Blackpool Safeguarding Children Board

Serious Case Review

FINAL REPORT

Child CA

Lead Reviewer: Stephen Ashley

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Section One – Introduction

1.1 What this review is about

This serious case review concerns a baby who, for the purpose of this review, is referred to as CA. CA lived in Blackpool with mother, known in this review as P1 and father, known in this review as P2. P1 and P2 moved to Blackpool in the summer of 2016. At the time of their move P1 was 4 months pregnant with CA. P1 and P2 had previously had considerable contact with Children's Social Care in Bolton. P1 and P2 had 15 other children between them. In the case of P1 all her previous children had been the subject of child protection procedures and in the case of P2, 3 of his children and been the subject of child protection procedures and 1 had been adopted. In April 2017 CA was found unresponsive in a bedroom in P1 and P2's flat. Attempts to resuscitate the baby were unsuccessful and the baby died at hospital. The cause of death is recorded as unascertained. A police investigation found no evidence that P1 and P2 were responsible for the baby's death.

1.2 Why this review was conducted

A case review panel was formed of professionals from Blackpool who were unconnected to the case; they followed guidance contained in Chapter 4 of *Working Together 2015.* They considered the facts of the case and agreed this case met the criteria laid down in Working Together 2015[1]and Regulation 5(1) (e) and (2) of the Local Safeguarding Children Boards Regulations, for a serious case review to be conducted.

The Independent Chair of Blackpool Safeguarding Children Board (LSCB) agreed and initiated this review.

1.3 How this review was conducted

1.3.1 Methodology

An independent reviewer was selected to conduct the review. The panel requested that the reviewer should follow the 'Welsh Model' for conducting reviews.[2]

The reviewer, Stephen Ashley, has extensive experience in the compilation of high-level reports into child protection issues, having been a senior police officer for thirty years and having worked for Her Majesty's Inspectorate of Constabulary. He has conducted several serious case reviews and is the independent chair of two safeguarding children boards. The lead reviewer is independent of Blackpool Safeguarding Children Board in accordance with *Working Together 2015* chapter 4 (10*).*

Relevant agencies were asked to complete timelines of their contacts with P1 and P2; these were combined in to a joint timeline. Further documents, including minutes from relevant meetings and assessments, were also obtained to form an evidence base. A number of working hypothesis were developed and these were tested against written evidence and at a practitioner's event conducted with front line professionals. From this work, the significant

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

[2] **The 'Welsh Model'** - This process consists of several inter-relate parts: Multi-Agency professional Forums to examine case practice, Concise Reviews in order to identify learning for future practice, and an extended review which involves an additional level of scrutiny of the work of the statutory agencies.

issues were agreed and analysed, from which a number of key themes emerged. The findings and recommendations were then developed.

1.3.2 Practitioner's Event

A practitioner's event took place with front line professionals who had been engaged in the case. They discussed the working hypothesis and provide an insight into to **why** events occurred and not just **what** occurred. The practitioner's event was well attended and provided significant detail in this case. Professionals are not named in this report.

1.3.3 Family Engagement

Requests have been made by the lead reviewer to visit the parents. At the time of completion of this report the parents had not responded to this invitation.

1.3.4 Parallel investigations

Lancashire Police investigated the death of CA and a report was submitted to the Coroner; as is standard practice in a case of this nature. There was no evidence that the parents were responsible for the death of the child. At the time of this report an inquest had not been held.

1.4 How this report has been structured

Section two sets out the story of CA and highlights any significant issues. These issues are further analysed in section three. Section four describes the key themes and section five the key findings. The recommendations are in part six with a conclusion that is an evidence based summary of the case.

Section Two – The Story of Baby CA

2.1 Introduction

This section tells the story of CA and the family over the agreed period of the review. It begins with a short description of the family and their environment, providing some context around this case. The section is divided into sections relating to specific events within the timeframe. A brief description of what occurred during that period is detailed and significant issues are highlighted.

2.2 The background of CA's family

P1 and P2 moved from Bolton to Blackpool. P1 had been involved in a family dispute and had suffered domestic violence at the hands of her son.

P1 had grown up in Bolton. P1 has reported how she and her siblings suffered physical and emotional abuse at the hands of her father, who is now deceased. P1's description of her childhood is a painful one and she has talked to a social worker about the serious abuse and neglect she suffered. P1 first got pregnant when she was 16 years old and the father of the child was 31 years old. P1 had her second child by a different father when she was 19 years old. At age 20 she entered a new relationship that lasted 20 years and had 5 further children. All of these children were removed from her by social services, based on concerns

regarding neglect of the children and domestic abuse and alcohol misuse issues. In 2009 P1 began her relationship with P2. P1 gave birth to her eighth child that year.

P2 had previously been in a long-term relationship that had resulted in the birth of 7 children. P2's wife died in the early 1990s. P2 has described how he found it difficult to cope with his own 7 children and as a result 5 of his children lived with other family members and 3 of those were subject to a child protection plan and1 has been adopted. These children are now adults. The way in which P2 treated his children has caused a rift in his family.

Following the birth of their son in 2009 there were a number of reported altercations between the couple and P1 contacted Children's Social Care and said she could not cope. Proceedings were instituted and an interim care order in 2010 was followed by a full care order in 2011 and the child was adopted in 2012. It was established that the relationship had become unstable and despite numerous opportunities, alcohol misuse and poor parenting resulted in neglect of the child and as a consequence court proceedings followed.

2.3 The family move to Blackpool

In July 2016 P1 and P2 moved from their home in Bolton to Blackpool. At this point P1 was 4 months pregnant. Children's Social Care in Bolton received a referral from midwifery regarding the fact that P1 was pregnant and were also informed the couple had moved to Blackpool and as a result made a referral[3] to Blackpool Children's Social Care (BCSC). The move to Blackpool appears to have been motivated by a desire to move away from their family, in particular P1's son, who had subjected P1 to domestic violence.

There is little recorded action from Blackpool Children's Social Care (BCSC), despite the history of the family, and the potentially high risk to the unborn child; including all elements of the toxic trio of parental mental health, alcohol misuse and domestic violence. The case was allocated to an inexperienced newly qualified social worker for the completion of a pre-birth assessment. The social worker was told that a legal planning meeting (LPM) should be considered.

The move to Blackpool was for family related reasons but there is no family connection to Blackpool. This is not an uncommon position and there is a disproportionate level of immigration to Blackpool. Blackpool is a town with a large amount of low cost housing and is perhaps perceived as a holiday town and a place that may be suitable to make 'a new start'. Consequently, Blackpool finds itself welcoming families from all over the country and Europe. Many of these families bring with them difficult issues that have developed over many years. Many of these families have had previous contact with agencies in the areas they had previously resided in. It is not uncommon that agencies in Blackpool should find that a family with complex issues arrives without warning and requires immediate assessment and support. Given this history of immigration, agencies should understand and be prepared to deal with these issues.

Significant issue one
Blackpool is a town with higher than average levels of transience. Agencies need to ensure they can deal effectively with new arrivals to the town and meet their health, safeguarding and social needs. It is the responsibility of front line professionals to acquire the historical information they need to provide the right level of service and protection to families.

[3] **Referral** - The referring of concerns to local authority children's social care services, where the referrer believes or suspects that a child may be a Child in Need or that a child may be suffering, or is likely to suffer, Significant Harm.

When P1 and P2 arrived in Blackpool maternity services engaged with P1. Information was requested from Bolton midwifery and a conversation took place between the two areas. As a result, a specialist midwife was allocated to P1. Because of P1's medical condition, care for P1 was shared by community midwifery and specialist midwifery services. Midwifery were aware that BCSC had received a referral. BCSC did not appear to have received a substantial briefing from children's services in Bolton. This is understandable given the case was not open to them at this time and they had followed procedures by making a referral. It was late September before Blackpool social services contacted Children's Social Care in Bolton and asked to view the files of P1 and P2.

2.4 Agencies engage with the family pre-birth

At the beginning of September 2016, a referral was made by midwifery to the 'Baby Steps' programme[4]. This is a commissioned support programme managed by the NSPCC and is for pregnant mothers. This programme allocates a Family Engagement Worker (FEW) to the family. The allocated FEW was made aware of the family's previous history and that BCSC would be able to provide further details. Numerous attempts were made by the FEW to contact P1 but contact was sporadic as either she did not attend appointments, or was not at home when the FEW attended.

In September, a MARAC[5] was held as part of a transfer from Greater Manchester Police and several actions agreed; including informing midwives of the previous episodes of domestic abuse by P1's son and consideration of a Clare's law[6] application for P2. It is unclear what the motivation for this application was, given the MARAC process concerned P1's son and there was only one reported incident between P1 and P2, when the police were called to an argument between the couple that had resulted in no further action. This application was made but no disclosures were made. It is unclear whether BCSC engaged with the Multi-Agency Risk Assessment Conference (MARAC) process and exactly what information was shared. There was no evidence of domestic abuse by P2 against P1.

At the beginning of October, the social worker received supervision from a team leader. The social worker was tasked to complete a Child and Family Assessment (CAFA) and family genogram. This request had first been made at the end of August but had not been actioned. The social worker was also tasked to arrange an initial child protection conference 8 weeks prior to birth and *"consider"* whether a legal planning meeting was required. This followed procedures laid down in the Pan Lancashire Multi-Agency Pre-birth Protocol (2012 revised 2014). This protocol was fully updated and a new protocol was formally adopted in March 2017.

In summary, there is clear evidence that P1 received a specialist midwifery service (referred to as universal plus) enabling her health risks to be considered. There is little evidence of a coordinated response and whilst midwifery services were aware of the complex needs of the family, despite receiving an early referral, Blackpool children's services failed to engage with Bolton children's services until September 2016 and so there was a lengthy delay in the information sharing process; either between areas or with other front line professionals.

[4] **'Baby Steps' programme** - Baby Steps is an educational programme designed to support Mums and Dads to be able to manage the emotional and physical transition into parenthood.
[5] **MARAC -** This is a forum to assess and manage the risk of adult perpetrators of domestic abuse.
[6] **Clare's Law -** the Domestic Violence Disclosure Scheme (also known as 'Clare's Law') commenced on 8 March 2014, across England and Wales. Under the scheme an individual can ask police to check whether a new or existing partner has a violent past. This is the 'right to ask'. If records show that an individual may be at risk of Domestic Violence and Abuse from a partner, the police will consider disclosing the information. A disclosure can be made if it is legal, proportionate and necessary to do so.

Significant issue two
There was no handover package between Bolton and Blackpool social care. Support services were put in place for the family but this was not co-ordinated by agencies who failed to share appropriate information. P1 was able to avoid contact with services.

2.5 The initiation of pre-birth child protection procedures

Throughout the autumn, the family engagement worker continued to try and engage with the family. This had limited success and P1 continued to avoid appointments with the Baby Steps programme.

An assessment[7] was commenced at the beginning of August but was not completed until the end of November 2016. A strategy meeting[8] was held on the 3rd November 2016 but this did not involve partners and appears to have taken place in order to comply with procedures and provide the trigger for convening an Initial Child Protection Conference[9] (ICPC). In fact, the first case conference took place in mid-December the day after CA's pre-mature birth. The Pan-Lancashire Multi-Agency Pre-birth Protocol is not referred to by any of the agencies and was not followed.

Significant issue three
The application of child protection procedures in the pre-birth phase was inconsistent and failed to comply with statutory guidance.

Whilst legal proceedings had been discussed on several occasions, no legal planning meeting took place until nearly a month after the birth of CA.

Significant issue four
Legal planning was considered but was not put in place quickly enough. It failed to provide the contingency that may have been required in this case.

2.6 The engagement of services post birth

CA was born prematurely at Blackpool Hospital delivery suite in mid-December 2016. This should have been anticipated given records have shown that in previous pregnancies P1 had given birth pre-maturely. The following day an initial child protection conference was held. The parents were consequently not present at this initial conference and were not represented. The conference was attended by two health professionals but not a representative of the Baby Steps programme. The plan stated that a social worker visit would take place every four weeks. In fact, the first visit took place on 6th January 2017. That visit was unannounced and found that there was evidence that bottles were sterilised, but the communal area of the flat complex smelt strongly of cannabis.

There was considerable support arranged by health professionals and plans for discharge were discussed with BCSC at a discharge planning meeting on 19th December. CA was discharged from hospital according to normal practice and community midwives visited P1 and CA. CA had been discharged on 20th December and was seen three times at home by

[7] **Assessment -** Assessments are undertaken of the needs of individual children to determine what services to provide and action to take.
[8] **Strategy meeting -** A Strategy Meeting (sometimes referred to as a Strategy Discussion) is normally held following an Assessment which indicates that a child has suffered or is likely to suffer Significant Harm.
The purpose of a Strategy Meeting is to determine whether there are grounds for a Section 47 Enquiry.
[9] **ICPC -** An Initial Child Protection Conference is normally convened at the end of a Section 47 Enquiry when the child is assessed as either having suffered Significant Harm or to be at risk of suffering ongoing significant harm.

health professionals prior to 6th January 2017. In that week, a health visitor visited the flat four times. Safe sleeping was discussed with P1 and it was noted the flat was very hot but there were no further concerns.

On the 12th January, an emergency request was made to the Families in Need (FiN) team to provide support. This request coincided with a legal planning meeting that was conducted on that day. The legal planning meeting highlighted a number of issues around the procedures that had been adopted up to that point and requested a number of actions be undertaken by BCSC. Whilst there were no grounds for removal of CA it was considered there may be grounds for an application to the courts for a Care Order[10]. A week after this meeting a senior managers' meeting took place. They acknowledged that legal proceedings should have been in place before birth and put in place very clear expectations of future activity including the Public Law Outline[11] process.

At this point, there was considerable activity put in place around the family. Family support workers from the Families in Need team were visiting daily. On the 16th January, a core group meeting[12] took place. This meeting achieved little but it is of note that the parents complained they were being visited too frequently. Family support workers continued to undertake regular visits throughout January. At the end of January, the family were allocated a new social worker. During February, the family were visited weekly by a health visitor and at least six times by a family support worker. A number of support packages were also arranged for the family. On 14th February, a core group meeting was held. Several issues were discussed including housing issues and support packages that might be put in place. Individuals were allocated specific tasks and this meeting was an improvement on previous core group meetings.

On 3rd March the first review conference took place. The relevant professionals were present or provided reports. Professionals presented a positive picture of the parents and the improvements they had made. Whilst the parents were able to self-report regarding mental health issues and alcohol misuse, actions were in place to ensure these claims were substantiated. It was agreed CA would remain on a child protection plan while the PLO was completed and to ensure that the parents were able to maintain their levels of care. A core group meeting followed this meeting. It was agreed the P1 would be referred for a SPOA assessment and that relapse prevention work would be conducted by the FIN. There would be a four-week parenting course made available, and the parents were seeking a change in accommodation.

Significant issue five

Following the birth of CA statutory child protection procedures were not applied in a consistent and effective way. The quality of the child protection plan in this case was poor. A legal planning meeting prompted senior management engagement and a step change in support and oversight took place.

At the beginning of April CA was found by P1 and was described as *"floppy".* CA was taken to Blackpool Hospital but attempts to resuscitate CA failed. CA was declared deceased on 3rd April 2017.

[10] **Care Order -** A Care Order can be made in Care Proceedings brought under section 31 of the Children Act 1989 if the Threshold Criteria are met.
[11] **Public Law Outline -** The Public Law Outline sets out streamlined case management procedures for dealing with public law children's cases. The aim is to identify and focus on the key issues for the child, with the aim of making the best decisions for the child within the timetable set by the Court, and avoiding the need for unnecessary evidence or hearings.
[12] **Core Group meeting -** Core Groups are made up of professionals from differing agencies, including the Lead Social Worker who are responsible for implementing and monitoring the Child Protection Plan.

Section Three – Analysis of Significant Issues

3.1 Introduction

This section provides an analysis of each of the significant issues. From this analysis the key themes have been developed.

3.2 Significant Issues

3.2.1 Significant issue one

Blackpool is a town with higher than average levels of transience. Agencies need to ensure they can deal effectively with new arrivals to the town and meet their health, safeguarding and social needs. It is the responsibility of front line professionals to acquire the historical information they need to provide the right level of service and protection to families.

The higher than average levels of transience that occur in Blackpool, mean that services in the town need to be structured in a way that means they can effectively deal with both families accessing universal services and those with more complex needs. Professionals expressed a view that the position of P1 and P2 is not an unusual one, and front line professionals regard it as one of the outstanding features of their working lives. However, professionals should expect to provide services to new arrivals as they would any other resident in Blackpool. It is a professional's responsibility to ensure they gather the required historical data around a family whatever the circumstances of arrival in the town.

Clearly, structures need to be in place to identify those families arriving in Blackpool who need significant support. The recently introduced Early Help Hub would appear to be the most effective place in which to deal with those families that do not meet the threshold for statutory intervention.

There is clearly much work being undertaken to support those families once their need has been established, but multi-agency arrangements should be in place to take a more pro-active approach in identifying troubled families and putting in place support at the earliest opportunity. The issues around 'new arrivals' are dealt with in section 4.

3.2.2 Significant issue two

There was no handover package between Bolton and Blackpool social care. Support services were put in place for the family but this was not co-ordinated by agencies who failed to share appropriate information. P1 was able to avoid contact with services.

- **Key Point One - There was no formal handover between Bolton and Blackpool Children's Services**

When the referral was received by BCSC a social worker was allocated to the case and an assessment process began. Supervision took place with the social worker who was told to complete an assessment and genogram. The supervisor also stated that the case should be subject to a legal planning meeting prior to birth. These requests are in accordance with agreed pre-birth protocols. The social worker was an ASYE (Assessed and Supported Year in Employment) and was inexperienced.

This case was not 'open' to Bolton Children's Social Care and so they passed a referral to BCSC. In the circumstances, it is understandable that Bolton did not take any further action. If a strategy meeting had been called then an invitation should have been extended to them. The allocated social worker did however go to Bolton and review the files relating to the family, but not until late September. There is no explanation as to why this took so long.

- **Key Point Two – Midwifery services worked swiftly to ensure P1 received the correct level of medical care and support**

Midwifery services did contact their counterparts in Bolton and received information regarding P1, including her previous contacts with children's social care and her medical history. As a result, she was referred to specialist midwifery services. Midwifery followed policies and were quick to respond. Midwifery services referred P1 to the Baby steps programme which is commissioned on behalf of the Better Start Partnership. It is led by midwives and health visitors with NSPCC family engagement workers supporting health, who are the clinical lead.

The correct level of support was put in place by health professionals to reduce the risks to P1 and her unborn child.

- **Key Point Three - Pan Lancashire Pre-birth Protocols were not followed**

The pan-Lancashire multi-agency pre-birth protocol provides a clear process to be followed by all agencies to minimise the risk of harm to the unborn child. The protocol was not followed.

At no stage did a multi-agency meeting take place concerning the family. At the practitioner's event, it was agreed that it would have been useful for this to have occurred. A number of professionals commented on the fact that they did not know who the allocated social worker was and limited attempts to contact her had failed. It was agreed that professionals who were dealing with P1 should have escalated the matter to ensure BCSC were fully engaged and to agree a coordinated approach.

- **Key Point Four – No multi-agency meetings took place and professionals were left with an information deficit**

The Family Engagement Worker (FEW) was new in her role. Whilst she had received basic information concerning P1 and her previous history, she had not received a comprehensive briefing from midwifery services and whilst she had attempted to contact the social worker, she got no response. As a result, the FEW was not aware of the high level of risk P1 posed to her unborn child. At the practitioner's event the FEW acknowledged that she had not fully understood this risk and had been too willing to accept reasons given P1 not to meet. Given the high risk P1 posed the FEW should have been more fully briefed by the social worker and the relevant health professionals.

Midwifery services should have escalated this case when they received no response from BCSC.

In summary; midwifery services understood the risks to mother and baby and put in place the right levels of support to ensure her medical needs were met. The FEW was correctly asked to engage with P1 but her inexperience and lack of a comprehensive briefing resulted in a level of naivety around P1's failures to attend appointments. The inexperienced social worker failed to instigate any form of multi-agency meeting and in hindsight professionals accept this should have been escalated. The issues around formal child protection procedures are dealt with in section 3.2.3. The failure to follow the agreed Pan-Lancashire

Protocol resulted in a lack of information sharing between services. A lack of coordination by agencies allowed P1 to avoid contact when she wanted; without consideration as to how her living with the toxic trio would impact on her ability and willingness to engage.

3.2.3 Significant issue three

The application of child protection procedures in the pre-birth phase was inconsistent and failed to comply with statutory guidance.

- **Key Point One – An inexperienced social worker was allocated to a high-risk case**

Following a referral, a social worker was allocated to the case. The social worker was qualified and was an ASYE (Assessed and Supported Year in Employment) but was inexperienced. This meant the social worker was qualified but in the first year of employment and should have been receiving close supervision and support. This was not necessarily an issue if the social worker had significant previous experience in social care. In this case, the social worker was inexperienced. The only reason suggested as to why such an inexperienced social worker was allocated to this case was put forward at the practitioner's event. Social workers said at the event that BCSC is undergoing significant change. There has been an increase in the number of social workers but recruiting qualified, experienced social workers is recognised as a significant problem both locally and nationally and there is not the capacity to allocate experienced social workers to each case. Supervisors have to make difficult choices when allocating cases. However, given the high-risk nature of this case it was not appropriate to allocate an inexperienced social worker, and having done so there was should have been greater supervision and support provided to that individual.

- **Key Point Two - The Pan Lancashire Multi-Agency Pre-birth Protocol was not followed**

P1 and P2 had numerous issues around mental health and alcohol misuse. P1 had a history of neglect of all her previous 8 children who had been subject to child protection procedures. P2 had 7 children, 4 of who had been the subject of child protection procedures. Between them the couple had had 15 children and no longer had parental care of any of them. Given the multitude of issues facing P1 and P2 and their history of neglect, this was always going to be a difficult and complex case. It is difficult to understand why an ASYE would be allocated in the primary role of providing protection to the unborn child in these circumstances. Six of the seven risk factors identified in the Pre-birth Protocol were present in this case. This case was always going to be high risk.

As a result of this significant risk of harm, the Pan-Lancashire Multi-Agency Pre-birth Protocol (pre-birth protocol) should have been followed. There is no evidence in this case that the protocol was implemented or referred to at any point, despite the issues being apparent at an early stage.

There has been no explanation as to why there was no strategy meeting on receipt of the referral. The basic facts of the case clearly determined that a pre-birth assessment was required and that a strategy meeting[13] should have been held to determine whether a section 47 investigation was required. There is no explanation as to why this did not occur.

[13] **Section 47 strategy meeting -** Under Section 47 of the Children Act 1989, if a child is taken into Police Protection is the subject of an Emergency Protection Order or there are reasonable grounds to suspect that a child is suffering or is likely to suffer Significant Harm a Section 47 Enquiry is initiated.

- **Key Point Three – The pre-birth assessment was poor and failed to follow statutory guidance**

The pre-birth assessment began on 3rd August 2016 and was completed on 29th November 2016. This was two weeks prior to the ICPC. The assessment is poor in quality and lacks detail. It does not refer to any other agencies and is not compliant with statutory guidance. It is not credible to suggest it could have taken 4 months to complete and contains information that could have been obtained in the immediate period following the referral to BCSC. It was not shared with other agencies and would, in any case, have been of little use to other professionals. The assessment concentrates on the status of the family in 2016. It does not deal with any detail around the previous issues P1 and P2 had whilst in Bolton. Given the social worker had visited Bolton on 21st September this is inexplicable. Both P1 and P2 had a history with Children's Social Care that stretched back over 20 years, but there is little reference to previous issues. This was particularly relevant given P1 and P2's previous child had begun life living with them, but their level of care had rapidly deteriorated post birth, until the child was removed and later adopted. This undue concentration on present circumstances, as opposed to historical patterns of behaviour, is often referred to as 'start again syndrome' and can result in a failure to fully appreciate indicators of risk that remain present.

The FEW from Baby Steps was not contacted and yet she would have been able to describe the way in which P1 and P2 were avoiding contact. The midwifery service did not provide an input despite there being concerns regarding mother's health.

The assessment was based on two visits conducted by the social worker and a brief synopsis of the family history. There is no meaningful assessment of the alcohol and mental health issues that had previously affected P1 and P2 and no mention of domestic abuse issues, even though there had been a MARAC and a Clare's Law application had been made.

There is no explanation as to why this assessment was poor. The inexperience of the social worker was clearly a factor, as were the heavy workloads being experienced by social workers at this time. The assessment should have been seen by a supervisor. In addition, P1 and P2 had significant experience of dealing with professionals. Front line professionals all described the way in which both P1 and P2 expressed their determination to *"get it right"* with this baby. They regularly acknowledged the mistakes they had made previously, but stated their determination to bring this baby up themselves. Professionals saw evidence that P1 and P2 wanted to comply and were determined to keep their baby. This seemingly led to an over-optimism on the part of professionals in which present positives were emphasised at the expense of historical patterns of behaviour. There is no doubt that both P1 and P2 were experienced enough to present themselves in a way that would be seen as positive by professionals. It is a fact that both P1 and P2 had far more experience in the child protection system than many of those professionals they were dealing with, albeit from a different perspective.

This case has highlighted the need for comprehensive and proportionate assessments and clear supervision of cases.

- **Key Point Four – Statutory guidance was not complied with regarding pre-birth conferences**

A strategy meeting should have taken place once it was established that the unborn child would be at significant risk of harm. The first strategy meeting was conducted on the 3rd November, which followed a supervision meeting with the allocated social worker 2 days

previously. The strategy meeting took place between the social worker and her manager. It did not follow statutory guidance or agreed protocols. The result of the meeting was that an initial child protection conference was arranged to take place on 15th December. This ICPC would have been when P1 was 36 weeks pregnant. The meeting should have taken place at the 30-week point.

The ICPC was quorate and took place the day after CA was born. This was 4 weeks prior to the estimated date of delivery. The case was considered without parental representation (for obvious reasons) and it was agreed that CA would be placed on a child protection plan in the categories of neglect and emotional abuse. It seems that little thought went in to this categorisation. The chair had emphasised the need not to base any conclusions on past history but actually the only concerns were around the mental health and alcohol misuse by the parents and neglect was not in itself discussed.

Professionals at the practitioner's event commented that the ICPC was concluded very quickly. It is clear from the minutes that the report from the social worker was the main focus of the meeting. The police provided a report that contained details obtained from the Police National Computer but the police had not been involved with P1 and P2 since their arrival in Blackpool. A Children's Centre manager was present but had not seen the family, so was, in effect, in an information gathering role. A midwife reported that CA had been born the previous day. The family GP was invited but did not attend.

The information placed before the conference lacked a solid evidence base. Health professionals had been engaged with P1 throughout her pregnancy and were aware of her history. They were able to comment on her health needs. The police had not had contact. The conference based its decision on the social worker's report. This lacked evidence and was compiled without reference to key professionals, including the FEW. There was no mention of GP services or whether P1 or P2 had engaged around mental health issues. Given that the GP would have had access to historical medical records this was a gap in information sharing that reduced the effectiveness of the ICPC. One professional commented that at the conference a comment was made that the attendees should not get *"bogged down by the history",* and the couple's history was not explored in any depth.

There is no simple explanation as to why the statutory guidance was not complied with. The inexperience of the social worker and a lack of supervision were contributory factors. In addition, no other professionals escalated the case to ensure it received closer attention, which would have been expected in the circumstances. One health professional acknowledged that she regrets not doing so, but with everything else she was doing escalation slipped down the list of priorities. The FEW was inexperienced and the Baby Steps programme was a new service that had not reached maturity in terms of its processes and procedures. Both the FEW and her manager have acknowledged that they should have escalated the case and are sure that developments since this case, in terms of training and policy development, ensure that the case would now be escalated.

The ICPC took place later than it should and, because of CA's premature birth, took place after she was born. Given the earliest date of delivery was estimated as 18th January 2017 the meeting was in effect scheduled for a month prior to CA's birth. The ICPC complied with guidance but could not be described as effective. The attendees relied on the social worker to supply a report, and whilst there was sufficient information to agree that the unborn child should be placed on a child protection plan, the meeting lacked effective engagement with relevant professionals and minutes of the meeting reflect a brief meeting with little challenge or meaningful discussion.

There is a simple question worth asking. What difference did this failure to follow guidance make?

P1 was not a healthy mother, but her health needs were closely monitored by health professionals. The specialist attention she required was provided to her and she was monitored throughout her pregnancy, including through routine enquiry about domestic abuse. In terms of P1 and her unborn baby, health needs were met.

Statutory guidance required an initial strategy meeting to be held. This would have given professionals the chance to discuss the case and share information. Effective plans could have been put in place to monitor the family. This would have provided a far more accurate picture of the family and the risks a new baby would face. The ICPC should have provided a solid foundation for the work that would be required following the birth of CA. It did not do that; although it achieved its primary function of agreeing CA should be placed on a child protection plan.

It is not possible to know whether the failure to comply with statutory guidance during the period of P1's pregnancy had an adverse effect on CA. However, it did set a tone for the work that was to follow and the failure to comply was not only poor practice but hindered an effective response and support to this family.

3.2.4 Significant issue four

Legal planning was considered but was not put in place quickly enough. It failed to provide the contingency that may have been required in this case.

- **Key Point One – instructions to put in place legal planning meetings were not followed**

The supervisor of the allocated social worker instructed her to put in place a legal planning meeting on 26th August 2016. This position was reiterated in a supervision meeting at the beginning of October. On the second occasion the social worker was told to *"consider"* a legal planning meeting. By the time of the ICPC no legal planning meetings had been arranged.

The first legal planning meeting was held on 12th January 2017. A Public Law Outline was put in place on 2nd February. There is no explanation as to why the social worker did not arrange an earlier legal planning meeting or why supervisors did not insist that it was put in place. The matter was not considered at the ICPC. At the first core group on 19th December the social worker insinuated it was arranged. It had not been. In addition to the inexperience of the social worker, she was also absent with periods of sickness; but this issue should have been picked up by her supervisors.

- **Key Point Two – Effective legal planning was a catalyst for intensive intervention and support**

It is clear from the timelines in this case that the legal planning meeting on 12th January 2017 is the catalyst for step change in how the family were being regarded. This meeting involved a number of managers and it lays out a significant level of work that is to be conducted. P1 and P2 were at this meeting and were legally represented. This was the first time that clarity around the expectations for the parents was laid out.

Legal planning meetings and a public law outline should have occurred far earlier in the pregnancy. There is no reasonable explanation as to why this didn't occur. A supervisor established immediately after referral that a legal option should be considered and may have

been required. When a legal planning meeting took place it was the catalyst for a change in focus and more effective process was put in place.

3.2.5 Significant issue five

Following the birth of CA statutory child protection procedures were not applied in a consistent and effective way. The quality of the child protection plan in this case was poor. A legal planning meeting prompted senior management engagement and a step change in support and oversight took place.

- **Key Point One – Following discharge from hospital an effective child protection plan was not put in place**

Following the ICPC on 15th December a child protection plan was written. A core group was held on 19th December and a series of visits to the family was agreed.

The child protection plan is dated 19th December. It states that a legal planning meeting had been held. This was not correct and would have misled other professionals when it was discussed at the core group. It would also potentially have given them a false sense of security. It seems more likely that the legal planning meeting referred to is a meeting that took place to complete the legal planning pro-forma.

The child protection plan contains a number of immediate actions that should have already been in place. It specifically states:

- *"Contact health visitor and see if she can offer further supports/visits*
- *check if mother is registered with GP in Blackpool – try and obtain consent from her to contact GP to check what medication/support she is accessing for her mental health*
- *no evidence alcohol misuse has been addressed only parents self-reporting. Can we get any testing and speak to parents again about engaging with relapse prevention support. Check if they engaged previously with an agency. If they say they have, get details contact them.*
- *Do a referral for Family Group Conference*
- *See if Mother would like a referral to Home Start*
- *SoE to be completed –XX kindly offered to assist with this*
- *Referral to be made to FIN – contact them today and request support until it can go on to panel*
- *Court records from Bolton – legal will request these."*

These actions are all logical but have an appearance of being a list of 'to dos' rather than clear SMART actions put in place as a result of thoughtful multi-agency discussions. The plan is unprofessional and lacks details. It does not contain named individuals or clear timescales.

This lack of detail and grip is further exacerbated by the timing. It was approaching the Christmas period when professionals acknowledged it would be more difficult to arrange action.

CA was discharged from hospital with P1 on 20th December. Midwives had conducted a discharge planning meeting, including BCSC, and agreed a series of visits to the family. These were followed through. A community midwife visited on 21st December and a health visitor on the 23rd December. It had been agreed that a social worker would visit on the 22nd December. There were no social worker visits until 6th January when an unannounced visit

took place. Health professionals conducted visits as expected and had attempted to coordinate with BCSC. There is no explanation as to why BCSC did not conduct visits, although the social worker did record that on 5th January they had been unable to gain access.

The level of support provided to the family by health professionals over this period was sufficient and ensured that CA was being properly cared for. Whilst there was some concern around the hot temperatures in the flat, safer sleeping arrangements were discussed with the parents and there were no concerns raised.

The actions from the child protection plan quoted above are described as; *"steps that need to be taken immediately to protect this child"*. This included contacting the Family in Need team to provide intensive support. In the three weeks over the Christmas period there is no evidence that BCSC put in place any of those steps.

- **Key Point Two - The legal planning meeting initiated a more intense response**

On 12th January 2017, the first legal planning meeting took place. This laid out specific actions for both parents and agencies. It is also the case that on the same day the Family In Need team were provided with an emergency referral and immediately began work. This team visited the family on the 12th January and made a further 20 home visits prior to the end of January. They visited at various times and on some occasions twice in a day. This was extremely good practice and ensured that a true picture of the family could be compiled.

There seems no doubt that the legal planning meeting heightened concern about the action that had taken place previously. A senior manager was also notified about this case.
On 16th January, a core group meeting was held. P1 and P2 complained that they were being visited too regularly by the FIN team. There was no one present from the FIN team. Both P1 and P2 were offered various avenues of support but these were declined.

On 19th January, a meeting of senior managers from BCSC took place. A more experienced social worker was allocated to the case. On 31st January, this social worker took full control of the case.

- **Key Point Three – Following management intervention the case was handled with more urgency and professionalism**

The legal planning meeting had led to intervention by senior managers. A senior social worker took over the case. The FIN team maintained intensive visits. By February a public law outline had been put in place and was being enacted. At a core group meeting in mid-February there are clearly defined actions in place to support the family.

In March a review conference took place. Whilst there was no health representation at the meeting (the family was not invited), reports were submitted. It is clear from the minutes that significant progress had been made with the family. At this meeting, all the professionals believed CA was being well cared for and they had no current concerns. The social worker indicated that P1 and P2 were complying with requests and the public law outline. Whilst progress had been made it was agreed that CA would remain on the child protection plan whilst various actions were completed and to demonstrate that the care they were providing could be consistently maintained.

In summary; the low-level work that had taken place during the pregnancy of P1 largely continued following the birth of CA. Midwives and health visitors conducted their visits and ensured they followed plans to maintain the health of mother and baby. BCSC allowed the case to drift over the Christmas period. The involvement of senior managers following the

LPM saw an immediate change. It seems at this stage, for the first time, BCSC acknowledged the high risk the family posed, and put in place both preventative and support measures. They also put in place a senior and experienced social worker to move the case forward.

At the time of CA's death BCSC had control of this case and were managing it appropriately.

Section Four – Key Themes

4.1 Information sharing between professionals

P1 and P2 arrived in Blackpool from Bolton. Given P1 was pregnant it was to be expected that health services would provide a handover and to some extent at least this did occur. Despite an early referral from Bolton CSC it was over 8 weeks before a social worker attended Bolton to view social care files. Given P1 or P2 had not engaged with Bolton CSC for 5 years the onus was on Blackpool to pro-actively engage.

On arrival, health were aware of a basic history of P1 and P2 and midwives had exchanged information. No strategy meeting was called so the available information was not collated. Because of this lack of information sharing, no joint plan was agreed.

Throughout P1's pregnancy health and BCSC worked in their own silos. No joint meetings occurred in the first 4 months the family were in Blackpool. There is no evidence this put any person at risk, but it is poor practice. The lack of information sharing during the pregnancy meant that clear multi-agency plans were not in place when CA was born. It is relevant that even though P1 had given birth pre-maturely in a number of her other pregnancies this information was not shared with other professionals.

The lack of a joint approach continued in the first weeks following the birth of CA. Health conducted their work and BCSC made plans but the failure to share information meant that there was not a coordinated approach. This was critical over the Christmas period.

Whilst the lack of information sharing and coordination did not put CA at an identifiable risk, it did mean that comprehensive planning was not in place and this meant that appropriate plans were not in place when CA was born.

4.2 The application of child protection procedures

There was little understanding of the Pan Lancashire Multi-Agency Pre-birth Protocol by any of the professionals in this case. This is of concern. The document has been in place since 2012 and was reviewed in 2014. A new document was agreed in March 2017. Work needs to be undertaken to ensure the new protocols are embedded into practice across all agencies.

No agency called a strategy meeting when they became aware of P1 and P2. Whilst professionals accepted they could have done so, this was left to the social worker who did not follow procedures.

A pre-birth assessment took several months to complete and was of poor quality. As a result, there were not strong plans in place when CA was born, professionals were ill informed and had not been able to express their views of the case. A strategy meeting (which also is recorded as a section 47 investigation) did not take place until the social worker had been told by a supervisor to book an ICPC. It is apparent that the strategy

meeting was only recorded as a means of showing procedures were being followed. In fact, no other professionals attended or were asked for reports. This was poor practice.
An ICPC was held but was brief in nature and some key professionals were not present. The lack of substantiated information could have been a real cause for concern, but the chair agreed to put CA on a child protection plan despite the lack of information available.

The child protection plan that was developed following the ICPC was poor. It had a number of steps that needed to be taken immediately, but none of these took place prior to 2017.

Following management intervention in January 2017 the standard of reports and intervention improved immeasurably.

Given the current work that is taking place at BCSC and the action plans in place following recent serious case reviews, there are no additional recommendations in this area.

4.3 Leadership

An inexperienced social worker was allocated to this case. Given the historical concerns, it is difficult to understand why such an inexperienced social worker was put in place. To add to the situation her supervision was sporadic. Eventually a management intervention saw a more experienced social worker put in place.

Other agencies were aware that a more coordinated approach would be useful but did not take the lead themselves and continued to concentrate on the actions required by their own agency.

No one questioned the drift that occurred in this case until a management intervention in January 2017. The case could have been escalated, but in any event the case conference chair should have questioned the quality of the assessment and child protection plan.

All aspects of this case contained drift and a lack of grip: suggestions for support not progressed; failure of parents to make themselves available were not questioned; key documents not completed or taking excessive time to complete; and poor quality assessments and plans.

This lack of leadership cannot be addressed by action plans. The LSCB should satisfy itself, through its current audit programme, that child protection plans are being properly and professionally managed.

Section Five – Key Findings

CA died from an unascertained cause but there is no evidence that the death of CA was attributable to her parents. Professionals could not have prevented the death.

This case has demonstrated several areas for improvements in child safeguarding across agencies in Blackpool. Whilst some agencies demonstrated good and expected practice, further work is required.

Namely:

- information sharing;
- the application of escalation procedures;
- the application of pre-birth protocols;

- stronger leadership;
- multi-agency arrangements to identify and support individuals and families arriving in Blackpool with complex needs.

These issues should be addressed by agencies as a matter of urgency.

Section Six – Recommendations

Recommendation One

The Safeguarding Children Board should assure itself that all agencies have systems in place to deal with families, including those with additional needs, arriving in Blackpool.

Recommendation Two

The LSCB should, assure itself that front line practitioners are aware of, understand and are applying, the pan-Lancashire pre-birth protocol.

Recommendation Three

The LSCB should assure itself that child protection assessments are proportionate and that plans are specific, measurable, achievable, relevant and timely.

Recommendation Four

The LSCB should assure itself that front line practitioners receive regular and meaningful supervision and that leaders are able to demonstrate they have a grip on cases assigned to their staff.

Conclusion

P1 and P2 moved to Blackpool to escape the difficult life they had in Bolton. Both had a significant history of mental health, alcohol misuse and domestic violence issues. P1 had 7 children from previous relationships. All those children had been the subject of child protection procedures; for reasons of neglect and emotional abuse. P1 no longer retained legal responsibility for any of those children. P2 had 7 children by a previous relationship and 4 of them were subject to child protection procedures. P2 had no legal responsibility for his children. The couple had a child between them in 2009 that was subject to child protection procedures for reasons of neglect. This child has now been adopted. P1 was 4 months pregnant when the couple arrived in Blackpool.

CA was born in December 2016 and sadly died from an unascertained cause in April 2017. There was no evidence that the death was attributable to the actions of her parents.

Professionals had some concerns about the way in which partners worked together in this case to protect CA and asked for the case to be reviewed under child safeguarding legislation.

This review has found that there were a number of areas where child safeguarding procedures in Blackpool need to improve. On their arrival in Blackpool, health services provided P1 and her unborn baby with the support she needed and continued with the right level of support throughout her pregnancy. Health practitioners failed to escalate the case

when they received no response from children's social care. Child protection protocols were not followed and strategy meetings were not held. This would have ensured a coordinated approach to the family. Pre-birth assessments were poor and no consideration was given to legal proceedings to support professionals' work; until CA had been born. Information was not always shared between agencies and plans were not made to ensure CA would be properly protected.

Following the birth of CA, the child was placed on a child protection plan, but the plan was poor and did not do enough to reduce risks to CA. Following a management intervention, a month after the birth of CA, correct procedures were implemented and plans were in place to support CA and the parents to ensure the baby was properly protected.

Agencies in Blackpool need to improve the way they work together and ensure that child protection procedures are understood and implemented. There was a lack of leadership in this case.