There were however some significant differences between the outline plan and that developed at the core group. The frequency of visits was reduced to monthly, and it was agreed that instead of a pre-birth assessment there was a request for a post birth parenting assessment. This was not in line with local policies and procedures. The Safeguarding Board has a Pre-birth Assessment Protocol that aims to reduce the delay in planning for babies where there are safeguarding concerns. This decision not to follow protocol is a cause for concern because the assessment should have been a key document when making future planning decisions. There is no explanation as to why this decision was made. It may be the case that the level of knowledge of the family by professionals, led to a view that there was already a clear understanding of the risks. Deciding to work outside of agreed protocols is a risk and should have been clearly explained and recorded at the meeting.

A legal planning meeting then took place. Legal advice was that the threshold was met to commence care proceedings when the baby was born.

The next child protection conference was held in April. By this point F1 and F2 had moved in to the supported housing and the conference had received a report from F1's GP. F2 had not attended the Brighter Futures programme but had stated he missed the beginning of the course and would need to go to the next one. The legal advice was presented to the conference. SCSC put forward their plan that they would commence care proceedings at birth and they had several options for how and where baby would be looked after. They also stated they were carrying out a pre-birth assessment.

This conference was regarded as contentious and difficult. Social workers have stated that they felt the chair did not support their plan. The Chair stated that the other members of the conference were *"shocked"* at plans to initiate care proceedings with the possible removal of the baby at birth. Agencies were impressed by the progress of parents and the co-operation they showed. Social workers pointed out that there were still a number of *"unknowns"* and the parent's relationship: *"remains unassessed".* Whilst the Chair questioned whether the baby could be subject to a CiN plan rather than a child protection plan it was agreed that the child protection plan would remain in place; baby should remain with parents after birth. The Chair summed up the meeting by saying: *"the risks have been reduced based on the information heard today".* This statement was not based on the actual evidence around compliance or the histories of F1 and F2.

Conferences should receive as much information as possible and there should be an environment in which professionals feel able to express their views based on the evidence in their possession. This conference appears to have worked well in that regard, although the differences of opinion between some professionals and social workers were not satisfactorily

resolved. Ultimately, the decision to keep the child protection plan in place was proportionate and correct.

It is of concern that within a relatively short period, several members of the conference were of the view that the risk posed by F2 was reducing. This issue was explored at the learning event. All of those present stated that they continued in their view that F2 was a high-risk individual. They agreed that they were encouraged by the progress of F2 and F1 but were not unrealistic about the risks he posed. The attitude of the parents seems to have been a big influencing factor. This does not appear to have been supported by evidence. It seems that disguised compliance by F1 and F2, and a degree of over optimism, combined to affect decision making.

This case was presented to Sandwell's Resource and Placement Panel and it was agreed parents and baby would move to supported lodgings post birth. In the circumstances, this seems a safe and proportionate decision.

After HS was born, a core group meeting was held. Reports were again positive. It was noted HS's development was appropriate, the baby was happy and contented. The couple were working with the PLO. There was agreement the community-based assessment would be presented at the next core group. The plan was to continue without change.

It was noted that the relationship of the parents appeared to have deteriorated and F1 had a bruise on her face and had had her mobile phone stolen. It is of concern that professionals did not question this. F2 had a history of perpetrating domestic violence, including taking a mobile phone from a previous partner. Professionals accepted the reasons given for the injury. This appears to be over optimism by professionals and warranted further investigation.

Assessments were also undertaken on F1's mother and grandmother concluding that relationships had improved and they could have access to HS supervised by F2.

A final PLO meeting was held in late July. It concluded that the PLO was ended and care proceedings would not be put in place. Given that the conditions of the PLO had been met and there were positive reports about improvement from professionals it is difficult to see that any other decision was possible. However, it is unclear why the deterioration in the parent's relationship and failure to accept support was not discussed. Given discussions at core group meetings also failed to deal with these issues it seems professionals had decided these issues did not materially change the improvements shown by the parents. This was a mistake and is dealt with in this report in terms of information sharing, over optimism and disguised compliance.

Child protection procedures are laid down in statutory guidance and supported by local protocols. Their application is critical to reduce the risk to a child. Whilst these procedures are contained in guidance any deviation needs to be properly explained.
The initial assessment did follow laid down procedures in terms of quality and timeliness. However, pre-birth assessments were not completed and the community based assessment was only concluded on the day HS was found to have been injured. No explanation was given as to why this deviation from laid down procedures was agreed. The most likely explanation is that professionals were in possession of a good deal of information about the couple and the pre-birth assessment was not seen as being required. Whilst this is poor practice it is unlikely to have had a significant effect on the outcome.

ICPCs, core group meetings and the legal meetings were conducted in a timely manner. The ICPC had a very small group with a number of important agencies absence. However, there was a clear plan put forward supported by a contingency plan. It is clear from this meeting

that Children's Social Care had a grip on the need to put strong supervision and support in place.

The first RCPC and the core group meetings began to see a weakening of the initial position. Some front-line professionals were seeing real improvements in the way F1 and F2 were conducting themselves. The conference Chair supported this. It is difficult to understand where there was a solid evidence base for this change of approach. F2, and to an extent F1, could convince professionals they were complying with their requests and this gave members of the conferences and core group a false sense of optimism. F1 and F2 convinced professionals that the reasons they gave for failing to comply with requests, missing appointments and non-attendance at courses were legitimate and reasonable. Another example of this over optimistic view occurred at the final core group meeting. The group had received information from Woman's Aid that the relationship between F1 and F2 had deteriorated and F1 attended the meeting with an injury to her face and reporting her mobile phone had been stolen. These signs should have alerted professionals that the confidence that had begun to develop in the couple might be questionable. Instead they believed F1 when she said she had bumped in to a door and been robbed of her mobile.

Legal planning meetings were conducted in a timely manner and were proportionate.

There are examples of assessments that should have been completed and some questions over the softening of approach to F1 and F2 in the first RCPC and subsequent core group meetings. Some agencies and professionals lacked attendance at vital times. Most notably the National Probation Service, Police and the General Practitioner. However, meetings were productive and effective plans were put in place. The aim to provide close supervision and support was largely met. In summary: despite the shortcomings of some of these processes a robust child protection plan and coordinated support plans were put in place.

3.3.5 Significant issue five

Professionals discussed several options for safely accommodating HS and parents. Safe and stable accommodation for the family was required.

- **Were sufficient accommodation options available?**
- **Was the accommodation provided suitable in the circumstances?**

F1 and F2 were living with F1's grandparents when agencies first became aware she was pregnant. As described in section 2.3.1 the relationship between F1 and both her mother and grandmother was a difficult one and included physical abuse. It was not the ideal situation into which to bring a new baby. F1 had no solutions herself as to how she should be accommodated following the birth of her baby.

Following agreement that F1 would be placed on a CiN plan, agencies sought different accommodation for F1 and F2. They considered placing mother and baby in foster care and considered the possibility of HS being placed alone in foster care. There was agreement amongst professionals that F1 was relying very heavily on F2 and this was likely to continue post birth. As a result, an application was made through the Housing Choice Team and a place was found at a supported housing scheme for the couple. The service provides a pathway to enable parents and their children to develop the skills to progress in to independent living. There is a support worker on duty 24 hours a day.

To be eligible for a place there are a number of criteria that must be met. The most basic of these is the age of the parents. F2 was too old under normal circumstances. Each couple is interviewed and then a risk assessment is undertaken before a place can be offered. F2

presented well to staff at the scheme and his age was overlooked as it was felt the couple fitted the criteria for a place in all other respects. The manager and support worker were interviewed as part of this process. F2's full criminal history was not disclosed to staff at the service in specific terms. They were informed that he had been to prison and that he was still on licence. They were also informed that he had been a domestic violence perpetrator.

The scheme manager contacted F2's probation officer and her note of the conversation stated: *"*[F2] *was not intimidating towards others and has been living in shared accommodation, has been doing really well over the last 12 months, he will accept help. The domestic violence with a partner was a long time back in 2010 when he also breached a restraining order. I asked about concerns of drug misuse,* [probation officer] *stated there had been no issues for some time and that there had been no class A drugs.* [probation officer] *stated that Dad has changed significantly for the better and felt he would do well in supported housing"*. The staff at the housing scheme accepted the application and made a flat available for the couple. They moved in to it in April 2016.

Staff at the housing scheme were very honest about their dealings with F2 and F1. They described F2 as very honest and open about his past and that he presented as a *"charming"* individual. The scheme manager felt that she had undertaken due diligence in the checks on F2. She was clear that if she had known the true extent and nature of F2's criminal history he would not have been offered a place in the housing scheme.

In spring 2016, the couple's case was placed before the Sandwell Resource and Placement Panel and an agreement was reached that the couple would move to supported lodgings, post birth. They moved into these lodgings with an experienced carer. The couple settled well and were prepared for the birth of their baby. There was consideration that if things continued to improve the couple and their baby might move back to the housing scheme later, but that it would be at least 4 weeks after the birth. A place was kept open for them.

Two weeks after HS's birth, the carer at the supported lodgings went on holiday and it was agreed by professionals that the family unit would move back to the housing scheme while the carer was on holiday. This was against the wishes of F1 who said she now felt settled. Professionals developed a support plan and put in place well-coordinated monitoring and support as the family moved back to the housing scheme. The couple remained there until the injuries to HS occurred.

Providing appropriate accommodation for F1, F2 and HS was critical to ensuring the safety of HS. Professionals at the learning event were of the view that there were sufficient options available to them in Sandwell and the decisions around housing had been thought through. When the family moved back to the supported housing a support plan was in place. Post birth, professionals engaged well with the family and a community assessment plan was put in place that coordinated the response given by the agencies.

Professionals agreed that supported lodgings were the best option for the family post birth but circumstances contrived to make this option a temporary one. As a result, a decision was made to return the family to supported housing. It was a pragmatic decision in the circumstances. The community assessment plan that was being undertaken and a coordinated multi-agency plan ensured that there was coordinated support and monitoring of the family daily. However, F2 did not fall within the age gap for this accommodation and furthermore, the service's manager was clear that if they had known F2's criminal history he would not have been offered a place. F1 did not want to return to the housing scheme. Given these facts and the type of offending F2 had previously engaged in, he should not have been housed with young, vulnerable females, including F1, at the supported housing scheme. The family should not have returned to the supported housing post the birth of HS but the

alternative option of community-based accommodation was a worse option for the family and a pragmatic decision was made.

Section Four – Key Themes

4.1 Information sharing between professionals

This case saw some excellent examples of information sharing, but also some areas of concern that require more work from agencies.

It was clear from front line professionals at the learning event that from the point F1 stated she was pregnant, professionals were aware of her vulnerabilities and the potential danger posed by F2. Referrals were made and all of those engaged were discussing the case. Whilst it is clear there were different attitudes towards both F1 and F2 these were openly shared.

The work conducted post birth demonstrated a coordinated approach by professionals. A community assessment plan was being developed and professionals from a number of agencies were involved in this work. It was recognised that returning F1 and F2 to the supported housing scheme with their baby had some risks. As a result, there was a coordinated support plan put in place and professionals were in daily contact with the family.

There were however some significant gaps in information sharing. To be effective all partners who are involved with the family must be involved in the formal child protection process. The ICPC was only attended by social care professionals and the family nurse and community midwife; as such it was not even quorate. This is unacceptable and agencies need to examine their policies to ensure they understand the responsibility they have in this regard.

Whilst attendance at meetings did improve there were issues with specific agencies. The GP for F1 did not attend any conferences or core group meetings. At the learning event, the GP understood that it would have been useful for a representative of the practice to attend. The GP explained that there was not the free time for a GP to leave the practice and that the Clinical Commissioning Group would not cover the cost of employing a locum, so there was potentially a financial penalty. These might be legitimate reasons for the failure to attend but this is an issue that must be resolved. It is unacceptable that a central member of the safeguarding partnership exempts itself from key meetings and whilst the attendance of the GP may not be required, an appropriate level of engagement must be agreed. Another frontline professional pointed out that her lack of understanding of F1's mental health issues (that a GP could have briefed upon), and this affected her view of the case and her understanding of F1's vulnerability.

The probation officer was invited to child protection conferences and core group meetings but did not attend. The difficulties for probation officers have been well documented and there is an appreciation that workloads for these officers are high. In this case, the criminal history of F2 was significant. A number of professionals needed to have a clear view of the potential danger F2 posed to F1 and their baby. Attendance at key meetings might have provided a more factual view of F2. Instead F2 was able to describe work he had undertaken whilst in prison and present a history of compliance, which went unchallenged. F2's failure to attend courses, designed to help him deal with issues around domestic violence, were excused because he described the work he had already undertaken. He appears to have given a false description of that work. When the manager at the housing scheme asked directly for a Probation Service view, she was provided with a positive view of F2. It is unclear what evidence this view was based on.

F2 was subject to MAPPA. F2 was graded at Level 1 and as such would not be under intensive and multi-agency scrutiny. Given the circumstances in which he was living and the fact that his child was to be subject to a child protection plan, a MAPPA meeting could have been held. The MAPPA panel should consider a review of this case and the role of the MAPPA panel in child protection cases.

Front line professionals at the learning event agreed that there was a lack of information sharing between the GP, Family Nurse Partnership and SCSC. One of the reasons for this was the IT system used to hold information. The GP used System One, which is in common use across health systems, although not all. The GP had opened a safeguarding 'node' on F1's health record. This contained details of the child protection plan that was in place. This system was described as cumbersome by professionals and information was not readily available. In addition, the Family Nurse Partnership failed to submit documents to ensure that the case was correctly flagged.

The other issue was that F2 was not registered with a GP and in fact only registered as part of the conditions for residing at the supported housing. When F2 registered, he used a different GP from F1. There was nothing on his health records about his previous history. When HS was born, they were initially registered with F1's GP but for some reason F2 re-registered HS with his own GP. F2's GP was not aware of the safeguarding issues and had no record that HS was on a child protection plan. It was not until HS's health notes were sent that the second GP was aware of the issues and by this point HS had been injured. It is a bizarre anomaly that the safeguarding information concerning a child is only retained on the mother's record and is not registered in any way on the father's health record.

Finally, there must be concern that the housing scheme were not provided with all the information regarding the history of F1 and F2. The housing manager was clear that a risk assessment took place but vital pieces of information were missing. Given the vulnerable nature of many of the residents at the scheme, a full risk assessment should be conducted and for that to be effective a multi-agency meeting should have taken place and that should have included the manager of the scheme. In fact, whilst a member of the supported housing attended the second case conference, no-one from the service was invited to the core group meetings. Support workers at the scheme were aware that the relationship between F1 and F2 was deteriorating following the birth of HS but did not provide other professionals with this information. Support workers at the scheme need to receive higher level safeguarding training and recording systems need to be improved.

There were good examples of information sharing but it did remain an issue in this case and should have been better. In particular: the liaison between the GP and other agencies; the failure to process F2 through MAPPA; the failure of the National Probation Service and GP to fully engage with key multi-agency meetings; and the lack of information provided to the supported housing scheme.

4.2 The use of child protection procedures

Child protection procedures are clearly laid out in Working Together 2015. The key to protecting a vulnerable child is following these prescribed processes in an effective and efficient manner. This relies on a number of critical factors:

- the application of child safeguarding thresholds[12],
- the completion of high quality and timely assessments,

[12] Thresholds – The SCSB produce a threshold document. This provides detail of the criteria that agencies should consider before contacting SCSC to express concern around the safety or well being of a child.

- the following of the statutory guidance regarding child protection conferences and core groups,
- the formulation and implementation of child protection plans.

Whilst these are the key elements to the process the procedures only work if agencies work together and are robust in their challenge of the information upon which they are basing their decisions. Section 4.3 deals in more depth with the assessment process and section 4.4 looks at decision making and leadership. This section is concerned with the effectiveness of the child protection process.

In this case, the application of the thresholds was critical to ensuring that early help was in place and professionals across a range of agencies understood the risks to HS. In this case the initial referral was made by the midwife who had dealt with F1. The referral was made on the basis that F1 disclosed some level of domestic violence. The referral was timely and appropriate. There was no opportunity to make an earlier referral. The referral immediately triggered a strategy meeting and as a result an assessment commenced. This was excellent practice by all of those involved and by the midwife, in particular. There is no doubt that her prompt action was a major contributing factor in ensuring pre-birth planning was put in place.

At the pre-birth ICPC, which was held in a timely manner, it was agreed that the case met the threshold for the unborn baby to be subject to a child protection plan in the category of neglect. The conference also agreed that the Public Law Outline process should begin. This was an appropriate and proportionate response.

Whilst the initial child protection conference was poorly attended this was remedied by a second conference. The lack of attendance by the probation officer and GP was an issue and this needs to be improved. In terms of the frequency of both conferences and core groups there is little to say other than they were held at appropriate intervals and within the timescales set in statutory guidance.

The use of the Public Law Outline was an important part of the child protection process. This was again dealt with appropriately. A legal planning meeting took place at the end of March and the Public Law Outline was agreed. Legal planning meetings were held regularly and the Public Law Outline was finally completed in July 2016. Children's Social Care had thought from the outset that HS would be subject to legal proceedings. The legal protocols were correctly applied and were thorough. Some professionals felt they were applied too strictly and were unfair to F1 and F2. Given the history of F2 and the vulnerability of F1 the legal process was fairly and proportionately applied. At the completion of the Public Law Outline it was obvious that any attempt to apply for any separation would not succeed given the Public Law Outline had been complied with and some professionals were reporting positively about F1 and F2 and their care of HS. In other words, it is highly unlikely that any further legal process would have been successful at the completion of the Public Law Outline.

The planning process resulted in a clear child protection plan for HS. This was a multi-agency plan and ensured that HS would be well monitored by agencies. The initial child in need plan had provided both F1 and F2 with opportunities to prepare for the birth of their baby and to deal with the underlying issues that were of concern to professionals. The fact that neither F1 nor F2 took advantage of the support being offered is dealt with in section 4.4.

In summary, child protection procedures and statutory guidance were followed in this case. The thresholds were met for referrals and the unborn HS was placed on a child protection plan that would have reduced risks and provided the family with every opportunity to succeed. Statutory meetings were held in a timely way and the Public Law Outline was correctly applied. No further legal proceedings took place because it was correctly assessed that this would not be proportionate or likely to result in any legal action. This assessment was correct in the

circumstances. There are areas for improvement, particularly around attendance at meetings, but child protection procedures were correctly followed in this case.

4.3 The quality of assessments

The assessment process is critical to ensuring that decisions at conferences and by professionals are made based on accurate facts. They should leave professionals with a clear picture of the family and the risks posed to the baby.

A single assessment was conducted by a social worker following the initial referral and strategy meeting. The assessment was completed whilst F1 was on a child in need plan. The assessment is comprehensive and provides professionals with a clear and factual description of F1 and F2's backgrounds. The report concluded that the prognosis for HS was *"very poor and almost unachievable"* with risk factors outweighing protective factors. It provides details about the couple's histories of violence. Combined with the physical, emotional and practical demands of caring for a baby 24 hours a day, and the issues the couple faced around jealousy, financial difficulties and poor mental health, the situation was understandably described as: *"a recipe for disaster".* This assessment was of a standard that would be expected in the circumstances and provided a stark and accurate view of the couple.

At the ICPC in March 2016 the local authority stated that pre-birth assessments should be completed as a priority. However, when the child protection plan was developed at the subsequent core group meeting this was changed to: *"social worker to undertake parenting assessment once baby is born".* One of the difficulties that social workers encountered was that the grandmother of F1 would not allow access to her home and hence it was not possible to begin the assessment until the couple moved to supported housing. There were several pre-birth assessment visits recorded but no evidence was provided that a final pre-birth assessment was completed. This was poor practice and whilst there were practical difficulties in producing the assessment, the lack of an analytical document (detailing the combined difficulties faced by the parents) left professionals with an information deficit when understanding the parenting ability of F1 and F2.
Following the birth of HS, a community-based assessment plan was put in place. This aimed to determine whether the parents had the capacity to care for the baby and the ability to prioritise the baby's needs and ensure they provided safe and appropriate care. A number of visits took place and there was a coordinated approach by professionals across agencies to ensure they saw the family at appropriate times. The carer at the supported lodgings was also interviewed. This assessment was not presented before HS was injured. A draft version did conclude that: *"the most appropriate course of action for HS is to live with their parents and to experience a consistent and stable home environment where all of their needs can be met….The LA* [local authority] *will continue to monitor the concerns highlighted in this parenting assessment through the child protection plan".* It must be emphasised that this was a draft report and as such was subject to amendment.

Sandwell Safeguarding Children Board's child protection procedures state that '*a pre-birth assessment should be undertaken on all pre-birth referrals as early as possible, preferably before 20 weeks*.' The Board has a Pre-Birth Assessment Protocol, which aims to reduce the delay in planning for babies when there are potential safeguarding concerns. It confirms that the Children and Families Service will lead on the assessment and care planning and highlights that '*the importance of compiling a full chronology and family history is particularly important in the assessment of risk and likely outcome for the child*.' This is reflected in SCSC's internal procedures, which state that '*A risk assessment of the parent(s) should be undertaken immediately the social workers are made aware of the mother's pregnancy and should be completed four weeks before the mother's expected delivery date and disclosed to the parent(s) and their solicitor where relevant.'*

Therefore, the lack of a thorough and robust assessment prior to the baby's birth was not in line with local policies and procedures. This is concerning because an assessment should have informed the decision-making, for instance at the child protection conference in April and at the legal planning meetings. The first assessment provided a solid foundation on which to build the case for a robust child protection plan. Unfortunately, this was not followed by pre and post birth assessments. This left professionals to make decisions and form opinions without all of the facts.

4.4 Professional curiosity and disguised compliance

There is evidence that both parents engaged in disguised compliance. This was particularly true of F2.

'Disguised compliance' involves a parent or carer giving the appearance of co-operating with child welfare agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention. The term is attributed to Peter Reder, Sylvia Duncan and Moira Gray who outlined this type of behaviour in their book *'Beyond blame: child abuse tragedies revisited.'*

F2 is described in various ways by professionals, and was regarded by some as *"charming"* and invariably as *"honest and open about his issues"*. F2's probation officer believed he was a changed and improved person. Many professionals stated that he was *"believable"* and that he clearly wanted to improve the situation for his family. The fact that F2 was so *"open and honest"* potentially masked worrying behaviours that were, consequently, overlooked.

F2 lied about rehabilitation work he had undertaken and so was not properly questioned about his repeated failure to attend support groups. He was referred to the Brighter Futures programme, which runs groups for perpetrators of domestic abuse, but he proved difficult to contact and twice failed to attend appointments and as a result could not join the groups. F2 was referred to IRIS in respect of drug-use and stated he attended one session. It is apparent that he had no intention of attending these groups or completing a full course. His references to previous work he had undertaken (without being required to provide evidence) and his apparent willingness to admit to his failings, was seen by professionals as a positive trait. Professionals were also informed about potential drug taking but again F2 admitted to some failings and convinced some professionals it was not an issue.

Both F1 and F2 co-operated well with some agencies, but not with others. There were very positive reports from the midwife and family nurse practitioner, who were impressed by the couple's engagement and commitment to caring for HS. They also co-operated with the social workers and were at home for appointments. They attended the conferences and core group meetings. Most of these appointments and meetings were with the couple together. F1 engaged with a social worker and was open about the growing difficulties in her relationship with F2.

It is recognised that in cases where domestic abuse is a concern disguised compliance is a common factor.[13] When F1 attended a core group with F2 in July 2016 she had bruises to her face and had reported her mobile phone stolen. The reason given for the bruising was that she had walked in to a fire door at the supported housing. Professionals were too easily convinced by this argument. However, F1 spoke regularly with a support worker from

[13] Domestic Abuse: Learning from case reviews. Summary of risk factors and learning for improved practice around families and domestic abuse. NSPCC 2015.

Women's Aid and did not state she had been assaulted although the support worker believed that she implied this was the case.

It is unlikely that practitioners were getting a true picture of what family life was like for HS. Given F1 and F2's previous involvement with agencies, they would have had experience of what to say and what not to say. This would have been reinforced by F1's experience in her own family who were clearly reluctant to engage with SCSC. It is apparent that F2 could present well, was articulate and appeared to be compliant.

SSCB's Safeguarding Children Procedures contain a section on Families who resist change [14]. This refers to resistance to change being '*masked by superficial co-operation'* and to the common feature in all cases being a failure to change and a refusal to acknowledge or address the risks to the child's welfare. This may well reflect F2's attitude. Action recommended in the Procedures include arranging a review of the risk assessment, to ascertain whether this indicates any change to the risk to the child, and convening a core group meeting to discuss. Such actions would have been helpful in considering the implications for HS's safety.

There was evidence that some professionals had become concerned that they might be subject to disguised compliance. A family nurse practitioner asked her supervisor to visit F1 and F2 to ensure she wasn't being over optimistic in her view of the family and a social worker in her supervision meeting with a team manager raised the issue of whether F2 had been controlling and manipulating professionals.

SCSC did remain to some extent sceptical of the progress being made by the family and documented discussions took place in summer 2016 about whether sufficient resources could be put in place to support the family living at the supported housing scheme and about the community parenting assessment and multi-agency plan which ensured daily contact with the family. They were clear in these discussions about the risks that were being managed. They were: baby's care and bonding; F2's substance misuse; potential domestic abuse; F1's wellbeing; parents' deteriorating relationship.
However, from reading the records, it is possible that some practitioners were keen for the family to succeed and impressed by their day to day care of the baby, who was progressing well. Risk factors in relation to the parents combined histories may have been minimised, so that when concerns arose about the growing indications of difficulties in the parents' relationship, domestic violence and drug use these were not followed up robustly nor was a risk assessment undertaken of the implications of these developments for the safety and wellbeing of HS, who was a vulnerable baby.

Some professionals focussed on the parents' current presentation, rather than remaining mindful of the risks posed by the couple's combined backgrounds. The over optimism of some professionals and the skill that F1 and F2 exhibited in disguising the true picture of their circumstances, influenced decision making by some professionals.

4.5 Leadership and decision making

The decision to make a referral was a good one and resulted in an immediate response from agencies. The single assessment conducted by SCSC provided sufficient information for them to make some immediate and correct decisions. When SCSC attended the ICPC they did so with a clear plan. They took the view that post birth the baby would be subject to a child protection plan and the local authority would initiate care proceedings with a view to the baby being placed in foster care or residential care with parents. They presented this plan at the meeting. It showed strong leadership and good decision making.

[14] West Midlands Safeguarding Children Procedures, Chapter 2.13: Families who resist change (including disguised compliance).

However, by May 2016 the plan initially presented had been changed with a view to allowing the baby to remain in the parents' care with a community based assessment being conducted. The RCPC in mid-April appears to have been a turning point**.** The Chair and other agencies were not in support of the plan presented by SCSC. The Chair of the conference commented that other agencies were *'shocked'* by the idea that legal proceedings might be considered. Further information was presented to the conference about F1's mental health and that the parents had been and continued to co-operate with agencies. There was also a plan to house the family. The Chair of the conference was of the view that the risk had reduced and that this case could possibly be managed through a child in need plan. However, the decision was that the child protection plan should continue and that HS would be placed with their parents post birth. In discussion, the Chair observed that the conference had fuller information and a '*truer picture'* of the family. This is open to challenge as whilst the information presented was important, it did not significantly alter the potential risk to the baby. which was not yet fully assessed and understood. To some extent the threat of legal proceedings was reduced when accommodation was found and the PLO completed.

There seems to be little evidence to support a weakening of the initial plan although the completion of the PLO is particularly relevant. Leadership in these key meetings was lacking. SCSC were clear about the risks but the lack of a pre-birth assessment and the delays in any post birth assessment were not challenged. Some professionals wanted to see a further stepping down but SCSC maintained its position. Strong leadership by SCSC was not reflected elsewhere in the process and the conference chair should have done more to achieve a consensus amongst professionals. SCSC could have been challenged to speed up the assessment process and other professionals asked to be more evidence based in their views. The Independent Reviewing Officer (IRO) should also have taken a more pro-active role at this point.

The conference chair was working with the information provided and this was not always the complete picture. It would have been good practice for the chair to have been informed when the family left the supported lodgings and returned to the housing scheme and when the PLO process was ended. The IRO and the conference chair could have shown stronger leadership in this case and work should have been undertaken to resolve the differences between some agencies and SCSC.

A decision was taken following completion of the PLO that there would not be an application to undertake further legal proceedings. Given the fact that the PLO was successfully completed and many professionals were reporting positive outcomes, this was a reasonable and proportionate decision. It is highly unlikely that any further legal proceedings could have succeeded and indeed would have probably drawn criticism in terms of proportionality.

Perhaps the most controversial decision was that relating to the accommodation provided to F1 and F2. The initial decision to place F1 and F2 in to supported lodgings following the birth of HS was a good one. The work undertaken to provide an alternative to F1 other than her grandmother's home was very positive. It is unfortunate that the carer at the supported lodgings went on holiday, it is difficult to understand why this wasn't foreseen. However, a pragmatic approach was taken when returning the family to the housing scheme. The supported housing scheme was not aware of the entire history of F2 and if they had known they would not have accepted them. In addition, F2 was too old to enter the scheme. In these terms, the scheme should not have been considered. However, what was the alternative? It is unlikely that legal proceedings would have succeeded and the reality is that community based accommodation would have been found for the family. Whilst moving the family back to supported housing was not the ideal solution it was pragmatic and considerable support was in place to mitigate risk. It would be unreasonable to assume that by not returning the

family to supported housing HS would have been unharmed. It was a reasonable decision in all the prevailing circumstances.

Section Five – Voice of the Child

It is understandable that in the pre-birth phase the focus was on ensuring that the parents could look after their child when born. In fact, this review has seen a large amount of evidence that in the pre-birth stage the focus was absolutely on the safety of the baby. Both parents were offered various support and help with their issues. Any reluctance by professionals to see legal proceedings invoked was born out of an understanding that the best outcome for HS would be to grow up in a safe and caring environment provided by their parents.

Unfortunately, some professionals were over optimistic. Conferences and core groups had parents present and the attitude of the parents brought them considerable empathy and a degree of support. It is often difficult to judge the point at which this empathy for the parents increases the risk to the child who has no voice.

The work conducted when the family returned to supported housing post birth was focussed very much on ensuring HS was safe and being properly cared for. There is no doubt from the evidence provided that HS's physical needs were being met. The Family Nurse Partnership were concentrating their effort in ensuring that F1 could look after HS and took practical measures to ensure that was the case.

SCSC were particularly forthright in their concerns for HS and in fact other professionals criticised them for failing to take account of the feelings of F1 and F2. This perhaps demonstrates and supports the other evidence that whilst empathy and over optimism by some professionals may have affected decision making. Ultimately, all of the professionals involved were clearly determined to see that HS was kept safe.

Section Six – Key Findings

This section summarises some of the key issues and provides an overall finding.

The key findings are:

- the initial referral and strategy meeting was timely and correct it represented good practice,
- information sharing was at times poor and resulted in some professionals being unaware of key issues,
- with the exception of the initial single assessment, pre-birth and post birth assessment protocols were not followed,
- some professionals were over optimistic about the parenting ability of F1 and F2,
- F1 and F2 were capable of disguised compliance,
- some professionals lacked professional curiosity when dealing with F1 and F2,
- child protection meeting procedures were adhered to,
- Children's Social Care demonstrated good decision making and positive leadership,
- child protection conferences failed to resolve differences between professionals,
- over optimism and sympathy for F1 and F2 by some professionals, including the conference chair, caused confusion about the long-term plan for the family and resulted in less understanding of the risk posed by F1 and F2,
- the legal planning meetings and Public Law Outline were proportionate in their actions and conclusions,

- the decisions around accommodation of the family were reasonable and pragmatic in the circumstances,
- throughout the pre-birth and post birth period F1, F2 and HS were well supported by professionals,
- regular and appropriate contact was maintained with the family throughout the review period.

These bullet points are a summary of a difficult and complex case. There are improvements that can and should be made to child protection procedures in Sandwell, but ultimately professionals have remained engaged in this case throughout and acted in the best interests of HS. In hindsight, it is easy to assume that the injuries to HS could have been prevented. In fact, the risks to HS were identified and understood by most professionals at an early stage and considerable work was carried out to mitigate the risk to HS and protect them. These mitigation factors failed to be effective because HS was allowed to remain with their parents who ultimately are responsible for their injuries. The only option that could have provided the degree of protection that in hindsight was required was to separate HS from their parents. There would not have been sufficient legal grounds to put that action in place.

The overall finding of this review is:

Professionals identified at a very early stage the risk posed to HS by parents. They acted quickly to put a plan in place to protect HS when they were born. While better information sharing and less optimism about the parenting capabilities of F1 and F2 would have potentially improved decision making; the level of protection and support provided to HS was reasonable and proportionate in the circumstances. The prospect of legal proceedings was considered, but would have been unlikely to succeed; this was the only additional protective factor that may have been afforded to HS.

Section Seven – Recommendations

The recommendations of this review are:

1. Sandwell Safeguarding Children Board should hold a post event learning work shop for professionals. This review should be used as a case study for professionals to understand their responsibilities and improve understanding of;
    a. pre and post birth assessments,
    b. child protection conferences and core groups,
    c. information sharing,
    d. disguised compliance,
    e. conflict resolution.

2. The local authority should review the protocols in place with those accommodation providers who are engaged with vulnerable adults and children. Specifically, they must ensure that training standards for staff and information recording and sharing practices are in place and understood.

3. Sandwell Safeguarding Children Board should facilitate a meeting of senior officers to agree a protocol for attendance and participation at key meetings. In particular, child

protection conferences and core groups. This should include; the National Probation Service, Police and General Practitioners.

4. The Sandwell Safeguarding Children Board should seek assurance from the MAPPA Panel that it is reviewing its role in cases involving offenders that are playing a key role in child protection. In particular it should seek assurance about the role of the National Probation Service in child protection cases.

Conclusion

F1 had been regarded as a vulnerable person for most of her life and had been subjected to and perpetrated violence. F2 had a significant criminal past and a history of violent crime, robbery and domestic abuse. This was a toxic mix and their baby was always going to be at high risk. An early referral by F1's midwife ensured that agencies became engaged with the couple at an early stage in F1's pregnancy. A strategy meeting took place and F1 was placed on a child in need plan. Sandwell Children's Social Care undertook a detailed assessment that ensured that professionals understood the risks. Children's Social Care showed strong leadership and good decision making when agreeing that, at the earliest possible opportunity, the unborn HS would be the subject of a child protection plan. A legal planning process would provide a contingency, and be in place upon the birth of HS.

Throughout the pre-birth phase, professionals were heavily engaged with the couple. F1 was offered support with mental health issues and parenting skills. F2 was offered significant help and support with his drug, domestic violence and parenting issues. Whilst the couple demonstrated to professionals that they were engaging and F2 was able to convince some professionals of the progress that he was making, the couple were continually missing appointments. Some professionals were over optimistic and F1 and F2 were able to present themselves in a positive way; this was 'disguised compliance'. Pre-birth assessments did not take place and a post birth assessment was not completed until HS had been injured. These assessments may have prevented some over optimism by professionals and presented the couple in a more realistic light.

A series of legal planning meetings were held and a Public Law Outline was in place. This could have provided a legal solution if professionals believed that the risk to HS remained so high as to make it dangerous for them to reside with their parents. Given the support supplied to F1 and F2 and the more positive view of many of the professionals, the requirements of the Public Law Outline were met; it is highly unlikely that any form of legal application to separate HS from their parents would have been successful.

Professionals did work well together but there were gaps in the information they were sharing and both F1's GP and F2's probation officer were unable to attend key meetings. While reports were provided to child protection meetings the attendance of key professionals at conferences and core groups is an essential part of the safeguarding process.

When HS was born they were placed along with parents in supported lodgings with 24-hour support. Unfortunately, circumstances changed when that accommodation became unavailable and the family moved back into a specialised housing project. This was not an ideal solution but was unavoidable. Considerable and well-planned support was in place to mitigate any risk to HS. The relationship between F1 and F2 deteriorated following the birth of HS.

Professionals did not at any stage reduce the almost daily support offered to the family. There are areas that can see some improvement by professionals, but ultimately, they acted throughout in the best interests of HS. Despite the support in place and the best efforts of

professionals, HS received serious non-accidental injuries while alone in the care of their parents. They must take full responsibility for those injuries.

Appendices

Appendix One – Terms of reference

Sandwell Safeguarding Children Board Terms of Reference in respect of HS

The period of Review for this Serious Case is from the point known that parents began a relationship in May 2015 to August 2016, when the incident occurred. Reference should however be made briefly about the extent of agency involvement prior to this period (if relevant and appropriate).
Agencies that identified significant background history (where relevant) on family members predating the review period and subsequently should submit a brief summary account of that history. An example is a summary of HS's mother's educational history.
All agencies should review all records held electronically, on paper or in patient held records.
Individual management reviews should be completed using the template provided by Sandwell Safeguarding Children Board.

Genogram

All agencies should submit a genogram using guidance supplied by Sandwell Safeguarding Children Board.

Chronologies

All agency chronologies should include significant events only and information about when HS was seen and any observations about his behaviour and/or demeanour.

IMRs

The following agencies should submit reports on the template provided by Sandwell Safeguarding Children Board:

- Children's Social Care
- SWBH NHS Trust
- West Midlands Police
- Probation
- BCPFT
- Sandwell and West Birmingham CCG
- WMAS
- Education
- Sandwell Women's Aid
- Sandwell Supported Housing Scheme
- Brighter Future

The Terms of Reference are as described in Working Together

- Keep under consideration if further information becomes available as work is undertaken that indicates other agencies should carry out individual management reviews.
- To establish a factual chronology of the action taken by each agency.
- Assess whether decisions and actions taken in the case comply with safeguarding procedures.
- To determine whether appropriate services were provided in relation to the decisions and actions taken in the case.
- To recommend appropriate interagency action and learning from the case in the light of the findings.
- To assess whether action is needed in any agency.
- To examine interagency working and service provision for children.
- To establish whether interagency and single agency policies and procedures supported the management of the case.
- Consideration how and what contributions can be sought from family members.
- To establish lessons for practice and clear recommendations and an action plan from the overview report.

Key Lines of Enquiry and Scope of the Review

- **How did professionals incorporate family history into assessments?**
  Agencies should give an analysis of how this was implemented.
- **Did professionals fully understand the way in which HS was being parented during the scoping period?**
  Agencies should explain the assessments that formed the basis of the agencies understanding of the family situation at the time.
- **Were all caregivers and extended family members appropriately involved in the assessment process? Was the child seen with all the caregivers and were they seen in their home environment?**
  Agencies should state what observations took place of the child, their context and follow up actions if any.
- **How robust were the pre-birth assessments?**
  Who was included in this and how was it carried out and monitored?
- **Were professionals feeling uncertainty about this case and if so were they discussing with their supervisors / managers or safeguarding leads. ?**
  Agencies should comment on supervision sessions and whether individual practitioner concerns were acted upon.
- **Was information sharing across agencies adequate in this case? Were internal processes in place to facilitate the fullest possible sharing of information?**
  Agencies should comment on methods of communication used, what was shared and when.
- **How were thresholds applied during the scoping period?**
  Agencies should comment on how individuals complied with child protection procedures?
- **How did professionals challenge parental explanations of bruising and injuries to mother and HS?**
  Agencies should comment on whether and how professional curiosity was exercised during the scoping period. Was there acceptance by professionals of the parents' explanation and plausibility when injuries were apparent? Did professionals seeing bruising make assessments regarding how they may have been caused?

  Lines of enquiry for individual agency reports
  The supported housing scheme should include in their IMR their detailed arrangements and criteria for accepting cases. They should indicate the amount / nature of supervision available to clients and whether specific support / supervision plans are devised for each case. (If so what was the plan for this case). They should also specify their commissioned number of cases and staffing and indicate the number of cases at the accommodation and staffing levels during the scoping period.

  All agencies should consider whether their policies, procedures, management and supervision resources adequately supported professionals working this case and aided appropriate decision making and professional judgement..

In addition to the requirements of Working Together to Safeguard Children the overview report writer will:

- Comment on whether the IMRs have addressed these Terms of Reference and all relevant issues.
- Analyse the inter-agency working assessments and provision of services.
- Determine whether actions taken, decisions made were in accordance with current safeguarding policies, procedures and practice.

- Comment on professional judgement and decision making based on evidence.
- Consider what different decisions if any may have led to a different conclusion.
- Identify whether more could have been done, the lessons learnt and make findings and recommendations.
- Provide an executive summary.
- Interview any relevant family members if appropriate
- Involve agency decision makers in an interim and final analysis of the decision making in this case based on the available information and case material presented
- Present the findings to the Sandwell Safeguarding Board and Partner agencies as a learning event if so invited.

Sandwell Safeguarding Children Board will follow Working Together 2015 which states:

'The LSCB should oversee the process of agreeing with partners what action they need to take in light of the SCR findings, establish timescales for action to be taken, agree success criteria and assess the impact of the actions.'
Working Together 2015, Page 79