



# Serious Case Review

Overview Report

Child LK

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\* NB: In order to protect identities, pseudonyms have been used throughout this report

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## Foreword

The untimely death of a child is always tragic and this is no exception. Rose's birth had been premature and the pregnancy concealed up to that point. Rose's mother had a history going back some years, which involved an incident of harm to a child. When she reported her pregnancy with Rose's sibling, services became actively involved and, following assessment, she was judged to be a person who could be trusted to care for her daughter, Daisy, although with the support of a care order. When Rose was born she had complex needs, due to her prematurity, and was also made subject of a care order on the basis of support to her mother to care for both children at home. Sadly, Rose died in 2017 and her mother was subsequently convicted of her murder. A support package was in place at the time of Rose's death.

This report sets out the findings of a review of multi-agency practice in respect of the support offered to Rose, and her sibling Daisy. The publication of the review has been delayed by legal constraints associated with court proceedings.

The purpose of the review is to identify any lessons arising from the case and the report seeks to pull out areas of good practice as well as areas where practice improvements need to be made. It covers a period of two years and 3 months in 2015-17, but also looks back at a connected situation which involved the mother in 2004.

Findings from the review are set out in detail in the report.

A number of the lessons which arise from the scrutiny of this case have been identified in other Reviews, either here in Lancashire or elsewhere. Bringing about changes in professional practice is not an easy task but I know readers of this report will reflect on the implications for the conduct of their own work.

While responsibility for Rose's death sits with her mother, it is always possible, with the benefit of hindsight, to identify opportunities to improve practice. The author of the report has made 17 recommendations for the Safeguarding Children Board to consider. In addition a number of agencies have developed their own single agency action plans. These, together with actions agreed by the Board, are monitored regularly and many are already complete. It is my hope that actions taken will contribute to the reduction of risk in the future.



Jane Booth  
Independent Chair  
Lancashire Safeguarding Children Board

**Child LK****“Rose”****Died 2017**

This serious case review was commissioned by the Independent Chair of Lancashire Safeguarding Children Board (LSCB) on 24 May 2017 in agreement with the recommendation of the LSCB Serious Case Review Sub Group that the circumstances surrounding the death of a child met the criteria for a serious case review (SCR).

**Subject of the review**

Child LK: Rose

Rose is not the real name of Child LK but the review will refer to her in this name to protect her real identity. The name has been chosen in consultation with Rose’s father and his family.

Sadly Rose died in 2017 after being seriously harmed. She was aged 8 months.

Rose had a sister who was also the child of father and the same mother together. The sister will be referred to as Daisy throughout the review, which is again a pseudonym chosen in consultation with her father and his family. Daisy was nearly 2 years old at the time of Rose’s death.

**Legal Context**

A serious case review was commissioned by Lancashire Safeguarding Children Board, following agreement at Lancashire Serious Case Review Sub Group in accordance with *Working Together to Safeguard Children (Department for Education 2015)*, which was the version of *Working Together* relevant at that time.

Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006 sets out the functions for LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB’s function in relation to serious case reviews, namely:

5. (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.
- (2) For the purposes of paragraph (1)(e) a serious case is one 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.

Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii)) must always trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), unless there is definitive evidence that there are no concerns about inter- agency working, the LSCB must commission an SCR.

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## Methodology

The methodology used was based on the Child Practice Review process (*Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012*).

This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for local safeguarding children boards to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which are succinct and centre on learning and improving practice.

However, because a review has been held, it does not necessarily mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of safeguarding boards is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the boards may identify additional learning issues or actions of strategic importance. These may be included in the final review report or in an action plan as appropriate.

The opportunity to conduct serious case reviews in this, and other ways, is as a result of the change in statutory guidance following *The Munro Review of Child Protection: Final Report: A Child Centred System, May 2011*. Munro suggests that local safeguarding children boards should use any learning model which is consistent with the principles in the *Working Together to Safeguard Children Guidance: Learning and Improving, HM Government 2015*.

Following notification of the circumstances of the death of Rose, and agreement by the chair of the Lancashire Safeguarding Children Board to undertake a SCR, a review panel (to be known as the Panel) was established in accordance with guidance. This was chaired by Detective Inspector Allen Davies of Lancashire Constabulary (to be known as the Chair).

The Panel included representation from relevant organisations within Health, Children's Social Care, the Police, the National Society for the Prevention of Cruelty to Children (NSPCC) and the Children and Family Court Advisory Service (CAFCASS). Information was also provided for the Panel to consider by the National Probation Service and an independent sexual health organisation.

Amanda Clarke, an independent reviewer from Derbyshire (to be known as the Reviewer) was commissioned to work with the Panel and to undertake the review.

The Panel identified the review timeframe as commencing 01/01/2015 and ending 21/04/17 which was when Rose died. The Panel had agreed that this was an appropriate period to review services relating to Rose and her sibling Daisy, on the understanding that historical information would be considered and shared where relevant, and to provide context.

A connected set of circumstances to which Mother was linked, involving a different young child in 2004 was also examined by the Panel. Some, but not all, agency records from the events many years before were available for scrutiny to inform the review.

Full terms of reference for the review are included as Annex 1.

All relevant agencies reviewed their records and provided timelines of significant events and analysis of their involvement for the identified review timeframe. These were considered by

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the Panel and provided opportunity for Panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the Reviewer with the Panel and informed of the areas of interest that required further exploration and consideration. The process also allowed for the identification of the key practitioners required to attend a learning event in order to understand the detail of the single and interagency practice in this case.

The practitioners' learning event was held in March 2018 and was attended by fifteen professionals. Most practitioners attending had had direct involvement with Rose and/or Daisy. Unfortunately, due to the non recent period during which the injuries were caused to the other child most professionals involved in 2004 were not available to take part in the learning event in 2018.

The Reviewer facilitated the learning event assisted by the Chair of the Panel and officers from Lancashire Safeguarding Children Board. Those attending who had not worked directly with the children were able to provide the position and perspective of the service delivered to the family.

The event was organised in line with Welsh Government guidance (*Child Practice Reviews: Organising and Facilitating Learning Events, December 2012*) and minutes were recorded. With the support of Panel members and the Lancashire Safeguarding Children Board team, further enquiries were made with professionals who were unable to attend the learning event, and this information is included in the report.

Following the practitioners' learning event, the Reviewer collated and analysed the learning to date for discussion with the Panel. Practice issues and themes originally identified by the Panel were re-examined in the light of the findings of the review. This provided opportunity to identify issues requiring further clarification with practitioners or managers. In reviewing the findings, the Panel gave consideration to what could be done differently to further improve future practice. A draft report was provided to the Panel in advance of the Panel meeting in July 2018. The report contains learning themes for the Lancashire Safeguarding Children Board to consider in developing an action plan to ensure learning from the case is embedded in future practice.

### **Circumstances and history resulting in the review**

In September 2004 serious injuries were discovered to a very young child who cannot be identified for legal reasons. There was suspicion that the person this report is referring to as Mother, who was involved in the care of the child at the time, was responsible. Mother did eventually make some partial admissions as to responsibility for the injuries being caused.

After a police investigation the Crown Prosecution Service were consulted in 2004 and 2005. After the evidence had been considered, including the direction that certain information was inadmissible, the person known as Mother was not prosecuted at that time for any criminal offences relating to the injuries.

The NSPCC were commissioned to undertake a specialist risk assessment of the person known as Mother and judgements from the assessment are reflected where relevant throughout the report.

Services became aware of Mother being pregnant with Daisy, the sibling of Rose, in early 2015. Daisy was born in 2015. Mother gave birth to another child, Rose in 2016 after a concealed pregnancy. In 2017 Rose sadly died and subsequently Mother was charged with

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her murder. At the same time she was also charged with serious assault offences for the injuries caused to the child in 2004.

In 2018 Mother was convicted on all criminal charges relating to the two separate children.

The following is a summary of key episodes and involvement of services with Mother and the children during the identified review timeframe. Analysis is included later in the report.

Date	Incident or involvement
January 2015	Mother booked as pregnant with (unborn) Daisy, the elder sibling of Rose. She disclosed to the community midwife her previous involvement with children's social care in 2004 regarding injuries caused to another young child. An immediate referral was made to children's social care about the unborn child.
9 March 2015	A pre birth assessment was completed.
30 March 2015	Initial child protection conference <sup>1</sup> held regarding the unborn child (Daisy). The decision of the conference was to place the unborn child on a child protection plan <sup>2</sup> under the category of risk of physical abuse.
10 April 2015	After an initial core group meeting Mother disclosed to the allocated early help outreach worker that she had felt suicidal at the fear of having the baby removed from her care.
14 April 2015	Pre proceedings <sup>3</sup> meeting where it was identified that Father had a learning difficulty which required further assessment. It was also concluded that Mother had not acted on any recommendations made as a result of the NSPCC risk assessment in relation to addressing concerns which related to the incidents in 2004.
30 April 2015	Antenatal contact by health visitor to Mother's home which was described as warm and appropriately furnished. Mother disclosed she has very little support from family or friends, and that the pregnancy was as a result of a "one night stand". Mother said she was undergoing a parenting assessment by children's social care.
5 May 2015	Core group meeting <sup>4</sup> . Father had had three assessment sessions. It was alleged by Mother that he was in a casual relationship with another woman and there may

<sup>1</sup> The purpose of an initial child protection conference is to bring together family members, the child (where appropriate), supporters/ advocates and those professionals most involved with the child and family to share information, assess risks and to formulate an agreed plan of management and services, with the child's safety and welfare as its paramount aim.

<sup>2</sup> A child protection plan is put in place when a network of agencies considers a child to be at risk of significant harm.

<sup>3</sup> The pre proceedings stage aims to try to intervene and help families before getting to the stage of making an application to the court regarding the child/children.

<sup>4</sup> The core group meeting will be made up of relevant professionals involved with a family who meet regularly if a child is on a child protection plan.

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	<p>have been some history of domestic abuse. Father's learning difficulties were said to be being explored.</p> <p>Mother presented as "adamant" that she wanted to be assessed as a single parent. She had at that time attended all ante natal appointments. A decision was made to enquire about supported mother and baby placements.</p>
27 May 2015	A care planning meeting <sup>5</sup> was held resulting in a decision to recommend a mother and baby foster placement and an application for an interim care order as soon as the baby was born.
4 June 2015	At a review child protection case conference the unanimous decision was for the unborn baby to remain on a child protection plan.
XX XX XX	The sibling of Rose was born, to be known as Daisy.
12 June 2015	A multi disciplinary discharge planning meeting was held. Decision made to discharge both Mother and baby to a foster placement out of the local area and an application was to be made to court for an interim care order. Supervised visits to the baby had taken place by Father on the ward.
15 June 2015	Mother and baby Daisy commenced placement at the foster carer's home. A strict working agreement was in place including that the baby would sleep in the foster carer's room and that contact between Mother and baby would always be supervised.
16 June 2015	Liaison took place between the social worker and health visitor regarding the placement resulting in communication with health visiting services in the placement area.
15 July 2015	<p>An initial court hearing took place regarding the care order application at which a psychological assessment on Mother was presented. The report reflected on Mother's history. Mother was upset by this as in her view it was negative with a focus only on non recent events.</p> <p>Mother was seeking a second opinion and the local authority agreed to fund a reassessment after cognitive behaviour therapy<sup>6</sup> (CBT) had taken place with Mother, which was recommended in the psychological report.</p>
29 July 2015	Mother made contact herself with her own GP surgery to update that she was living away from the area in a foster placement with her baby.
15 September 2015	<p>At a review child protection case conference the baby's name was removed from a child protection plan as an interim care order<sup>7</sup> was now in place and reviews would take place under child looked after procedures.</p> <p>Weekly CBT sessions were at the time taking place with Mother.</p>

<sup>5</sup> A care planning meeting is held after a decision that a child/children should become Looked After.

<sup>6</sup> Cognitive behaviour therapy is a talking therapy which can help a person to manage problems by changing the way they think and behave. It is most commonly used to treat anxiety and depression but can be useful for other mental and physical health problems, [www.nhs.uk](http://www.nhs.uk)

<sup>7</sup> An interim care order is an order that can be made by the court before a final hearing, when all the evidence is put before the Judge and a final decision is made about a child's future.

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12 October 2015	A statutory visit <sup>8</sup> took place and the placement was described as continuing to go well, with Mother said to be ensuring all the baby's needs were met.
15 October 2015	The psychologist completing the reassessment advised that it was time to reduce supervision of Mother with baby in a planned way, to give Mother chance to use her coping strategies whilst still having the safety net of the foster placement. As a result short spells of unsupervised contact were agreed and arranged by the social worker.
20 October 2015	The GP was informed by letter that the child protection plan had been discharged and that an interim care order was in place.
10 November 2015	A new social worker was allocated due to illness of the previous social worker. A statutory child looked after visit was undertaken by the social work practice manager until an introductory visit by the new social worker could take place.
12 November 2015	Foster carers reported a positive attachment between Mother and baby and that there were no concerns at the placement.
14 December 2015	Mother and baby moved into their own property in the original local authority area following positive assessments in foster care. A visiting plan was put in place commencing with daily visits then weekly from Christmas time. This was arranged to be reviewed at the next child looked after review in February 2016.
17 December 2015	At the final court hearing a home placement order <sup>9</sup> was granted.
02 March 2016	The child looked after review took place at Mother's home. Support was discussed with additional support also being provided by a voluntary church organisation and by Lancashire Intervention for Families Team (LIFT) <sup>10</sup> . At the review it was agreed that Mother would supervise Father's weekly contact with Daisy and this contact would no longer be required to take place at the contact centre.
29 March 2016	The looked after child health assessment took place at home with the health visitor. The child was noted to be progressing well and was seeing Father.
31 March 2016	On a routine contact by the early help outreach worker it was disclosed by Mother that the church group volunteer had suffered a close family bereavement and was unable to visit. Arrangements were made for more frequent visits by the outreach worker for the next three weeks.
06 April 2016	Mother attended the GP surgery to request contraception as she said was back in a relationship with Father.

<sup>8</sup> Statutory visits are a requirement for social workers when children are subject to child in need plans, child protection plans or are children looked after.

<sup>9</sup> A home placement order is when a final care order has been made at court but the care plan is for the child to remain at home.

<sup>10</sup> Lancashire Intervention for Families Team is a mentoring scheme whereby foster carers work with birth families to offer additional support when children are deemed as looked after.

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03 May 2016	During a home visit by the early help outreach worker Mother was upset as Daisy's Father had been arrested whilst allegedly "drunk". Mother was concerned how this might have affected contact arrangements. On the same visit it was observed that Daisy had a bump to her nose and left cheek which Mother explained that the child had fallen and bumped her face on the TV unit.
12 May 2016	During a home visit by the health visitor Mother disclosed that Daisy had had some facial bruising due to falling against the TV unit on the 2nd May. Mother said she had seen the GP about this the next day (not in GP records).
17 May 2016	In a supervision meeting for the allocated social worker a decision was made that the family support worker and early help outreach worker should reduce and conclude their involvement with Mother and Daisy due to the good progress which had been made by Mother.
02 June 2016	Email contact was received by an independent sexual health service from Mother who was requesting advice about a termination. Information was provided by Mother regarding her involvement with children's social care and the history leading to that involvement.
12 June 2016	Mother gave consent for the independent sexual health service to contact her GP for medical information regarding her plans for a termination.
16 June 2016	During a home visit by the early help outreach worker Mother was upset and shared that Father was alleging he had resumed a sexual relationship with Mother and that she was pregnant. Mother denied this and said she had "stopped the contact" between Father and Daisy.
20 June 2016	A statutory visit by the social worker took place, no safeguarding concerns were recorded.
21 June 2016	At the child looked after review Mother was reported to be engaging well with professionals. Father's contact was discussed and Mother disclosed he was unreliable and sometimes abusive. The recent arrest in May was highlighted, and Father's mental health was explored. The family support worker shared that Father had alleged Mother was pregnant with his child but this was denied by Mother at the meeting. The independent reviewing officer <sup>11</sup> (IRO) requested that a contact agreement was drawn up within 5 working days and for this to have an early review to check progress.
27 June 2016	The GP received a contact for medical information from an independent sexual health service regarding Mother's request for a termination of pregnancy.
15 July 2016	Mother did not attend her termination appointment.
4 August 2016	A supervision meeting took place between the allocated social worker and manager. The record shows the alleged pregnancy was discussed but that Mother had denied being pregnant.
4 August 2016	The health visitor conducted a home visit. Also present with Mother and Daisy was the church group volunteer and another friend with a child. Mother disclosed that

<sup>11</sup> The Independent Reviewing Officer chairs reviews for children looked after to ensure the care plan for the child reflects the child's needs and the child's wishes and feelings are given full and due consideration.

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	Daisy had bumped her head on the DVD player. During the visit Mother spoke about difficulties regarding Father's contact and alleged a family member of his had raised unsubstantiated concerns about Mother's parenting to children's social care. Notes from the visit state Mother was mostly in a positive mood but became tense when the child seemed tired and needed a nap. Advice was given to manage behaviour.
22 August 2016	The involvement from early help was closed after children's social care had advised support was no longer needed. Mother was informed by a letter from the early help outreach worker.
7 September 2016	The ambulance service was called to the home of Mother, who was in labour. Mother said she thought she was around 24 weeks pregnant and gave some history of her family circumstances to the ambulance crew.
8 September 2016	Rose was born in hospital. The baby was thought to be approximately 23-24 weeks gestation and was transferred to the neonatal unit. The birth was noted as an un-booked pregnancy and the emergency duty team for children's social care were informed by the enhanced support midwife. Rose was described as "very poorly".
8 September 2016	A discharge planning meeting took place regarding Mother's discharge from hospital. Both Mother and Father in attendance. The prognosis for Rose was not yet known.
21 September 2016	Legal advice sought by Children's Social Care as the home placement agreement for Daisy had been broken by both Mother and Father. Advice was to go into pre proceedings in order that Mother can benefit from legal advice. The case was described as "about support and not about hostile proceedings".
22 September 2016	Letter received at the GP practice highlighting the concealed pregnancy and birth of a 24 week old baby who remains on the neonatal unit.
10 October 2016	Rose said to be making good progress in terms of respiratory effort and is slowly gaining weight. Further specialist review of brain images was to take place.
17 October 2016	Mother attended the GP for post natal check. Mother disclosed Rose was still in the high dependency unit (neonatal) at hospital. Contraception was discussed and Mother reported her "partner" was visiting evenings and weekends.
21 October 2016	Legal advice sought by children's social care.
11 November 2016	Information received from the neonatal ward expressing concerns that Mother "had held Daisy's toe with her finger and thumb for 30 seconds – the child had not cried and went quiet". A discussion took place with the police and a section 47 <sup>12</sup> enquiry was initiated. Single agency enquiries were made by children's social care and Daisy and Mother were seen at hospital. No injuries were noted on the child and Mother denied the allegation. She stated she had a poor relationship with the nurse who had made the allegation. No other concerns were raised by nursing staff regarding mother's parenting ability on the ward.

<sup>12</sup> A section 47 enquiry means that children's social care must carry out an investigation when they have reasonable cause to suspect that a child is suffering, or likely to suffer significant harm.

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	After enquiries had been made the allegation was recorded as unsubstantiated with no further action taken.
18 November 2016	The social worker updated the health visitor that the allegation received from the neonatal ward about Mother pinching Daisy was unsubstantiated.
2 December 2016	Pre proceedings legal meeting held.
7 December 2016	A social work statutory visit took place and public law outline <sup>13</sup> (PLO) letter was delivered to Mother to share with her solicitor for a meeting on 14.12.2016. Daisy was seen during the visit and no concerns for her welfare were noted.
13 December 2016	A supervision meeting was held with the manager and social worker. Discussion took place around whether there was the necessity for an initial child protection conference to be held given that Rose is safe in hospital and the local authority plans to issue care proceedings in respect of her once she is well enough for discharge. The manager stated that a child protection plan is not thought necessary at this time given the plans of the local authority.
14 December 2016	Pre-proceedings meeting held to advise Mother and Father of the local authority's intention to issue care proceedings in relation to Rose. Parents were also to be advised of the assessment process regarding Daisy and plans that this would complete in 2 weeks. Arrangements to feedback the outcome of the assessment and the local authority's intention for Daisy were discussed. The parents should have been sent a letter regarding proceedings in order for them to obtain free legal advice but Father's letter had not been issued.  The meeting notes show the parents were informed a foster placement for Mother and both children was not an option. It was clear that the local authority were now considering removal of Daisy and Rose.
20 December 2016	The health visitor recorded receiving a telephone call from Mother who was very upset. She had been informed that children's social care would be making an application to remove Daisy, and Rose once she was fit for discharge, due to the concealed pregnancy. There had been discussion about Mother's ability to care for both children, particularly as Rose has additional needs. Mother was obviously shocked and upset and was advised to seek legal advice.
22 December 2016	A hand delivered letter was left at Mother's address to give notice to remove Daisy from her care. Mother was not home at the time.
5 January 2017	The child and family assessment was completed by children's social care which recommended removal of Daisy. The assessment outcome for Rose was to seek further legal advice.
12 January 2017	Father attended his GP supported by family members feeling low in mood and with suicidal thoughts. The health of Rose and relationship with Mother were noted as "life stressors".

<sup>13</sup> The public law outline (PLO) sets out the duties the local authority have when thinking about taking a case to court to ask for a care order to take a child/children into care. When a PLO letter is sent this is before court proceedings and asks parents to attend a meeting.

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12 January 2017	The health visitor called children's social care for an update on the case and was informed a new social worker had been allocated.
18 January 2017	A legal meeting was held with a children's social care senior manager. The decision was no threshold was met now to remove Daisy; an interim care order for Rose was to be applied for with home placement agreement.
31 January 2017	Father attended a review appointment with the GP, he was noted as "feeling better, sleeping better, mood appears better" and that his baby was "due for discharge".
1 February 2017	An initial court hearing was held but was adjourned. Further detail was required in documentary evidence of the support and monitoring that was to be put in place before a home placement could be considered and approved by the court and the children's guardian.
2 February 2017	A discharge planning meeting was held for Rose. Plans were being made for the child to be discharged on a home placement order. A tight package was to be in place and included daily visits from children's social care, a minimum 3 weeks of overnight cover from agency support staff, a part time nursery place for the elder sibling Daisy and visits from health professionals as indicated by Rose's health and medical needs.
6 February 2017	Court hearing, short adjournment required for further clarity regarding support plan.
10 February 2017	Care proceedings were issued and home placement agreement granted at court.
16 February 2017	Mother attended two days of oxygen training in preparation for Rose coming home.
24 February 2017	Father attended to see his GP. Noted to be feeling low again, not sleeping, his mood appears to be linked to his daughter. Medication dose increased with review planned in four weeks.
28 February 2017	The home placement agreement was signed by the children's social care team manager, senior manager and both parents, to be implemented upon Rose's discharge. The agreement gave clear details of expectations and plans for support within the home, including which professionals and agencies would be visiting, and when.
15 March 2017	Discharge planning meeting held with both parents attending. Positive feedback shared regarding Mother managing well when she stayed in the transition unit with support from Father with the sibling Daisy. Mother also reported to have coped well at night with both children. The discharge was planned for 20.03.17 with a tight social care plan for support at home from that time.
15 March 2017	Review GP appointment with Father, noted as feeling better in self, medication working. Father spoke about his daughter and "plans to discharge home to mum".
17 March 2017	A child looked after health assessment was undertaken by the health visitor at home for Daisy. No concerns were recorded with the child's growth or presentation.
20 March 2017	Rose's discharge was delayed due to the Daisy being unwell.
23 March 2017	Rose was discharged from hospital to home with a package of support in place.

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24 March 2017	Mother contacted the ambulance service reporting Rose as having a coughing fit and high temperature. The child was admitted to hospital.
30 March 2017	Daisy was unwell with a cough and was taken to the GP where Mother shared information that the younger sister, Rose, was also in hospital with coughing symptoms.
05 April 2017	Rose was discharged home from hospital after a discharge planning meeting.
10 April 2017	During a home visit Mother disclosed to the family support worker that she was in debt regarding non-payment of council tax.
11 April 2017	<p>A joint visit took place to the home by the social worker and the family support worker to discuss the amount of £550 now owed to the enforcement agency. Mother failed to answer the door and telephone for a long period before eventually coming to the door looking very tired. Daisy was seen to have a “full nappy which needed changing”, however Rose “looked fine”. Mother had not informed children’s social care of the debt issue which had been ongoing since May 2016.</p> <p>The social worker informed the manager via a case note that the debt breached the home placement order and may have a detrimental effect on the placement should Mother not be able to pay.</p> <p>The social worker also highlighted that the 11 April 2017, which was that evening, was the last night for the planned overnight support cover under the home placement order’s seven day arrangements. The support agency in their daily records had noted that “Mother was tired last night” (10 April 2017) and “a smell of cannabis” was suspected in her room.</p> <p>The social worker informed the manager he was concerned and proposed the end of the support at home should be delayed. His professional opinion was that Mother needed monitoring for another week.</p>
12 April 2017	Children’s social care reviewed the level of support in place at home in a meeting with Mother and Father. Other professionals were not involved but the health visitor arrived during the meeting, for a planned weight review of Rose This weighing was rearranged for the next day. At the meeting Father said he was unhappy with the amount of contact he was allowed with Rose. Other contact arrangements were explored. The overnight support at the home had ended but was re- introduced to reduced evening support from 18.00 to 23.00, for a period of a further week.
13 April 2017	The health visitor attended the home address for the rearranged plan to weigh Rose. Both children were seen with Mother but weighing did not occur as Rose was unsettled. She eventually went to sleep during the visit. A note was left for the professional attending the next day to weigh Rose.
13 April 2017	The amended evening cover for support at the home commenced on this date, from 18.00 to 23.00.
18 April 2017	Rose was taken to the GP with oral thrush, and a prescription was given.
19 April 2017	At 00.19 Mother called the ambulance service via the 999 system. Mother stated that Rose had vomited and then became unresponsive with no signs of life. Basic

	life support was carried out by Mother under instruction of the emergency call taker before she was transported to hospital by ambulance.
19 April 2017	Rose was transferred at 06.30 to children's paediatric intensive care unit. A CT scan <sup>14</sup> performed prior to transfer had showed subdural bleed <sup>15</sup> , and was considered severe brain trauma. The police were informed.
21 April 2017	The police were notified of the decision to withdraw life support from Rose due to the severe brain injury.
21 April 2017	Rose died.
21 April 2017	A child protection medical examination took place with Rose's sibling Daisy. There was no evidence of non accidental injury to Daisy.

### Family involvement

Involvement of significant family members in a review process is important to gain an understanding of the family's experiences of the services offered to them. Specifically, in this case, family members provided feedback relating to services provided to the children Rose and Daisy, and themselves as adults involved during the review timeframe. The carers of the child in the connected non recent incident were also able to contribute.

A summary of the views of family members is given below. Other comments are included in the analysis section of the report where relevant. Views are the personal opinions of individuals who have contributed.

#### The carers of the child injured in 2004

The Reviewer and Chair of the Panel met with the carers of the child who had suffered injuries in 2004. They cannot be identified for legal reasons. They recalled being told only brief details at the time about the injuries, despite becoming responsible for the care of the child. They became aware of, and were upset to hear, the full extent of the severity of the injuries during the criminal trial in 2018.

The carers recalled several changes in the allocated social workers who were involved with the child over the years, which they felt prevented a trusting and positive relationship being built. They had limited involvement with other professionals around the time of the injuries being found and investigated. They did however have detailed knowledge of the person known as Mother and her lifestyle, which was knowledge they had in 2004/2005, some of which they shared in court during the 2018 trial. They described Mother in their opinion, as aggressive and manipulative.

The carers spoke very positively of the police officers who reinvestigated the 2004 injuries to the child. These enquires took place after Rose had died. In particular they said they felt well informed and sensitively treated, especially through the court process.

<sup>14</sup> A computerised tomography (CT) scan uses x-rays and a computer to create detailed images of the inside of the body, [www.nhs.uk](http://www.nhs.uk)

<sup>15</sup> A subdural bleed (haematoma) is a serious condition where blood collects between the skull and the surface of the brain, [www.nhs.uk](http://www.nhs.uk)

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The child who was injured is fortunately now well and has been kept informed of the review process by the carers.

### Father

Father of Rose and Daisy met with the Reviewer and the Panel Chair, accompanied by his own mother and step father (paternal grandmother and step grandfather to the children) The sister of Father (aunt of the children) was present for part of the meeting. She is currently the carer for Daisy and therefore the Reviewer and Chair were fortunate to be introduced to Daisy before the meeting with family took place.

Father has learning difficulties and attended a school for children with special needs. He finds reading and writing a challenge but with some support was able to articulate his thoughts and feelings. He does not originate from Lancashire but described how he met Mother through her being a lodger where he was living in Preston. They commenced an "on and off" casual relationship which after about a year resulted in Mother becoming pregnant with Daisy. This was unplanned.

Father said he had become aware of Mother's previous relationship with a man before him, which allegedly had aggression on both sides. Mother had also told him in brief about the historic incident with the child who was injured many years ago. However, it wasn't until services became formally aware about the pregnancy that Father says he was told by a social worker about the seriousness of the injuries to that child.

Father was clear in his opinion that he thought social workers involved with Mother did not feel that he was a suitable carer for the child soon to be born. He said this opinion of him never changed and that all social work staff treated him as if he was a danger to his children.

He admitted to having some previous convictions for mostly drink related offences and problems in a previous relationship but he had no history of serious offences in his opinion, and nothing compared to what Mother had allegedly done to the child many years prior. He felt his chances of being a proper father were always dismissed.

Father said this was demonstrated by the children's social care decision to have all his contact with Daisy supervised. He felt this was unfair under the circumstances particularly as he felt he was considered more of a risk to Daisy than Mother was, even with her known history.

Father disclosed that he knew that Mother was drinking alcohol and smoking "weed" (cannabis). Mother was also allowing Father to see his daughter Daisy outside of contact arrangements. This meant both Mother and Father were knowingly breaching the home placement agreement which was in place. Father alleged Mother often threatened him to pay her money or she would stop his contact with Daisy.

Father explained the conception of Rose was a "one off incident" although at the time he would have liked to have "made a go" at being a family as he wanted to be with his children. Father said Mother told him about the pregnancy straight away and he paid for the morning after pill which Mother said she took at a pharmacy. However, the pregnancy continued and when Mother tried to stop Father's contact with Daisy around the time of the child's birthday he told separate social work professionals that Mother was pregnant.

Father alleges the response to him by one professional was that she called him a "liar". Father continued to tell social work professionals that Mother was pregnant but he says he was not believed or taken seriously. He knew that Mother was denying this when asked and

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Father thought Mother was believed. He said he thought she always seemed to be able to convince the workers that she was telling the truth about everything.

Father recalled that when Mother went into labour with Rose he was at her address with Mother and Daisy. Therefore the home placement agreement was being breached by both parents again.

Once Rose was born Father described the contact arrangements with Daisy as inconsistent. Sometimes he was allowed unsupervised contact with his eldest daughter but other times he was not. Father said he still felt Mother was trusted more than him even after she had concealed the pregnancy.

Father said throughout the timeframe of the review he was invited to some processes, such as meetings or reviews. He said he was not offered the services of an advocate to help him understand. Father's sister said she had been concerned about his ability to make sense of some of what was happening but when she asked if she could attend to support him this was declined. Father signed a number of children's social care documents including the home placement agreement, but Father's own mother said it was unlikely that he would have been able/ or have taken the time to try to read the documents properly. Sister of Father wrote to children's social care to express concerns about her brother's (Father's) learning difficulties and the lack of support being offered.

Father said he felt unclear about the legal process regarding the care of his children. He was told they were being removed from Mother's care then this soon changed to her being allowed to take both children home.

Father's sister said she had been very upset and worried about the home placement decision, and she expressed her opinion about Mother not being able to cope to the social worker in charge of the case at the time.

Father spoke of being contacted by the Police when the injuries had occurred to Rose leading up to her death. He was at home and the Police took him to hospital.

Father's own mother, the children's grandmother spoke of her distress at not being allowed by professionals, who she perceived to be children's social care staff, to kiss her baby grandchild goodbye once life support was withdrawn for Rose.

Overall the family collectively felt that they were never properly listened to by children's social care. They shared emails with the reviewer that the sister of Father had sent to children's social care, throughout the review timeframe, but said they had received no response.

The family said they felt due to Father being labelled a risk that Mother herself was able to convince professionals that she herself was no risk to the children.

They had concerns about the number of social workers allocated to the case and that the lead worker changed regularly which in their view was not helpful. They also had concerns that a support worker within children's social care was allowed too much responsibility throughout the case in regards to decisions made. They felt she had become too close to Mother.

Father and his family did provide very positive feedback regarding the police team who worked on the investigation when Rose was injured and after she died. The family praised their professionalism, care and sensitivity.

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## Mother

The Mother of Rose and Daisy was visited in prison by the Reviewer and Chair.

Mother described her upbringing as having what she wanted in terms of material things but that she was devoid of love and attention. She said she had not received support from any close family members for many years as an adult.

Mother said she met Father when she had become homeless after the breakdown of a long relationship. Similar to Father, she described their relationship as casual. When she became pregnant with Daisy she felt that she would have the baby taken from her once born, due to her history. She said she had tried her best to do all she could to comply with children's social care in order that she might be able to keep Daisy.

Mother spoke about her general lack of trust of most professionals who she came into contact with. She said this was made worse, in her opinion, with the family social worker constantly being changed. She did not feel properly supported by children's social care and "was petrified" that they would remove Daisy. This was the main reason she failed to disclose the pregnancy even when asked by professionals.

Mother said she recalled when Father had reported that she was pregnant. She felt this was due to her not allowing him to take Daisy swimming on her birthday. She said children's social care staff asked her if she was pregnant and because she was frightened she denied she was. Mother said no further enquiries were made of her about the pregnancy.

When asked about Father's contact with Daisy, Mother said she felt social workers were "very harsh" with him. She could not understand why he was only allowed the limited contact with his daughter and said contact was often cancelled due to other commitments of workers who were involved in the arrangements. Mother admitted that she had allowed Father more contact with Daisy than what was in the home placement agreement. She also highlighted that the contact arrangements with Father became inconsistent after the birth of Rose. He was allowed extra contact with Daisy whilst Rose was in hospital but then this reverted to strict contact arrangements once more when Rose was discharged home.

Mother said she had been confused by the legal processes before Rose was discharged. She believed that as soon as children's social care thought that Rose would survive that they made plans to remove both children. This resulted in a letter being posted through her door at Christmas time to give notice of the imminent removal. On receiving this letter Mother had no opportunity to discuss the decision due to the Christmas leave period. Soon after she discovered that the decision had changed and the children would be allowed to live with her on the home placement agreement.

Mother was unclear as to how and why decisions were made in the legal process relating to the children. She felt that this was not transparent and "thought that secret meetings often took place within children's social care" alongside meetings where she and Father were invited.

Although pleased to have the children at home when this was eventually agreed, Mother found the placement arrangements were challenging. In particular she said the plan resulted in different individual support workers attending overnight which was difficult to work with. She had to try to get to know a different worker every night, which was not easy due to her trust issues, and felt she had a stranger in her home for each session. She said this was particularly difficult for Daisy as a toddler to get used to. Mother gave an example that one night Daisy woke up in the early hours and the male support worker came into the room.

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This caused Daisy some distress as he had arrived for the night shift after Daisy had gone to bed therefore was an unfamiliar person to the child.

Mother said she felt unable to raise concerns about the home placement support arrangements as she didn't want to give the impression she was not cooperating. Overall she felt the support workers "just watched her and noted her every move" rather than offering any assistance.

Mother had limited feedback to share regarding health professionals who had worked with her throughout the review timeframe. Her view was that she rarely needed to seek medical advice from the GP surgery for her or the children's health needs. Mother did acknowledge the support which the family, Rose in particular, had received from the neo natal staff. Mother felt they provided good care and were non judgemental of her history.

All meetings with significant family members provided a valuable insight into the children's and family's experiences. Information from those seen was shared with Panel members and account was taken of the views when writing the final report and formulating learning considerations for action by Lancashire Safeguarding Children Board. The Reviewer is grateful for all contributions by family members.

### **ANALYSIS: Practice & Organisational Themes Identified**

Rose, her sibling Daisy and the family had received services from a number of agencies during the period of the review. Scrutiny of the timeline, information shared and reflections at the Panel meetings and the learning event have provided an opportunity for wider learning to emerge about the ways in which services work together. Some areas of positive practice have also been highlighted within the report.

The history of Mother and her involvement in injuries being caused to a young child many years ago has been considered by the Reviewer and Panel and has provided useful context for the more recent events.

Some, but not all agency records from 2004/ 2005 were available to be examined to inform the review. Unfortunately, as stated earlier due to the non recent period when the injuries were caused most professionals involved at the time were not available to take part in the practitioners learning event.

The following, in no order of priority, is an analysis of the learning themes identified regarding Rose, Daisy and the child injured in 2004:

#### Disguised compliance

Mother did generally demonstrate cooperation and engagement with professionals and services throughout the review timeline. An example of this compliance is during the antenatal period with the unborn child Daisy and when Mother and Daisy were placed in a foster placement out of area, until the baby was six months old. This cooperation and willingness to change was confirmed as observed by the professionals who were involved with her at that time.

There was what was perceived to be continued cooperation with services once Mother and Daisy were living independently back in the original area from December 2015. What is known now is that Mother was not complying with the agreement made with children's social care, having resumed a relationship with Father as early as March 2016. Father admitted to the Reviewer he was regularly visiting Mother and Daisy, and that they both knew this was not

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allowed in the agreement. By April 2016 Mother was pregnant with Rose and did not disclose the pregnancy; this being evidence of a clear breach of the home placement agreement.

In fact Mother continued to regularly see professionals, most of whom she had known for several months, and gave the appearance of a person engaging with services. In June 2016 when Father raised the concern that Mother was pregnant she immediately denied this. Mother was believed, which may have been due to the cooperation and compliant behaviour she had shown previously, supported by the rapport and close relationships that had been built with some professionals. It should be noted that Mother was describing Father at that time as unreliable and abusive, with mental health issues, which also had an impact on how Father was judged in terms of the allegation he was making about the pregnancy. Involvement of fathers is discussed later.

*The NSPCC Information Service Summary of Learning from Case Reviews* suggests “disguised compliance involves parents giving the appearance of co-operating with child welfare agencies to avoid raising suspicions and allay concerns”. Published case reviews highlight that professionals sometimes delay or avoid interventions due to parental disguised compliance.<sup>16</sup>

By complying on most occasions to meet and see professionals and by attending formal safeguarding processes such as meetings, Mother gave an impression of cooperating with agencies, therefore showing disguised compliance. Mother herself told the Reviewer she did all she could to comply, and whilst not admitting to disguised compliance, this demonstrated her intention was to make professionals believe she was willing to work with them. As a result this appears to have added to the optimistic view of some professionals of Mother’s intention and capacity to cope and change, and therefore to improve the lives of the children.

Furthermore, disguised compliance can lead to a focus on adults, in this case predominantly Mother, rather than on achieving safer outcomes for children.

For all professionals, disguised compliance should be included as a key area of concern when assessing risk to a child, and therefore be included in supervision discussions about decisions and risk analysis. Professionals must consider disguised compliance, even in cases where families appear to be making progress and where there is full cooperation. Of course this means professionals need to have awareness of the issue in order that it may be properly explored as a risk. If the issue of disguised compliance in families is not brought to the attention of managers or if managers do not routinely include it as a supervision agenda item, then the impact of disguised compliance and subsequent risks will not be addressed.

### **Learning consideration 1**

**The Lancashire Safeguarding Children Board should consider, through the learning and development team a training analysis to examine how disguised compliance is included in current learning opportunities, and where inclusion of the issue can be enhanced, to ensure all staff across the partnership has sufficient awareness of disguised compliance as a significant risk to children.**

#### Focus on children

Two children are subjects of this review. One is Rose the child who died, the other is the sibling Daisy. Both children were too young to verbally communicate their own wishes and feelings

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<sup>16</sup> Learning from reviews highlights that professionals need to gather evidence about what is actually happening in a family, rather than accepting a parent’s presenting behaviour and assertions. By focussing on outcomes rather than processes professionals can keep the focus of their work on the child”, March 2014.

to professionals and therefore the children were reliant on professionals acting for them, in their best interests with focus on their needs to keep them safe and well.

When Rose was born at around 24 weeks of the pregnancy she was seriously unwell requiring full time care in hospital for the first six months of her life. There is no doubt from information available in agency records and from professionals' involvement at the learning event that the focus of health professionals within the hospital setting was absolutely and unequivocally on Rose. Similarly there was focus on Daisy whilst Rose was in hospital in that a nursery place was arranged for Daisy within the vicinity of the hospital. Overnight accommodation was also made available to the family in order that Mother and Daisy could be close to Rose.

Another example of focus on the children was when a member of neonatal staff reported a concern she witnessed on the ward when Mother allegedly pinched Daisy's foot. This incident is scrutinised later.

Daisy, as a child looked after, received statutory health checks by the health visitor throughout the review's timeframe and other statutory multi agency child looked after reviews took place as required indicating focus was on the looked after child at those times.

Mother and Daisy were regularly seen by other professionals; in particular a family support worker and early help outreach worker were both closely involved with the family for several months. There is evidence to show that these professionals did their best to support Mother and the children throughout the review timeframe. Recording by these professionals evidences focus on Daisy, and positive interventions before Rose was born included arrangements made for Mother to attend local provision of parenting groups which would have been of some benefit to Daisy.

It is acknowledged that working alongside families with complex histories and needs, such as in this case, can be very difficult. Professionals need to build trust, particularly when adults have had limited opportunity to build positive relationships in their own lives. However with a person like Mother, who herself was vulnerable in many ways with no real family support, it was evident at times that the focus shifted to supporting her first. Whilst this often provided indirect support to the children due to Mother having care of them it still appeared that focus and attention was prioritised on Mother's needs with the children's needs sometimes being secondary.

An example was when Mother was upset by the findings of the psychologist's report for court proceedings whilst she was living in foster placement with Daisy in October 2015. Mother spoke about this when meeting with the Reviewer. She voiced her concerns that the same clinician who was involved in the assessment process from the incident in 2004 was also involved after Daisy's birth. As a consequence Mother received support and reassurance from children's social care and eventually an alternative clinician was commissioned. The findings were different and more sympathetic to Mother's circumstances, being positive about progress she had made. The psychological assessments are explored later.

Other decisions and interventions, whilst indirectly beneficial to the children, did appear focussed on Mother and what she wanted. For example Mother wanted Father to have more unsupervised contact with Daisy soon after she had returned to the home area to live independently with the child. This was around the time the couple's relationship was resuming, but was unknown to all services involved, and was a breach of the agreement made with children's social care.

Whilst the benefits of a child seeing their father more cannot be dismissed, the contact arrangements had been made for what was perceived by some professionals as good reason after an assessment of Father. It appears it was Mother's persuasiveness of professionals

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with whom she shared good rapport which appeared to result in the contact arrangements becoming more flexible in favour of Mother and Father's wishes.

Notes from the legal gateway meeting<sup>17</sup> soon after Rose's birth further highlight focus on Mother's needs in that Mother was viewed sympathetically regarding how the pregnancy occurred, with blame apportioned to Father for allegedly persuading Mother to resume their relationship when she was lonely, resulting in Mother getting pregnant. Having met both Mother and Father it is the Reviewer's professional opinion that it was unlikely that Father had the persuasiveness skills to coerce Mother into a relationship if she had not wanted one.

There was continued focus on Mother rather than the children's needs in legal advice provided. This is evidenced in notes which state "the fact that Mother has had a baby without telling the social work team shouldn't go against her". This was noted as the consensus for the social work team involved in the legal gateway meeting, who shared the view that the pregnancy was "not the more common concealed pregnancy scenario that we normally see, which can often signal non-cooperation by parents in the future".

This opinion is questionable even without the history of Mother, particularly as she had numerous opportunities with professionals with whom she shared good relationships to admit she was pregnant. Non-cooperation and non-compliance with the home placement agreement had taken place by Mother, and Father, and therefore could absolutely be expected in the future. Responses to the concealed pregnancy are explored below.

It appears Mother's ability to influence and manipulate judgements on her circumstances by being the focus for support continued throughout the timeframe of the review. Overall, Mother's needs were always for the children to remain in her care and control. Professionals worked very hard to ensure her needs were met despite the overwhelming history of concerns and associated risks, which resulted at times in a lack of prioritisation and focus on the children themselves. The children's lived experience and desired outcomes for them often seemed overlooked.

## **Learning consideration 2**

**The Lancashire Safeguarding Children Board should consider opportunities to ensure disguised compliance and focus on children, are identified as key areas of scrutiny for every case, to be examined regularly for example in staff supervision meetings and when identifying and reviewing desired outcomes for children.**

### Concealed pregnancy

Rose was born prematurely in September 2016 after Mother had concealed the pregnancy to all professionals involved. Father of Daisy was also the Father of Rose and he had known about the pregnancy himself since at least May 2016. Records indicate Mother made enquiries regarding a termination in early June 2016. In what is now thought to be an attempt to deflect attention and scrutiny she also informed a professional in mid June 2016 that Father was alleging she was pregnant but went on to deny the pregnancy to that worker.

Father told the Reviewer that he was not believed when he tried to tell children's social care professionals about the pregnancy.

Between June 2016 and when the premature birth occurred Mother was seen separately by the health visitor, social worker, family support worker, early help outreach worker and the

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<sup>17</sup> The purpose of the legal gateway meeting is to provide advice to children's social care regarding the legal options available to safeguard and promote the child's welfare.

church volunteer. Mother also attended a looked after child review for Daisy within that period. The pregnancy was denied by Mother to at least three professionals separately and was not disclosed by Mother despite the opportunities she had to ask for support.

Lancashire Safeguarding Children Board are currently finalising a concealed and denied pregnancy protocol which defines a concealed pregnancy as *when a woman knows she is pregnant but does not tell any health professional; or when she tells another professional but conceals the fact that she is not accessing antenatal care; or when an expectant mother tells another person or persons and they conceal the fact from all health agencies.*

The implications of concealment and denial of pregnancy are wide-ranging and include a lack of antenatal care meaning that potential risks to mother and baby may not be detected and underlying medical conditions and obstetric problems will not be revealed. Concealment and denial can also lead to a fatal outcome, regardless of the mother's intention.

When Mother gave birth to Rose correct procedure was followed at the hospital in that an urgent referral was made to the emergency duty team of Children's Social Care. The action then taken is explored below.

The Pan Lancashire multi agency pre-birth protocol (refreshed in March 2017 after previously being published in 2012) was not followed when suspicions about the pregnancy were initially raised in June 2016. The protocol is clear that *where any professional has concerns about concealment or denial of pregnancy, they should contact any other agencies known to have involvement with the expectant mother so that a fuller assessment of the available information and observations can be made.* This would also be expected practice.

A contact with the GP, a professional who had involvement with Mother and Daisy, as part of enquiries into the possible concealed pregnancy should have revealed that Mother had sought advice from an independent sexual health organisation regarding pregnancy and termination. Patient confidentiality would not have been an issue as the welfare of the unborn child should override a mother's right to confidentiality.

Mother had also attended the GP for contraception advice in April 2016 and had volunteered that she "was back in a relationship with Father". If enquiries had been made with the GP such information would also have strengthened suspicions that Mother was possibly pregnant. Furthermore, the breach of the home placement agreement would have then been identified.

It is not clear what specific enquiries, if any, did occur once the allegation of a pregnancy had been made, other than asking Mother if she was pregnant. It is positive that Mother was challenged and that the concealed pregnancy was discussed in supervision of the social worker. However, with consideration of Mother's history and what is now known about Mother's propensity for disguised compliance there should have been more proactive professional curiosity used to help assess the concealed pregnancy concern.

In circumstances of suspected concealed pregnancy or delayed presentation to ante-natal services the protocol states "a referral to Children's Social Care is not automatic but must be made if, after consideration of the reason for the delay or concealment, there are concerns about complex/ serious needs or evidence of significant harm". Discussions are ongoing now within antenatal services to amend the protocol to include requirement for an automatic referral to be made.

In Mother's case there was evidence of significant harm to a child in her care previously. The protocol says "a referral to children's social care for a pre-birth assessment must always be completed if there is a reasonable cause to suspect that the unborn baby is likely to suffer significant harm before, during or after birth".

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Another section of the protocol which relates to Mother's specific circumstances was that "the parent, (or their partner/potential carer) has children that have been made subject to a child protection plan, or care or supervision order at any time in the past (or if proceedings are ongoing)". Mother's child Daisy was on a care order at the time the pregnancy was suspected.

Research suggests there is no clear profile for women who conceal or deny pregnancy and there are clear challenges of predicting and identifying women likely to conceal or deny a pregnancy (*Denial of pregnancy, Jenkins et al, 2011*). However, Mother's circumstances and history could have reasonably been expected to arouse strong suspicion once another person, albeit an estranged partner, was continually voicing concerns about a pregnancy.

The issue when the pregnancy was first being spoken about was whether the disclosure of the pregnancy was taken seriously. For reasons discussed in this report, regarding focus on children and involvement of fathers, Mother's denial was readily accepted, Father's claims were dismissed and consequently there was no consideration for a referral to children's social care under the pre birth protocol.

The outcome was that the pregnancy remained concealed until the actual premature birth of Rose. It has not been possible to attribute the premature birth to the lack of antenatal care accessed by Mother.

The newly introduced concealed and denied pregnancy protocol includes clear expectations of what action should be taken when a pregnancy is first discovered at the point of a birth of a child. However the pre birth protocol was not followed regarding the information provided regarding the suspected pregnancy.

### **Learning consideration 3**

**The Lancashire Safeguarding Children Board should consider the viability of an exercise to explore all known cases of concealed and denied pregnancy within the county over a designated period before and since the concealed and denied pregnancy protocol was introduced, to ensure there is compliance with the guidance and in particular appropriate use of linked procedures is occurring, such as the pre birth protocol, when criteria and threshold has been met.**

#### Opportunities for multi agency working

In this case the concealed/ denied pregnancy and how it was assessed appears overshadowed by the very premature birth of Rose and subsequent intensive treatment and care which followed. Initially it was not known whether the baby would survive, which may be a reason that immediate safeguarding processes for Rose were not instigated. However, within five weeks Rose was making good progress in terms of respiratory effort and was slowly gaining weight.

As a result of the concealed pregnancy and birth there was clear evidence that significant harm could be properly suspected of having been caused to a child, Rose, by Mother. Rose was very ill and may not have survived, which is absolute proof of significant harm. Despite this, a strategy meeting<sup>18</sup> was not convened and a section 47 investigation was not commenced. Whilst accepted the concealed and denied pregnancy protocol for Lancashire was not finalised at the relevant time, professionals involved should have had sufficient

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<sup>18</sup> A strategy meeting (or strategy discussion) is normally held when an initial assessment indicates that a child has suffered significant harm. It should be a multi agency process to establish whether there should be further child protection investigation.

awareness of agreed thresholds and procedures and applied this to the circumstances for Rose. Unfortunately, this did not occur and subsequently a child and family assessment was not commenced for Rose in her own right as soon as it was known that she would live.

At the review's learning event health professionals who were involved in the first weeks of Rose's life described the "chaotic circumstances" in terms of who knew what information and what action was being taken. A strategy meeting, which should have formed part of formal safeguarding processes, would have ensured timely, appropriate multi agency information sharing and planning.

It has been reported that the neonatal staff caring for Rose and having significant contact with both parents were initially unaware of the full history of Mother. At the learning event neonatal staff who had been involved said that Mother herself disclosed the previous history after "about three weeks" on the ward. As Mother had not booked her pregnancy with services no previous information was on health records. Consequently at the safety huddle meetings<sup>19</sup>, the history of Mother's involvement in an assault on another young child was not discussed as it was not known.

Health professionals providing one to one care to very sick children will have close contact with parents and carers at hospital. It is a necessity that relevant staff are aware of all historical information in order that children can be protected and risks appropriately managed. In this case due to formal safeguarding processes not being initiated for Rose as an individual in her own right there was a missed opportunity for some involved professionals to be fully informed of the whole circumstances enabling better protection of Rose.

Children's social care records for the initial period of Rose's life indicate that she was not recorded as an open case as an individual in her own right. This was also the position much later when Rose was four months old. Notes from a legal gateway meeting in January 2017 state she "has no status (in Lancashire), she is not subject to a child protection plan, or child in need plan, and there is no child and family assessment."

Much of the early social care recording related to the sibling Daisy with a focus that the home placement agreement for Daisy had been breached by Mother. This was clearly a priority for children's social care as during this stressful time for the family whilst Rose was considered to be in a safe environment in hospital, Daisy was still living with Mother and having contact with Father.

A legal gateway meeting was held within two weeks of the birth where discussions took place between children's social care professionals about the circumstances for Rose, Daisy's home placement and Mother's history. Legal advice was provided and a further legal meeting planned in five weeks. There is recorded evidence on the review's timeline that regular liaison was taking place at that time between the social worker and Daisy's health visitor but it is unclear what information and plans was shared with other key professionals, outside of children's social care, who were also involved in the lives of both children and the parents.

As normal child protection procedure and activity did not commence for Rose, meaning a strategy meeting, section 47 investigation and initial case conference did not take place, there was no opportunity for formal information sharing, multi disciplinary planning and collective consideration of risk.

The processes above, which are integral to any response to suspected significant harm to a child create a mechanism for ongoing involvement of multi agency professionals. In this case, compliance with safeguarding procedures would have helped all relevant professionals to be

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<sup>19</sup> Safety huddles are meetings held twice a day on the ward to discuss any important past issues.

aware of history of the family and developments in such a complex set of circumstances and provided an opportunity for current pertinent information and views to be shared to help ensure the safest outcome for both children.

#### **Learning consideration 4**

**The Lancashire Safeguarding Children Board should consider an audit with an emphasis on open/ongoing cases of families with multiple children and/or siblings where new concerns arise to ensure expected procedure is followed in terms of status and recording of those children, and that agreed processes take place such as strategy meetings and section 47 investigations which enable a multi disciplinary approach to help ensure focus is maintained on all children involved.**

#### Responses to minor injuries to looked after children

On two separate occasions in the review timeline Daisy was said to have sustained minor facial injuries. The first incident was in early May 2016 when Daisy was eleven months old. The injury was described as a bump to the nose and left cheek. Mother told the early help outreach worker that the child, who was toddling at the time, had fallen and bumped into a TV unit which was considered a plausible explanation. Just over a week later the health visitor saw the child with Mother, and Mother told her (the health visitor) about the bump to Daisy's face. Mother said she had taken the child to the GP the day after the bump but there is no record of an appointment.

The second incident was in early August 2016 when Daisy was 15 months old. The health visitor was told by Mother that the child had bumped her head on the DVD player. It is unclear whether an injury was visible to the health visitor. In the same visit Mother spoke about an unconnected allegation believed from Father's family, which had been made to children's social care about her alleged poor parenting of Daisy, which Mother denied. She also spoke about Father not having contact for about six weeks. These additional issues for Mother could have been viewed as stress factors for her but in records she was described as in a mostly positive mood during the visit.

Whilst accepted that both incidents and the injuries sustained were minor, with plausible explanations provided, Daisy was on a care order with home placement when both incidents occurred. In addition, Mother's history should have been known to the professionals involved in each episode. This should have resulted in Daisy being considered as a vulnerable child who also, by reason of age was not able to speak for herself and give an account about the incidents.

In the *Serious Case Review Child LB, Lancashire Safeguarding Children Board* (as yet unpublished) several minor injuries were noted by professionals to a child within a short time frame. Possible explanations were given by the carers involved and no action was taken. Eventually serious non accidental injuries were found on the same young child.

Best practice regarding the minor injuries to Daisy would have been to explore and record the incidents thoroughly. More robust enquiry may have elicited a response from Mother which either fully satisfied the professionals, or aroused more concern relating to each injury. Either way a reasonable expectation would also be for the allocated social worker of a looked after child to be informed of any injuries incurred. This did not happen for either incident. Furthermore, the anomaly of Mother saying there was a GP attendance for the first injury was never explored.

Professionals must be prepared to enquire without apology when circumstances present, however minor, which could have an alternative and more concerning explanation. Sustaining

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a positive professional relationship with families must include challenge when necessary to ensure children are continually safeguarded.

Regarding balancing support and challenge in *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 Final report: May 2016, Peter Sidebotham, Marian Brandon et al*, it states “without professional curiosity professionals fail to recognise risks, downplay them, or focus on parents’ needs to the detriment of the child’s”.

### **Learning consideration 5**

**The Lancashire Safeguarding Children Board should consider the development and implementation of guidance relating to looked after children who sustain injuries, including who should be informed and what action should be taken/ recorded.**

In November 2016 when Rose was two months old and still in hospital an incident was witnessed by a member of nursing staff when Mother allegedly pinched the foot of Daisy whilst they were on the ward. The concern was referred on appropriately and a section 47 enquiry took place. The child’s foot was examined with no visible injuries, and due to her age sibling could not give an account herself about what had occurred.

Mother was questioned by the social worker but strongly denied any wrongdoing. She was immediately believed by professionals leading to no further action being taken.

As in the two incidents referenced above, at the time Daisy was a looked after child but unlike the incidents at home the social worker for the children was informed about the allegation on the ward. The difference with the incident at hospital is that there was an independent witness to the alleged behaviour by Mother to the child. However, Mother’s account was accepted over the account of a professional and no further action was taken. The nurse involved attended the practitioner learning event and maintained that what she had seen was accurate.

The response to the referral gives a further indication of Mother’s ability to influence the judgement of professionals to believe her and empathise with her position as a mother of a very poorly, premature baby. That was despite the known history of Mother’s concerning behaviour previously regarding physical abuse, and her proven history of misleading professionals exemplified by the concealed pregnancy. Focus on children and disguised compliance was explored earlier.

### **Learning consideration 6**

**The Lancashire Safeguarding Children Board should consider issuing a reminder or further promotion of the resolving professional disagreements policy, for neonatal and other similar staff groups who may not routinely experience the need to make a safeguarding referral or escalate concerns, to ensure all staff has awareness of the pathway to professionally challenge decisions made impacting on the safety and wellbeing of children.**

#### Consideration of fathers

Rose and Daisy had the same birth father but the relationship between Mother and Father was not permanent. When Mother became pregnant with Daisy she described this as due to a casual encounter. Father also described the relationship as “on and off”. Prior to becoming pregnant with Rose the couple were still not in a stable relationship but had been in regular communication due to the contact arrangements for Father to see Daisy, and also the unofficial contact which is now known to have been occurring. The opinion and account of

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both parents regarding their relationship was reflected in detail earlier, and is largely consistent, particularly about contact.

Children's social care records show the contact arrangement for Daisy with Father was due to concerns relating to Father's mental health, alcohol use, his previous convictions and allegations made by Mother about his aggressive behaviour. At a point later in the review timeline Father spoke to his GP when feeling particularly low. He claimed to have access to a firearm but this was not substantiated.

Father was identified as being a significant person in Daisy's case from the initial child protection conference for the unborn child (Daisy) at the end of March 2015. Professionals became more involved with Father from this point and a parenting assessment was commenced with him. It is positive that support was offered for his alcohol use and there was signposting to housing services. However, Father had a learning difficulty, and despite this being considered when he was assessed he was not offered support to ensure he fully understood the ongoing safeguarding processes. Father's own close family could not easily provide him face to face support due to the area where they all lived, which was several hours' drive away.

Although reassuring that Father was included in formal processes such as case conferences and reviews it is of concern that despite Father's limited ability to read and write he was asked, without any assistance being offered, to read and sign formal children's social care documents relating to his children. The Reviewer on meeting Father, and on speaking to his own Mother about Father's education, was of the opinion that Father would have required an advocate or supporter to assist him with the complicated safeguarding processes of which he was an integral part. The Police, when interviewing Father as a witness after the death of Rose, used an appropriate adult to support Father and to ensure he understood what was happening during the criminal investigation.

Father's contact initially with Daisy was supervised in a formal arrangement at a contact centre. After some positive feedback from Mother about Father in early 2016 the contact changed to being supervised by Mother. This highlights the trust that professionals had in Mother as an individual and in her parenting capacity, that she should be viewed as the more responsible parent, with less risk to Daisy, than Father. What is now known is that this was the period when Rose was conceived but neither Mother nor Father declared their developing relationship to professionals.

A common feature in some serious case reviews nationally is that fathers are not routinely considered by some professionals working with families. There is evidence in records for this case relating to both children that agencies did involve Father. Mostly they did try to ensure he was a part of the children's lives with restrictions, and in decisions being made relating to the family, albeit he may not have fully understood the ongoing process. Additional support which should have been provided to Father to assist his understanding is discussed above.

Despite the positive practice of Father being invited to and included in many of the safeguarding processes for the children there was an obvious difference in the way he was judged by some professionals, in comparison to Mother. This is a view shared by Father and his own family, and evidenced in much of the information now collated from records for the timeframe of the review. Even Mother shared her opinion with the Reviewer that the way Father was treated by children's social care, particularly regarding contact, was "harsh".

The concerns about Father, which were properly considered and assessed, are detailed above. However similar concerns also existed for Mother in terms of mental health issues, alleged cannabis use, past alcohol misuse and of more significance the known previous incidents of physical abuse. Regardless of this information about Mother, and the

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assessments which took place, professionals believed her to be the more responsible, trustworthy and less risky parent of the two. Furthermore, Mother appeared able to hold the attention of some professionals in raising further concerns about Father's behaviour, for example allegations of verbal threats, concerns which were generally not corroborated.

In *Hidden Men: Learning from Case Reviews, NSPCC, March 2015* it is highlighted that professionals can sometimes "rely too much on mothers to tell them about men involved in their children's lives. If mothers are putting their own needs first, they may not be honest (about the risk these men pose to their children)", or as in this case the risk they themselves pose.

In the Summer of 2016 when Mother's pregnancy denials and allegations about Father's verbal abuse were being believed, she was manipulating professionals with her lies, whilst Father's claims were not properly listened to and were dismissed. This is further indication of the faith and trust which professionals had in Mother over Father.

The *NSPCC Hidden Men* study suggests professionals may not always talk to other significant people involved in a child's life which can result in them missing crucial information and failing to spot inconsistencies in a mother's account. In this case Mother's circumstances were that she had no family and friends, which limited the amount of additional information from others which could be considered. However Father, who offered information about the pregnancy and his relationship with Mother, was not taken seriously. Furthermore, close relatives of Father told the Reviewer that they tried to report concerns about Mother's parenting but they did not feel properly heard. These were missed opportunities for professionals to consider a wider perspective on the family as a whole, and to keep a more open mind about possible risks to the children.

### **Learning consideration 7**

**The Lancashire Safeguarding Children Board should consider requiring an audit of cases which include contact arrangements as a significant issue to explore that fathers are being heard, involved and provided with appropriate support in order that they are given the same opportunities as mothers when exploring best outcomes for children.**

### Assessments

Mother, as a known perpetrator of physical abuse to a child previously, was subject to formal assessment processes relating to her parenting capacity of Daisy. It was positive that assessments commenced for the unborn child, Daisy, as soon as the pregnancy became known to services. This was not the position for Rose as the pregnancy was concealed; responses relating to the pregnancy were discussed earlier.

As a result of the injuries to the child in 2004 an independent assessment was commissioned by Lancashire County Council which was undertaken by the NSPCC in 2004/2005. The assessment was comprehensive. A conclusion was that there was limited change for Mother within the assessment period, which was over several months, and the assessor "could not predict Mother's ability to sustain or develop her skills for parenting long term". A key finding was the view that Mother's own poor childhood experiences had impacted on her deeply as an individual, but most significantly if she was ever to parent a child. It was highlighted that "these experiences had left her with limited ability to meet the needs of children for nurture, stability, routine, care, socialization and boundaries".

To reinforce what has been highlighted earlier about Mother's more recent disguised compliance the NSPCC report in 2005 identified Mother as appearing to be working with

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agencies on the surface, but that she had difficulty internalising information and advice given. It was judged that she would find it difficult to benefit from groups and classes aimed at parents and carers, because she was inconsistent in her responses and understanding of what the role of parent/ carer entails. It was of concern to the NSPCC that throughout the assessment Mother had minimised her involvement in inflicting the serious injuries to the child.

The NSPCC shared all information and professional judgements collated within the assessment process with Lancashire County Council. Therefore the full information was retrievable from children's social care records when the pregnancy of unborn Daisy was reported in 2015, and for subsequent interventions regarding the family.

The GP medical records for Mother contain some historical information that highlighted her own adverse childhood events. This included dysfunctional family experience, maternal alcohol misuse, being a victim of suspected physical abuse as a young child, suspected failure to thrive and bereavement of her own Mother at a young age. Such significant adverse experiences may be judged as impacting on Mother's future parenting capacity.

There is no note in GP records that suggests information sharing was requested or took place in terms of the content of Mother's medical records that may have contributed to any risk assessments or parenting assessments of Mother. GP involvement in child protection processes is explored in more detail later.

It is positive that the child and family assessment for unborn Daisy in early 2015 contains some information about Mother's experiences in her own childhood and adult life. There is reference to disclosures which Mother made to children's social care for the assessment in 2015; Mother shared details of her own unhappy childhood and spoke about alcohol and drug misuse whilst an adult, and some mental health difficulties. The disclosures were consistent with information shared by Mother for the NSPCC assessment in 2005.

The outcome of the children's social care assessment relating to the unborn Daisy was that a care order was applied for and as soon as the baby was born and discharged from hospital Mother and child went to live in a foster placement away from the home area.

During this time two psychological assessments of Mother took place to inform the overall assessment of Mother's parenting capacity. The findings of the psychological reports are considerably different despite both assessments being conducted over a short period of time during 2015.

The assessment by the first clinician, who had also been involved after the previous incident of significant harm in 2004 concluded that any progress by Mother was due to the artificial environment of the highly supported foster placement. That clinician raised the concern that no significant work recommended after the NSPCC assessment in 2004/2005 had been undertaken by Mother to address her behaviour.

The second clinician was the professional responsible for Mother's cognitive behavior therapy, arranged by children's social care after the first clinician's assessment was being challenged, whilst Mother was still living in the foster placement. The second clinician concluded that Mother "had engaged well and openly with the psychological therapy, that she showed insight into her previous difficulties and had motivation to make further changes". Overall the second clinician felt with ongoing support Mother could provide safe care for her child.

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It is unclear in children's social care recording how the very different professional opinions were managed. However it can be assumed the more positive findings of the second psychological assessment were accepted and informed the decisions to allow the home placement agreement regarding Daisy in late 2015 to be made.

Whilst Mother and Daisy lived in the foster placement, which was away from the home authority it was positive that statutory visits took place as required. Mother was assessed by children's social care professionals as generally making good progress.

Unfortunately within a few months of returning to live independently with Daisy, Mother had breached the home placement order by resuming the relationship with Father, thus allowing him contact with Daisy which was outside of the formal contact arrangements. He himself had been part of the assessment for the unborn Daisy in early 2015 when a number of risks regarding Father were considered leading to the formal contact arrangements for him, as explored earlier.

Statutory reviews did continue to take place for Daisy as a looked after child. There is evidence that professionals conducted health reviews and multi disciplinary liaison occurred as required to inform the looked after child review process.

However, once Mother and Daisy were living independently from early 2016 the frequent interventions by a number of different professionals appeared often to focus on the needs of Mother, without assessing holistically the needs of Daisy and without full consideration of the wider circumstances including the significant history of Mother.

*Working Together to Safeguard Children, HM Government, March 2015* suggests "a good assessment is one which investigates three domains: the child's developmental needs, including whether they are suffering, or likely to suffer, significant harm; parents' or carers' capacity to respond to those needs; and the impact and influence of wider family, community and environmental circumstances". This is commonly known as "the assessment framework".

It was regularly documented that Mother had little close family support and limited ties within the community. Her personal life in terms of relationships was complicated, with only a casual relationship with Father, which was allegedly volatile at times. It has also been suggested that aggression was a factor in Mother's previous relationship.

As explored earlier, Mother became pregnant but went on to conceal the pregnancy until the premature birth of Rose. It is now accepted that Mother was intent on deceiving all professionals regarding the pregnancy, whatever her reasoning for this. However, it was highlighted before that a more robust response to Father's claims about the pregnancy, including increased scrutiny and assessment of Mother should have occurred.

After the birth of Rose and once her condition improved, assessments to inform the important decisions of where and with whom Rose and Daisy would live, should have included full exploration of the history for Mother including a return to the original NSPCC assessment findings. Sufficient scrutiny and weight was not given to the original judgements relating to Mother's ability to parent, and the substantial adverse childhood experiences which Mother herself had disclosed.

The clinician from the 2004 circumstances had the benefit of a psychological reassessment of Mother in 2015 whilst she and Daisy were in the foster placement. However the follow up psychological assessment findings were overlooked in favour of an alternative clinician's findings, who was commissioned after Mother was unhappy about the original clinician's opinion of her progress. There appears little evidence that the differences in the two professional judgements to inform the assessment was scrutinised.

The assessment leading to the final decision that both children should return to Mother's care on a home placement agreement did not appear to take into account the clear breach of the first home placement agreement which occurred less than 12 months earlier. When Mother allowed Father into the home to visit herself and Daisy, outside of agreed contact times this was a breach of the order and showed Mother to be untrustworthy and non compliant in terms of her daughter's needs and the formal expectations of children's social care.

The assessment leading to the home placement failed to consider a challenge to the decision by the children's Guardian<sup>20</sup> as evidenced in Children and Family Court Advisory and Support Service (CAFCASS) records. The Guardian shared her concerns and suggested a mother and baby/child foster placement arrangement but this was overruled.

The requirement for assessments to focus on the needs of the child seemed overlooked in terms of the faith placed in Mother, despite all the information known about her and her history. Some professionals still feel the need to respond to a perceived expectation that a child or children must be placed with a birth parent, more often the Mother, which can lead to a less robust assessment of the whole circumstances and even a dismissal of overwhelming evidence to indicate this is not in the child's best interests.

It was clear that Rose's health needs included the necessity for intense care and support from Mother as a result of the premature birth. The assessment of Mother's parenting capacity that she would respond well to such complex needs, whilst also providing sole care for Daisy as a toddler, was at best over optimistic, at worst, flawed.

Another area explored in the review was the capability of the home placement support workers to assess Mother during the time spent in her home, including overnight, as part of the home placement package. Mother spoke about daily changes to the support workers who attended and that this was a challenge in her view as there was no opportunity for any rapport or knowledge of routines within the home to be properly developed. Mother said workers did note her actions, such as when she fed the children or changed a nappy. However recording what occurred is only the first part of any assessment; applying professional judgement informed by experience, training and reinforced by research should follow.

A case note completed by a support worker in the final days leading to the significant incident which caused Rose's death recorded a smell of cannabis at the home and Mother being tired. Other notes for the dates when support was provided within the home have not been made available.

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<sup>20</sup> The Guardian is the independent voice of the child in court, they are experienced social workers but do not work for the local authority or the court [www.cafcass.gov.uk](http://www.cafcass.gov.uk)

It is positive that action was taken by the social worker after the observation by the support worker as detailed above. A request was made for an extension to the planned involvement of support workers in the home placement package, which had been due to end around that time. However it is unknown what other concerns may have been observed within the home, which were not noted, actioned and properly assessed.

Assessments, particularly when relating to safeguarding, should be an ongoing process. Every contact with a family by any professional is an opportunity to assess for strengths, for areas requiring additional support, and most importantly for risk. Of paramount importance is keeping the child or children at the centre of any assessment, and sharing on any identified concerns.

### **Learning consideration 8**

**The Lancashire Safeguarding Children Board should consider requesting assurance and evidence from commissioners of external providers of support workers, such as in the case of Rose (Child LK), that safeguarding training and awareness programmes for staff are mandatory, fit for purpose and whether packages include assessment and recording as standard.**

#### GP involvement in safeguarding processes

The GP could be described as the central health professional in the life of the children in this case, and Mother. All were registered at the same local practice which Mother had used for many years.

GP records should contain recording of all contacts between the GP and patient but also normally a wealth of other health information including contacts and treatment of the patient by other health providers. Additionally, for this family the GP records contained information and flags alerting the reader to safeguarding information about the children. This is a routine occurrence for most GP practices. For example, there was a flag attached to Daisy's record when she was made subject to a child protection plan and later when a care order was granted.

Mother told the Reviewer that she "did not feel the need to use the services of the GP very much as she and the children were mostly well". The records show that Mother generally used the GP service appropriately and actually notified the surgery herself when she was moving to the out of area foster placement with the new born Daisy.

Other information shared later by Mother with the GP service is relevant to the review's circumstances. Once back in the home area with Daisy on the first home placement agreement Mother attended the GP service in April 2016 for contraception advice. Records show she disclosed she was "now back with Daisy's Father." The records for Daisy were flagged for her being a looked after child and would have been linked to Mother's record but the GP service had not been part of the decision making leading to the home placement agreement or been informed of the specific conditions of the agreement. Therefore, it may have been reasonable for the GP to assume the status of Daisy as a looked after child meant she lived away from Mother, which was obviously not the case. Mother's attendance at the GP surgery for contraception and her admission that she was resuming the relationship with Father should have raised concerns, had the GP service been fully informed of the home situation. The information should have been shared with children's social care, as the developing relationship was evidence that the home placement agreement may be being

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breached putting Daisy at risk of possible harm, but the GP involved had not been provided with sufficient background information to enable this judgement to be made.

When Mother made contact with the independent sexual health service to explore options regarding being pregnant she gave permission for a routine contact to take place with her GP for medical history to be shared. The GP records contain a written contact by the independent service at the end of June 2016 which clearly states Mother is pregnant. There is no information regarding the Father's identity but the letter should have aroused concerns within the GP service had the service been aware of the detail of the ongoing processes for Mother and Daisy. Unfortunately, the GP service was not aware of the full circumstances for Daisy as a looked after child and no information was shared with children's social care or other agencies.

The response by children's social care professionals to Father's claims that Mother was pregnant was explored earlier. No enquiries were made other than with Mother therefore the content of the GP records was not known. This was a missed opportunity for Mother's pregnancy to be confirmed.

The GP service received notification of the birth of Rose two weeks after her premature birth. This was highlighted with significant events comments<sup>21</sup> that the baby's sister was subject of a care order. At this point had the GP service had full knowledge of the home placement of Daisy and the other family circumstances in addition to the standard notification of a looked after child from children's social care for flagging purposes, then full information of Mother's recent medical history could have been shared. This information included the developing relationship with Father and the concealed pregnancy. Furthermore, had the GP service had the opportunity to contribute to professionals' meetings being held at hospital around that time this valuable evidence relating to the actions of Mother in the months leading to the birth should have had a significant impact on the assessment of Mother and her future parenting capacity.

There is no indication that the information held in GP records for Mother during 2016 was ever requested or considered even after the birth of Rose. Mother attended a GP appointment for a post natal check in October 2016 and records show that contraception was discussed; Mother said that "partner visits evenings and weekends". For the circumstances at the time this was again very useful information being casually disclosed by Mother. Unfortunately, the GP service was not aware of the detail of what had been agreed in terms of the contact between parents and more importantly Daisy as a looked after child. Therefore the information was not considered relevant and was not shared.

The GP service involvement and information held on GP records through 2016 cannot be underestimated in terms of its value to the ongoing safeguarding processes and assessments after the birth of Rose. GPs and the information they hold must be seen as an integral part of any safeguarding process and particularly in complex cases with high risk.

GP involvement in safeguarding processes has been regularly scrutinised by local safeguarding children boards across the country and in many serious case reviews. The issue in this case is not simply whether GPs contribute to, or attend case conferences and similar meetings, which is of course important and necessary. What this case demonstrates is that

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<sup>21</sup> Significant events comments are summarised in GP patient records and include noteworthy episodes for a patient, for example the birth of a child.

the GP service became aware of, and held in records, significant information relating to the family but due to a lack of involvement in the ongoing processes did not make the link that the information was important and needed to be shared.

Other health professionals with continuing involvement in formal safeguarding processes will have a structured professional connection to GP services. The health visitor for Daisy was regularly in contact with the family due to Daisy being a looked after child. There was documented multi agency liaison between the health visitor and children's social care professionals which indicates the health visitor was in touch with some, if not all, activity within the case.

In some areas regular safeguarding meetings take place within GP surgeries or GP clusters. The meetings enable key health professionals connected to a surgery's area and patients to share information and progress on the most complex cases, children and adults, linked to the GP service. The nominated GP safeguarding lead in attendance is then in a position to disseminate relevant information to GP colleagues. When operating effectively, such a process should ensure that other GPs are better equipped to manage sensitive information and disclosures which may be presented to them in appointments.

It was reported that within the GP practice where Mother and the children were registered monthly meetings take place at the surgery where information is shared between the health visiting service and the GP service about children and families. This is a positive arrangement but if information is not known to be relevant, as highlighted above regarding Mother, then it will be not be shared.

GPs can often be in the unique position that patients will disclose key information to them which has not been disclosed elsewhere or may have even been hidden from other professionals. Mother's trust issues were well documented and she herself even admitted to problems trusting professionals. Despite this she spoke to the GP about her relationship with Father when discussing contraception. She also gave consent for the GP service to be contacted when exploring a termination of the pregnancy which she was trying to conceal.

Father was also regularly attending a different local GP service after Rose's birth due to anxiety, low mood and some suicidal thoughts, all identified by Father as connected to his family circumstances at the time. There is no information that Father's GP service was included in the safeguarding processes for the children despite Father's continuing relationship with the surgery, and the ongoing parenting assessments of Father which included assessment of risks.

The issues of Mother's GP service not being fully aware of the detail of the case and of the home placement agreement have been explored above. However, Father's interaction with his GP was also relevant and useful for other professionals to be aware of when decisions regarding contact and risk were being considered.

As demonstrated in this case the GP surgeries connected to both Mother and Father held key information within records which would have informed assessments and decisions relating to the children. Children's social care professionals must routinely involve GPs of both parents to ensure all information relating to children is available for consideration.

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At the same time and especially in cases where there is long term involvement of children's social care, GPs should remain professionally curious to the circumstances which patients present, even when the full detail and history is unclear, to ensure all vulnerabilities of the patient, or others connected to them may be properly addressed.

### **Learning Consideration 9**

**The Lancashire Safeguarding Children Board should consider, in consultation with local CCGs and other partners, options for ensuring the continued and meaningful engagement of all relevant GP services throughout safeguarding processes and particularly for those cases with additional complexities to ensure information sharing is continuous, effective and can inform assessments and decisions, including in legal proceedings, relating to the wellbeing of children.**

#### Consistency of professionals involved with families

Mother was fortunate to have had experience of a number of professionals who remained involved with her and the children over a long period. Families often comment that it is difficult when constant changes are made to key professionals with whom they are expected to form sound working relationships.

In this case individuals with long term knowledge and experience of supporting the family included professionals from midwifery and health visiting, who had contact with Mother due to the births of both children and antenatal period for Daisy. The family support worker was involved with the family from the period when Mother and sibling lived in the foster placement, until the death of Rose.

Other support provided regularly over an extended timeframe to Mother was from professionals and volunteers with whom she was able to develop strong relationships, for example the early help outreach worker and the church organisation volunteer. There is no doubt that many professionals worked hard to develop a good rapport with Mother to try to support her and the children. The ability of professionals to build positive working relationships with Mother should not be overlooked particularly as Mother, from her own adverse childhood experiences had difficulties in developing trust and connecting with others on a personal level.

Unfortunately, it is now known Mother had the propensity to manipulate professionals using disguised compliance, discussed earlier. Such behaviours may have been more challenging for some professionals to identify in Mother, particularly those with whom she had developed good longstanding relationships. However, as long as professionals maintain the skills to offer support with respectful challenge, a stable longer term involvement should be more beneficial to children and families receiving a service.

Due to the circumstances of the case there was considerable children's social care involvement, with Mother and the children receiving social work support. Through the timeframe of the review the social worker involved for the pre birth period and foster placement for Daisy and Mother remained allocated to the case until a month before Daisy and Mother returned to the home area to live independently.

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A different social worker was then allocated who remained involved throughout 2016, through the concealed pregnancy period until around the time of the birth of Rose. At this point another social worker took over the case until the end of 2016, being replaced, due to a routine team transfer, by an agency social worker at the early part of 2017. This social worker was involved leading up to and including the time that Rose was discharged from hospital under the home placement agreement. When the incident occurred in April 2017 leading to Rose's death another change in allocated social worker had been agreed, with a different agency social worker taking responsibility for the case up to and including when the child died.

In summary five social workers were allocated during the review timeframe, a period of 28 months. It is acknowledged that statutory requirements in terms of reviews, core groups and other formal processes were met and not impacted by the social worker turnover. However, the frequent changes in social work allocation to the family is unsatisfactory for such a complex case particularly in the significant period of the timeframe after the concealed pregnancy was discovered with the birth of Rose.

Any social worker newly allocated to this family with its complicated chronology would need protected time to familiarise themselves sufficiently, especially regarding Mother's concerning history. Unfortunately, the tragic events which unfolded for the children clashed with the period of highest turnover of social work allocation within the case. Therefore, the detailed familiarisation and analysis of the case chronology would have been a challenge for any new social worker leading to the probability that assessments and decisions relating to placements and risk for the children were not fully informed.

Father of the children told the Reviewer that he did not find it easy to work with the constant changes in social workers particularly towards the end of the review timeframe. Father and other members of his family held the opinion that the family support worker, who had been allocated long term, was "leading the case in terms of children's social care involvement towards the end of Rose's life". Whilst accepted that this professional had extensive knowledge of the family history, she was not a qualified social worker and therefore not responsible for key decisions and actions relating to the children.

Mother's views regarding the challenge that frequent changes to allocated social workers presented to her has been detailed earlier.

Turnover and changes in social workers allocated to the non recent case of the injuries to the other child was also highlighted as a negative issue by the family members who contributed to the review regarding their experiences.

A number of articles have been written about the issue of social work retention, which obviously links to consistency of social work allocation for families. In *Social work recruitment and retention*; S.Bowyer/ A,Roe, [www.rip.org.uk](http://www.rip.org.uk) (research in practice), July 2015 a number of factors were identified which result in workers leaving the role/profession. These include lack of clarity about roles, high levels of stress/burnout, "blame culture" and overly bureaucratic systems.

High numbers of agency social workers and the impact of such arrangements have also been subject to scrutiny in many local authorities. A professional who was involved long term with Mother and the family commented that she was surprised an agency social worker was

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allocated to such a challenging case, when complexities within the case were at the highest level.

The Reviewer was told that there had been a requirement for the Authority to use high numbers of agency staff to ensure the needs of the service were met. This is not unique to one local authority but is a common requirement throughout the country. Unfortunately, agency social workers by the temporary nature of their roles do frequently move on. If agency staff have been allocated to complex cases invariably this means that cases need to be reallocated leaving families with the challenge of building new relationships with different workers. This was an experience which both parents of Rose and Daisy spoke about.

However, the key issue to question is the movement/ change of social workers, whether permanent or agency staff, on this complex case and specifically at significant points when high risks to the safety and wellbeing of very young children were being managed. Little information has been shared to indicate that the reason for changes in social work staff in this case was due specifically to retention within the authority.

Those responsible for organising allocation of social workers to complex cases must consider the needs of the children and family as a priority. Managers should plan accordingly to ensure, other than in extenuating circumstances that experienced, permanent social workers are allocated to provide the highest quality of service to those most in need. Good practice in complex cases would be for managers to record a reason or rationale for a change in a lead professional on the case record.

### **Learning consideration 10**

**The Lancashire Safeguarding Children Board should consider requiring assurance and evidence from the Director of Lancashire Children's Services that allocation of lead professionals to complex cases is being managed effectively particularly when there is a need for transfer of cases, with rationales for changes in allocation being clearly recorded.**

#### Safeguarding awareness and responses in non statutory organisations

During the review timeframe Mother and Daisy were in contact with numerous professionals and some volunteers. Whilst accepted that safeguarding may not have been the main reason for the involvement of those individuals, or their core business, the full circumstances for Daisy, Mother and Rose (pre and post birth) were very much linked to safeguarding including management of risk.

A church volunteer accessed the home of Mother and Daisy regularly and was said to have developed a strong bond with Mother. She was often present when other professionals attended the address to carry out health and developmental checks and social work statutory visits.

When the second minor injury had occurred to Daisy in the summer of 2016 the volunteer was present when the incident was discussed by Mother and the health visitor.

The voluntary group to which the volunteer was linked was a local Christian family support organisation. Unfortunately, the group is no longer in operation and records are not available

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but there is general evidence for the specific timeframe that some volunteer training took place and volunteers were subject to criminal records checks.

Mother, in her meeting with the Reviewer, explained that her relationship with the volunteer developed into more of a friendship over time. Due to the closure of the organisation it is unclear whether the volunteer was still in contact with the family during the latter part of the review timeframe in an official voluntary capacity or by personal choice as a friend.

Families involved in safeguarding processes from early help level to complicated child protection cases, such as the circumstances of this review, can benefit positively from the involvement of voluntary organisations which provide additional support. Mother said that the volunteer she knew did “grow into a friend who provided help with a house move” and other assistance.

Unfortunately, there is limited evidence of information sharing or inclusion in the formal multi agency safeguarding processes which were ongoing for the family by the volunteer. This includes at key points in the review timeframe when concerns such as minor injuries to Daisy, contact issues and the concealed pregnancy were evolving. Mother recalled that she thought the volunteer was involved early on, in formal review processes for Daisy but not later, which may have been due to the closure of the voluntary group.

It is essential that any organisation with volunteers or staff, having face to face access to vulnerable children and families operates safe recruitment, and that staff and volunteers are appropriately trained in safeguarding. If, as may have happened here volunteers then choose to continue personal involvement with families after volunteering has ended they will hopefully work within safe boundaries and still benefit from and utilise safeguarding awareness they have received should concerns occur.

Mother also became engaged with an independent sexual health organisation when seeking support and information regarding a possible termination of the concealed pregnancy. Engagement with this service was not face to face as Mother failed to keep an appointment which was offered. However, Mother did have some telephone and email contacts with the service and discussed personal details including medical history. Mother also volunteered some history regarding her involvement with children’s social care in the past and informed the clinical service advisor with whom she spoke that she had a child (Daisy) on a care order.

Records show that the organisation made contact with Mother’s GP surgery requesting medical history. This is routine after a request for a termination. There was no other contact by the organisation with any other professionals known to be providing a service to Mother and her family. Therefore, the information which Mother shared with the organisation to inform the process prior to a termination was the family position from her point of view and personal experience. It is unlikely that full details of all risks were provided, and it is not known whether Mother spoke specifically about Father, with whom she had formally agreed with children’s social care to not have contact, apart from organised contact arrangements. From records shared Mother clearly spoke to the clinical service advisor about restrictions as to who she could arrange to care for Daisy whilst any appointment regarding a termination took place.

The independent sexual health provider has shared all information from the contacts with Mother. Details have been provided of the safeguarding arrangements and procedures which the organisation has in place. A safeguarding children and young people policy states how

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advice is available through safeguarding named nurses for the organisation with safeguarding leads based in each centre. The policy includes information on types of abuse, information sharing and confidentiality. All clinical service advisors undertake safeguarding training to appropriate levels.

In assessing Mother on the information provided no further advice was requested by the clinical service advisor from a centre lead or named nurse for safeguarding, despite Mother disclosing significant history with children's social care and having a child on a care order. As a result, no information sharing or raising of concerns was forthcoming from the independent provider, and the pregnancy remained concealed.

Safeguarding is not the core business of the independent sexual health organisation, but as proved by this case the service was contacted by an adult (Mother) who was involved with her child in a complex and protracted safeguarding process. Other similar circumstances may arise for the independent organisation, due to the sensitive nature of the service and therefore all staff would benefit from awareness of the circumstances of this specific serious case review.

### **Learning consideration 11**

**The Lancashire Safeguarding Children Board should consider a request to the independent sexual health organisation involved that they review the contents of this report and in particular encourage the use of safeguarding centre leads and named nurses within the organisation to advise when similar circumstances are disclosed, including when there is extensive involvement of children's social care within a family and when a child is subject to a care order or other legal proceedings.**

Professionals for whom safeguarding is a key part of their work must be aware of the need to seek out and involve all relevant parties known or suspected to be offering a service or support to a family in order that they can contribute to safeguarding processes including assessments and where necessary formal processes such as children's reviews. For some cases this may include services or individuals outside of the standard agencies routinely involved

In the case of Mother the organisations and individuals above, albeit involved with the family for very different reasons, could have contributed usefully. For the reasons explored this did not happen; at all for the independent health provider and did not continue to happen for the volunteer/ voluntary group.

### **Learning consideration 12**

**The Lancashire Safeguarding Children Board should consider an exercise to explore how non statutory organisations, including voluntary or independent agencies who may not be routinely involved with families, can be identified and included in safeguarding processes to ensure valuable information which they may hold regarding children and families can be contributed to inform assessments and decisions.**

### Decisions relating to legal proceedings

Legal proceedings were ongoing throughout the timeframe of the review due to Mother's concerning history with another young child many years ago. There was a substantial gap of significant children's social care involvement with Mother, between 2006 and 2014. This was

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due to Mother not being known to have significant contact or care of any children during that period.

An interim care order was granted for sibling in the summer of 2015 and the decision made for Mother and baby to be placed in a foster care setting. Supervised contact between Father and sibling commenced from this time. The decision to place with foster carers after Daisy was born was a sound judgement to ensure the protection of the child and support for Mother whilst further assessments of Mother's parenting capacity took place.

In late 2015 Mother returned to the original area and a home placement was agreed for Daisy to live with Mother independently. This was largely due to Mother's perceived good progress in the foster placement and the positive second psychological assessment by the second clinician. The differences in the two psychological assessments, consideration of the findings and the subsequent outcome was explored earlier, but in summary Mother was assessed to have made fundamental progress over a very short time frame. This progress was perceived as positive but it is unclear if Mother's position of living in a highly controlled environment when the therapy and second psychological assessment took place was properly considered, or compared to the very different, chaotic settings of Mother's recent past.

Supervised contact with Father continued as part of the home placement agreement, and this has been explored throughout the review. During the first home placement Mother concealed the pregnancy resulting in Rose's premature birth.

Legal meetings are known to have taken place regularly after Rose was born with children's social care appropriately seeking legal advice. The status of Rose as a child in her own right and subsequent safeguarding processes was explored earlier.

Some records from legal meetings were shared with the Reviewer during the review, but not all records were available. Strenuous efforts to locate documents continued after the review was complete, with the search for records overseen by children's social care senior managers. Eventually some notes from legal meetings were traced in February 2019 and were shared with the Reviewer. The Reviewer has been assured that all notes and minutes made at the time have now been found. Children's social care recording of legal meetings evidencing key decisions and clear rationale regarding the future of the children should have been completed and uploaded in a timely manner. Recording at this significant point in the case did not meet expected practice which is unacceptable.

Legal advice was provided on the basis of information and assessments collated by children's social care. The quality of some assessments and subsequent decisions throughout the review has been questioned earlier.

Both Mother and Father said they were confused over legal decisions made once it appeared that Rose was making progress and would survive. Both parents spoke separately but similarly about their frustration of how decisions were made and then changed regarding removal and placement of the children. Mother, in particular gave the example that she received a letter around Christmas 2016 informing her of the local authority's planned intention to remove Daisy from her care. At this time Rose was still in hospital and as such was considered to be in a safe environment.

Within two weeks this decision was overturned and Daisy whilst still on the care order remained living with Mother. Over the weeks which followed the detailed home placement plan for both children was developed and agreed.

The rationale for the change in direction and decision regarding the immediate future of the children was not made clear to Mother. Father and his family said they were also not informed of the reasons for the change of plan. The sister of Father recalls specifically her distress on discovering the decision to return both Daisy and Rose to Mother's sole care.

The Reviewer and Panel have attempted to explore the change in direction for the planned arrangements for both children. The documents for the period December/ January 2016 were finally located and shared with the Reviewer in February 2019. These indicate the decision to inform Mother of the planned removal of Daisy was made by the local authority as a result of the child and family assessment completed in December 2016. It appears the plan to remove was not endorsed by legal advice at that time.

Information submitted by children's social care to the review Panel indicates that a legal meeting with a senior manager took place on 18 January 2017. There was a delay in locating children's social care notes of this meeting but these were finally traced. The legal notes were located much later and supplied to the Reviewer in February 2019.

The children's social care notes from 18 January 2017 and the legal notes submitted to the Reviewer in 2019 have been examined. It is clear that the legal advice on 18 January 2017 was in direct contrast to the suggested action which the local authority had outlined to Mother in December 2016. The legal notes state "firm advice is that the test for removal is not met in respect of either child". The children's social care notes from 18 January 2017 suggest there "was no threshold to remove Daisy as the care by mother was reported to be good", which was very different to the conclusion of the child and family assessment completed the month before. It was suggested further information should be obtained from the psychologist regarding Mother's ability to care for two children. The plan was for a full risk assessment to be completed once a further psychological report was available.

At a court hearing on 6 February 2017 the interim care order and home placement agreement was not granted by the Judge or children's guardian due to lack of detail and clarity regarding the support plan and contact plan for Father. A short adjournment led to the agreement of the home placement on 10 February by the Judge, children's guardian and local authority with a detailed support plan in place.

Further scrutiny of this key point in the review timeframe indicates the court expressed the view that it would not be appropriate for the same psychologist to be the appointed expert in the case as she had been a treating clinician for Mother previously. The court invited the parties to consider the identity of an appropriate expert for Mother and whether there should be an up to date assessment of the Father.

Unfortunately, there is no further evidence on file to demonstrate that an updated psychological assessment of Mother took place by any other expert within the care proceedings. Therefore, no further professional clinical opinion was obtained about Mother's parenting capacity prior to both children being returned to her care, despite being requested at court.

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Furthermore, the significant change in the children's social care opinion of Mother from the assessment concluded in December 2016 to the legal meeting on 18 January 2017 has not been sufficiently explained. Of note is that this period was one of the points within the case that a change in allocated social worker took place. The outgoing social worker who had been involved since the birth of Rose attended the review's practitioner learning event and was clear that her assessment at the end of 2016 was for Daisy to be removed and for further legal advice to be obtained regarding Rose's future. The newly allocated agency social worker contacted her in January 2017 to share that decisions had now changed and that a home placement agreement was being requested. The outgoing social worker was clear that this had not been the outcome of her assessment and suggested the new social worker would need to write a new statement and care plan in his own name.

Due to the re-allocation of social workers to the case, as discussed earlier and above, some of the children's social care professionals involved at the time are no longer employed by the authority and cannot contribute to the review. The social worker allocated in January 2017 was an agency worker who has now left.

It is regrettable that the review has been unable to completely unpick the key decisions and changes in direction for the case in January 2017, regarding the future of both children. This was in part due to records not being easily retrievable and available, and also due to the lack of recorded rationale by children's social care to explain the decisions made.

The view of other professionals involved longer term and at that period was also one of confusion as to the apparent sudden change in direction for the case and placement of the children in January 2017. Health professionals in particular voiced their concern to the Reviewer that both children were returned to Mother's care at home.

The Reviewer, having examined notes which were found in February 2019 was then able to see that all professionals in attendance at legal meetings were from children's social care. Legal meetings of this nature are for children's social care professionals to obtain advice and guidance from local authority legal departments to ensure the safest outcomes for children. The very nature of cases being placed in the legal arena indicates the seriousness of the circumstances and vulnerability of the children involved. Specialist legal advice can be requested and arranged if necessary but it is not routine and was not obtained in this case.

In circumstances such as for Mother and the children the legal advice provided was for children's social care. In the legal meetings for Rose and Daisy all those attending were in a children's social care related role with some involvement in the case. The purpose of assessments completed to inform processes where legal action is being considered is to ensure a holistic picture of the family's needs is presented to include information from all agencies. Children's social care should share all current and non recent assessments, professional judgements and other information from partner agencies to enable legal advice to be formulated from all available evidence.

However, as the review has illustrated, large numbers of multi disciplinary professionals were closely involved with the children and family, some with alternative views of what might be in the best and safest interests of the children. Such opinions may not have been voiced as robustly by professionals presenting information on behalf of other colleagues or read from summaries in assessment reports. Furthermore, not being present in meetings gives no

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opportunity for others to emphasize a particular concern, to challenge advice given or decisions made, or for a different course of action to be suggested and properly considered.

### **Learning consideration 13**

**The Lancashire Safeguarding Children Board should consider requesting that the Director of Children's Services issues a requirement that all legal meetings whatever their status are recorded by children's social care to include at a minimum- attendees, advice given, a rationale for decisions and actions, and uploaded to the Lancashire County Council recording system for the relevant case.**

### **Learning consideration 14**

**The Lancashire Safeguarding Children Board should consider encouraging Lancashire Children's Services and partners to explore options to enable key involved professionals, or one lead professional to represent multi agency partners, to be included in legal meetings where advice is being provided to children's social care relating to family court processes, to ensure the views of partners regarding safest outcomes for children are fully considered.**

### Use of home placement agreements

Throughout the review's timeframe the use of home placement agreements or orders has been scrutinised in detail. The Reviewer and Panel have queried throughout the review process the assessments and decisions which led to both children being returned to the care of Mother in March 2017.

The Reviewer was informed about a piece of work undertaken nationally which identified that the North West (including Lancashire) have higher percentages of home placements than the rest of the country. It was explained that this has also been raised with the designated family judge in Lancashire but was stressed that each case was considered on its own circumstances before important decisions regarding placement of children were made.

The position in the case of Daisy and Rose being returned to Mother's care with home placement agreements has been examined closely. A number of issues have been highlighted which relate to final decisions leading to the home placement of the children and whether this was the appropriate and safest option for the family.

### **Learning consideration 15**

**Lancashire Safeguarding Children Board may consider to require the local authority to complete and share the outcome of an analysis of children placed at home, the circumstances and decisions which led to placements being initiated and how compliance is monitored, to ensure the safety of all children who are subject to home placement agreements.**

### Criminal investigation regarding the non recent incident in 2004

As stated at the start of the review, and connected to this case, serious injuries to another young child were investigated in 2004/ 2005. For legal reasons the full circumstances of the incident are not for inclusion in this report or for publication.

It is clear that a criminal investigation commenced immediately after the injuries to the other child were identified. Mother was interviewed under caution but denied any responsibility for the injuries. Other adults were also interviewed but it could not be proved who caused the significant harm to the child. Advice was received from the Crown Prosecution Service that there was insufficient evidence to charge Mother or any other person.

In February 2005 Mother made some partial admissions during other proceedings and the police were informed. An application to the court was made by the police to obtain a copy of the admissions along with copies of medical expert reports relating to the injuries caused. A judge granted the application but stated that the admission could not be used against Mother in any criminal proceedings. There is clear case law outlining the admission and use of evidence which has been found during other proceedings outside of a criminal case.

The police did not re-interview Mother, despite the new information providing grounds to do so. The Crown Prosecution Service were consulted again and advised that there was still insufficient evidence to for a criminal prosecution.

Mother went on to confirm her admissions during the NSPCC assessment commissioned by Lancashire children's social care in 2005. In the initial meeting for the assessment in May 2005 she admitted responsibility for the injuries. All findings and information were included in the assessment report provided by the NSPCC to Lancashire in July 2005. It is not known if the further detailed admissions made by Mother to the NSPCC were shared for consideration by the police, as this was after the second consultation with the Crown Prosecution Service had taken place when the admissions in February 2005 had been made.

When the death of Rose occurred in 2017 the non recent incidents involving the other child and Mother were reinvestigated. Mother was eventually charged with the 2004 assault offences on the other child and the 2017 murder of Rose.

In the 2017 police investigation, a witness statement was obtained from a health professional to whom Mother made an admission of being responsible for the injuries to the other child. The admissions were made in 2006 during a health assessment of Mother. Mother did not have care of or contact with any children at the time, and the information was not shared. As is shown in the timeframe of the serious case review, from 2015 Mother spoke quite openly to a number of safeguarding professionals about the injuries caused to the other child.

It is commendable that the police were able to compile sufficient evidence to secure convictions for Mother relating to the separate incidents involving Rose and the other child. Furthermore, as detailed earlier, Father and his family, and the carers of the child assaulted in 2004 were all very positive regarding their experience with the police investigation team who brought the whole case to trial.

It could be questioned what was the reasoning for Mother not being re-interviewed under caution once the information was known that she had made some admissions, despite the challenge of family court information being inadmissible. Mother was not provided with an opportunity to give a different explanation to investigating officers, despite the knowledge that

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she was openly admitting responsibility for the injuries to other professionals. Had Mother changed her account to the police in a further interview, the view of the Crown Prosecution Service regarding action which could have been taken may have been different.

However, it is a subjective decision for any senior investigating officer leading a complex enquiry whether to re-interview a suspect about additional information. The Panel was informed by experienced officers that different police senior investigating officers may reach different decisions as to re-interview or not, but all would be based on a clear, recorded rationale.

The police at the request of the Reviewer have researched the earlier investigation into the other child's injuries. Unfortunately, due to the length of time elapsed since the 2004/2005 incidents there are only limited records still available within the police and no relevant Crown Prosecution Service documentation has been retained from that period.

Lancashire Constabulary were inspected in October 2017 by *Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services, part of a rolling programme of inspections of child protection of all police forces in England and Wales*. Findings published in March 2018 said "the Lancashire Constabulary demonstrates a clear commitment to providing a good service for vulnerable children in need of protection. However, it needs to provide better protection for those children most at risk".

#### **Learning consideration 16**

**The Lancashire Safeguarding Children Board may consider a request to the Lead Officer for Criminal Investigation, Lancashire Constabulary to provide assurance and evidence to the Lancashire Safeguarding Children Board that there is a clear, recorded rationale behind decisions and actions for current investigations into complex child abuse allegations carrying most risk and that cases are being managed in a timely and effective manner.**

#### **Learning consideration 17**

**The Lancashire Safeguarding Children Board may consider sharing the content of the serious case review for Child LK with the Local Family Justice Board(s) in Lancashire to ensure there is awareness of the position which occurred in 2005 when admissions by an adult in proceedings were ruled inadmissible in a criminal investigation leading to no further action at that time against a person who continued to make admissions of physical assault, and was eventually convicted of that assault, and another, many years later. Family Justice Boards and other partners may wish to explore the issues raised which may help to reduce the risk to other children in similar situations in future.**

#### **Conclusion**

The circumstances in any serious case review are tragic. The prelude to the timeframe of this review was a serious assault many years ago on a young child, who fortunately survived. The Mother of the subjects Rose and Daisy was involved in the care of the child and after initially denying responsibility for the harm caused made partial admissions, including to professionals, to having caused the injuries. Unfortunately, there was insufficient evidence to charge Mother at that time.

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When Mother reported she was pregnant with Daisy in early 2015 services immediately became involved due to the risk of physical abuse after the historical incident. Mother gave the appearance of cooperating with professionals but was using disguised compliance. She was judged as a changed person, making progress, who could be trusted to care for her daughter at home. Father of Daisy had learning difficulties and some alcohol related convictions. Despite Mother's known background of harming another child, Father was assessed as a higher risk and granted only supervised contact.

By 2016 Mother was living independently with Daisy on a care order with home placement. Unknown to services Mother resumed the relationship with Father whilst breaching the home placement agreement allowing him extra contact with Daisy. The resulting pregnancy was concealed and Father was dismissed and disbelieved by the professionals he told, who made no enquiries other than asking Mother who denied she was pregnant.

Rose was a premature baby with Mother giving birth around 24 weeks in September 2016. The pregnancy was concealed until this point. Legal advice was obtained by children's social care regarding Daisy's future, and Rose's once it was known she would survive. The legal position was complicated and swayed from sympathising with Mother to the planned removal of Daisy. Some records to explain key decisions and a clear rationale for action taken were not readily available to the review.

Eventually in February 2017 a care order was granted for Rose but with the decision that both children, a toddler and a baby born premature with complex needs, would live with Mother on a home placement with a robust plan of support. This included commissioned overnight support workers staying at the address.

The overnight support was amended to evenings at a time when some concerns had been raised regarding Mother's lifestyle. Unfortunately, in April 2017 within only a short period of the new support arrangements, the support worker had left for the night when Mother called an ambulance reporting Rose was unwell.

A serious head trauma was diagnosed to Rose suspected to have been caused non accidentally. Rose sadly died and Mother was arrested. After an investigation she was charged and subsequently convicted after a trial in 2018, of the murder of Rose and the non recent serious assault on the other child.

The findings of this serious case review identify missed opportunities which if acted upon or responded to differently may have altered the outcome of the case. However, working with families in complex circumstances is continually challenging, made more difficult when individuals who professionals are working hard to support, have intent to manipulate and deceive.

Some organisational issues throughout the review timeframe were also identified as areas for development. Scrutiny of practice always provides an opportunity to reflect on ways in which services can improve and be further enhanced. As a result of the significant incidents in the lives of Rose and Daisy there is an opportunity for Lancashire Safeguarding Children Board and its partner agencies to consider learning from the case and ways by which services and practice may continue to be developed.

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## Considerations for learning

The following considerations for Lancashire Safeguarding Children Board have been made based on the learning from the case:

1. **The Lancashire Safeguarding Children Board should consider, through the learning and development team a training analysis to examine how disguised compliance is included in current learning opportunities, and where inclusion of the issue can be enhanced, to ensure all staff across the partnership has sufficient awareness of disguised compliance as a significant risk to children;**
2. **The Lancashire Safeguarding Children Board should consider opportunities to ensure disguised compliance and focus on children, are identified as key areas of scrutiny for every case, to be examined regularly for example in staff supervision meetings and when identifying and reviewing desired outcomes for children;**
3. **The Lancashire Safeguarding Children Board should consider the viability of an exercise to explore all known cases of concealed and denied pregnancy within the county over a designated period before and since the concealed and denied pregnancy protocol was introduced, to ensure there is compliance with the guidance and in particular appropriate use of linked procedures is occurring, such as the pre birth protocol, when criteria and threshold has been met;**
4. **The Lancashire Safeguarding Children Board should consider an audit with an emphasis on open/ongoing cases of families with multiple children and/or siblings where new concerns arise to ensure expected procedure is followed in terms of status and recording of those children, and that agreed processes take place such as strategy meetings and section 47 investigations which enable a multi disciplinary approach to help ensure focus is maintained on all children involved;**
5. **The Lancashire Safeguarding Children Board should consider the development and implementation of guidance relating to looked after children who sustain injuries, including who should be informed and what action should be taken/recorded;**
6. **The Lancashire Safeguarding Children Board should consider issuing a reminder or further promotion of the resolving professional disagreements policy, for neonatal and other similar staff groups who may not routinely experience the need to make a safeguarding referral or escalate concerns, to ensure all staff has awareness of the pathway to professionally challenge decisions made impacting on the safety and wellbeing of children;**
7. **The Lancashire Safeguarding Children Board should consider requiring an audit of cases which include contact arrangements as a significant issue to explore that fathers are being heard, involved and provided with appropriate support in order that they are given the same opportunities as mothers when exploring best outcomes for children;**
8. **The Lancashire Safeguarding Children Board should consider requesting assurance and evidence from commissioners of external providers of support**

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workers, such as in the case of Rose (Child LK), that safeguarding training and awareness programmes for staff are mandatory, fit for purpose and whether packages include assessment and recording as standard;

9. The Lancashire Safeguarding Children Board should consider, in consultation with local CCGs and other partners, options for ensuring the continued and meaningful engagement of all relevant GP services throughout safeguarding processes and particularly for those cases with additional complexities to ensure information sharing is continuous, effective and can inform assessments and decisions, including in legal proceedings, relating to the wellbeing of children;
10. The Lancashire Safeguarding Children Board should consider requiring assurance and evidence from the Director of Lancashire Children's Services that allocation of lead professionals to complex cases is being managed effectively particularly when there is a need for transfer of cases, with rationales for changes in allocation being clearly recorded;
11. The Lancashire Safeguarding Children Board should consider a request to the independent sexual health organisation involved that they review the contents of this report and in particular encourage the use of safeguarding centre leads and named nurses within the organisation to advise when similar circumstances are disclosed, including when there is extensive involvement of children's social care within a family and when a child is subject to a care order or other legal proceedings;
12. The Lancashire Safeguarding Children Board should consider an exercise to explore how non-statutory organisations, including voluntary or independent agencies who may not be routinely involved with families, can be identified and included in safeguarding processes to ensure valuable information which they may hold regarding children and families can be contributed to inform assessments and decisions;
13. The Lancashire Safeguarding Children Board should consider requesting that the Director of Children's Services issues a requirement that all legal meetings whatever their status are recorded by children's social care to include at a minimum- attendees, advice given, a rationale for decisions and actions, and uploaded to the Lancashire County Council recording system for the relevant case;
14. The Lancashire Safeguarding Children Board should consider encouraging Lancashire Children's Services and partners to explore options to enable key involved professionals, or one lead professional to represent multi agency partners, to be included in legal meetings where advice is being provided to children's social care relating to family court processes, to ensure the views of partners regarding safest outcomes for children are fully considered;
15. Lancashire Safeguarding Children Board may consider to require the local authority to complete and share the outcome of an analysis of children placed at home, the circumstances and decisions which led to placements being

initiated and how compliance is monitored, to ensure the safety of all children who are subject to home placement agreements;

16. The Lancashire Safeguarding Children Board may consider a request to the Lead Officer for Criminal Investigation, Lancashire Constabulary to provide assurance and evidence to the Lancashire Safeguarding Children Board that there is a clear, recorded rationale behind decisions and actions for current investigations into complex child abuse allegations carrying most risk and that cases are being managed in a timely and effective manner;
17. The Lancashire Safeguarding Children Board may consider sharing the content of the serious case review for Child LK with the Local Family Justice Board(s) in Lancashire to ensure there is awareness of the position which occurred in 2005 when admissions by an adult in proceedings were ruled inadmissible in a criminal investigation leading to no further action at that time against a person who continued to make admissions of physical assault, and was eventually convicted of that assault, and another, many years later. Family Justice Boards and other partners may wish to explore the issues raised which may help to reduce the risk to other children in similar situations in future.

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### **Statement by Reviewer**

**REVIEWER** Amanda Clarke (Independent)

### **Statement of independence from the case Quality Assurance statement of qualification**

**I make the following statement that prior to my involvement with this serious case review-**

I have not been directly concerned with the subject children or significant others connected to the children, and have not given professional advice on the case.

I have had no immediate line management of the practitioner(s) involved.

I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review.

The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the terms of reference.

### **Reviewer (Signature)**

*A. Clarke*

### **Name**

Amanda Clarke

### **Date**

15/02/19