THEO

Local Child Safeguarding Practice Review

February 2024

This Local Child Safeguarding Practice Review has taken steps to preserve the anonymity of the child subject and of other family members.

Children and family members are represented by names chosen at random.

The names chosen do not necessarily reflect the children's true gender.

The review refers to professionals and service providers only by their function.

The exact dates of events are not given.

1. Background to Review

1.1 Theo is the second child of Ms. Taylor and Mr. Walker. Theo died in his parents' care when he was ten months old. On examination, Theo was found to have multiple injuries. There was sufficient evidence to conclude that his death was likely to have been the result of abuse.

1.2 Police who attended the family home found conditions to be unsanitary, with a strong smell of cannabis. There was blood on Theo's bedding and clothes. A police investigation began. Theo's older sister, Ruby, was taken by police to the home of a family member.

1.3 Theo and his older sister were the subjects of care proceedings when Theo died. This means that both children were known to have suffered, or to have been at risk of suffering, significant harm in their parents' care. It also indicates that the threat of harm was such that legal measures were required to keep the children safe while plans for their future were determined.

1.4 After Theo's death, the local safeguarding children partnership undertook a rapid review of information readily available to health services, police and children's social care. The national Child Safeguarding Practice Review Panel endorsed the safeguarding children partnership's decision to conduct a local child safeguarding practice review. To that end, the safeguarding children partnership commissioned an independent reviewer to complete the task.

1.5 The focus of a local child safeguarding practice review is on learning. Its purpose is to establish why things happened the way they did to reduce the likelihood of a similar situation arising in future. Its enquiries should be designed to consider the quality of practice as a child's story unfolds and to highlight the systemic factors which may have contributed to making good safeguarding practice more or less likely. It is not the purpose of a local child safeguarding practice review to ascribe blame.

1.6 Local child safeguarding practice reviews should be proportionate to the circumstances of the case. In this instance, a child died as the result of abuse when he should have been one of the most protected children in the local authority area. The safeguarding children partnership agreed, therefore, that the review's enquiries should be comprehensive.

1.7 For that reason, the review has taken a long view of professional involvement with the family, starting from when Ms. Taylor was pregnant with Ruby. This has allowed the review to understand some of the factors which cumulatively affected practice with Theo.

1.8 The review is informed by:

i. Individual management reviews conducted by all agencies and organisations which provided services to family members, using a bespoke template;
ii. Individual conversations between key members of staff and the independent reviewer, both in-person and virtually;
iii. A learning event for practitioners and front-line managers who worked directly with, or made decisions in respect of family members;
iv. A conversation with family members caring for Ruby (Mr. and Mrs. Anderson), facilitated by the independent reviewer and a member of the safeguarding children partnership review panel;
v. The views of parents (now in prison).

1.9 The progress of the review has been overseen by the safeguarding children partnership review panel, which has contributed to its analysis and learning. The review panel also agreed the key lines of enquiry for the local child safeguarding practice review and has ensured that recommendations are appropriate. Where possible, recommendations have been linked to current strategic plans.

1.10 The safeguarding children partnership is grateful for Ruby and Theo's carers contribution to the review. The safeguarding children partnership would like to offer them their sincere condolences for their life-changing loss. The safeguarding children partnership also extends its thanks to Ruby's current social worker who supported Mr. and Mrs. Anderson's participation in the review with professionalism and sensitivity.

1.11 The safeguarding children partnership is pleased that Ms. Taylor and Mr. Walker agreed to meet with the independent reviewer and similarly, is grateful to the prison offender managers and staff who made this possible.

1.12 Parents' and family members' views were recorded and shared in full with review panel members. Where pertinent, their comments are contained in the body of the review.

1.13 The safeguarding children partnership would also like to thank all members of staff who took part in this review. It appreciates their willingness to contribute to learning despite their own sorrow and at times, distress.

1.14 Finally, the independent reviewer would like to thank the safeguarding children partnership staff group for their support which has greatly enhanced the conduct of this review. Specifically, they are the business services officer, the partnership manager and the child safeguarding practice review manager. In particular, there are thanks to the child safeguarding practice review manager who organised and took notes of in-person meetings with parents and family members.

1.15 The safeguarding children partnership acknowledges the delay in publication of this report. This was due to a combination of circumstances including parents' criminal trial and the conclusion of family court proceedings in respect of Ruby.

2. Case Summary

a) Ms Taylor's pregnancy with Ruby and Ruby's early experiences

2.1 Ms. Taylor and Mr. Walker identify as white British. They are English speaking.

2.2 Ms. Taylor was 17 years old when Ruby was born and Mr. Walker was in his mid-twenties. Mr. Walker and Ms. Taylor had been known to agencies prior to Ms. Taylor's pregnancy. Concerns about Ms. Taylor had emphasised her difficult family relationships; her emotional and mental health difficulties; her previous experience of trauma and her cannabis use. Mr. Walker's circumstances were more complex. They included an unhappy, abusive childhood; mental health problems; early experience of drugs misuse; abuse of a previous female partner and a history of offending behaviours and non-compliance with sanctions. These circumstances suggest that, both as individuals and as a couple, Ms. Taylor and Mr. Walker were likely to experience difficulties caring for a new baby.

2.3 During Ms. Taylor's pregnancy, health professionals began to identify accumulating evidence of safeguarding issues. Unborn Ruby was therefore made the subject both of a child protection plan and of a pre-proceedings plan within the Public Law Outline. As part of those plans, parents agreed that when Ruby was born, she and Ms Taylor would live with designated family members while assessments were being completed. Ms Taylor's care of the baby would be supported and supervised. Ruby's contact with Mr. Walker would be restricted and supervised. These actions indicate that professionals believed that the risks of harm to Ruby were high.

2.4 When Ruby was born, she was a very small baby. Her birth had been induced due to her restricted growth, linked to Ms Taylor smoking in pregnancy. The local authority began a parenting assessment. Mr. Walker was in prison at that point, serving a short sentence for non-compliance with a community order relating to his threatening behaviours towards a previous girlfriend. When Mr. Walker was released from prison on licence, he was included in the assessment.

2.5 The parenting assessment was wide-ranging in its scope and was conducted over a number of months. Parents' contributions were recorded in their own words. Observations of contact between Ruby and her parents were also taken into consideration.

2.6 The assessment was, however, overly reliant on parents' accounts and on their optimistic expectations of their capacity to care for Ruby. It did not give sufficient weight to the extent of Ms. Taylor's vulnerabilities or to the long-

standing nature of Mr. Walker's difficulties and problem behaviours. The particular vulnerabilities of a small baby, in the context of already established risk of harm, were not adequately addressed. As a result, the assessment's positive conclusions offered misleading reassurance to parents and professionals.

2.7 When the assessment was completed, there was no managerial challenge within the local authority to the report's analysis and conclusions. The full parenting assessment was not shared with partners.

2.8 The couple's wish to live together with Ruby was subsequently endorsed by the child protection core group. Agency records suggest, however, that the reasons for the positive assessment were not explored in detail. Consistent with the assessment's findings, Ruby's pre-proceedings plan also came to an end.

2.9 Initially, Ms. Taylor and Mr. Walker appeared to be managing reasonably well. Over the course of the next few months, however, family circumstances deteriorated significantly. Professional concerns included: poor home conditions; financial difficulties; parental conflict; Ms Taylor's emotional wellbeing and the couple's disengagement from services. There were suspicions, supported by complaints from neighbours, that the couple were misusing cannabis. The family had also acquired a dog and other pets. The couple had not registered Ruby with a local GP.

2.10 On one occasion, the social worker arranged for Ruby to stay with a family member for a few days as the family nurse[1] and social worker had judged that Ruby could not be safely left in the house[2]. A few days later, home conditions were observed to have improved and Ruby returned to her parents' care. Within a short time, however, concerns increased again. Parents began to avoid contact with practitioners. There were two police callouts following reports of domestic violence. There were unconfirmed suspicions that Mr. Walker was involved in drug-dealing.

2.11 Around this same time, Mr. Walker's period of post-sentence supervision was due to end. Shortly before that could happen, however, he was convicted of drugs related offences. Mr. Walker received a 12 month community order with a programme requirement, rehabilitation activity requirement and unpaid work hours. He continued with the same probation practitioner.

2.12 By now, Ruby had been living with her parents for about eight months. During this time, Ruby's life was more miserable than it had been before. She was less physically well cared for and she had little safe place to play. In addition, she had witnessed both Ms. Taylor's explosive responses to frustration and

[1] The family nurse was employed by a commissioned service similar to the Family Nurse Partnership
[2] See section 3b) Recognising the difference between 'family arrangements' and being looked after.

Mr. Walker's threatening and aggressive behaviours towards Ms. Taylor. Ruby was also exposed to the risks associated with her parents' cannabis misuse[3].

2.13 Professionals concluded that changes needed to be made. Pre-proceedings were initiated for the second time[4]. As part of that process, Ruby went to live with family members, Mr. and Mrs Anderson[5]. Hair strand drugs testing of parents was also agreed.

2.14 Pre-proceedings should have offered an opportunity to work actively with parents to determine whether they would be able to make the changes necessary to look after Ruby in the long term. Ms. Taylor and Mr. Walker, however, continued to avoid professionals and to prevent access to the family home. They made only a very small number of visits to see Ruby. Ms. Taylor and Mr. Walker continued to test positive for cannabis use. Neither sought support from the substance misuse team. A graded care profile assessment was allocated for what was now the fourth time but could not be completed 'due to parents' lack of cooperation'.

2.15 Ms. Taylor and Mr. Walker, in conversation with the independent reviewer, acknowledged that they had been avoiding contact with services during this period. They suggested that this was related to what they experienced as a difficult relationship with the allocated social worker.

b) Events during Ms. Taylor's pregnancy with Theo and Theo's birth

2.16 A few months later, Ms. Taylor disclosed that she was pregnant. On examination, however, her pregnancy was found to be considerably more advanced than she had suggested. The hospital determined that Ms. Taylor's pregnancy had been 'concealed'[6].

2.17 By this stage, parents were aware that the local authority had concluded that Ruby's future should be with her extended family. There appear to have been no dissenting views to this plan among other professionals working with the family. Care proceedings, however, had not yet begun.

2.18 At this point, it would have been expected that unborn Theo would become the subject of a child protection plan and be joined with Ruby in pre-proceedings. It was not until almost 3 months later, however, that a child protection conference was held. No pre-proceedings plan was developed prior to Theo's birth.

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[3] See section 3e) Parental cannabis misuse as a feature of family life
[4] See section 3c) The effective use of pre-proceedings
[5] See section 3b) Recognising the difference between 'family arrangements' and being looked after
[6] See section 3d) Concealed pregnancies

2.19 Around the time that Ms. Taylor's pregnancy was confirmed, the results of the couple's hair strand tests suggested that cannabis use was now a significant part of the couple's way of life. Ms. Taylor and Mr. Walker, however, continued to deny or to minimise their use, even when challenged about the smell of cannabis and the observed evidence of cannabis-associated equipment in the house. Mr. Walker was subsequently referred by his probation practitioner to substance misuse services.[7]

2.20 When legal planning for Theo ultimately began, there were differences of opinion within the social work team about what the children's care plans should be. In the end, however, it was agreed that care proceedings would be issued in respect of both children. It was anticipated that neither child would live with parents in the short term, while permanence plans were considered. Gaps in social work documents necessary to support the local authority's legal case were identified.

2.21 In the days before Theo was born, Ms. Taylor and Mr. Walker attended for review by the perinatal consultant psychiatrist. A full assessment was undertaken. Although Ms. Taylor was anxious about children's social care's plans for Theo, the assessment concluded that there was no evidence that she had a mental health disorder.

2.22 Ms. Taylor was subsequently admitted to hospital for early induction of labour due to concerns about the baby's slow growth. Theo was safely delivered by emergency caesarean section.

2.23 Three days later, the local authority issued care proceedings in respect of both Ruby and Theo. The proceedings were allocated to lay justices (magistrate's court) although the first and second hearings were heard by judges of the family court. Theo remained in hospital with his mother until the initial court hearing had taken place.

c) Care proceedings and the impact of Covid 19 and public health measures

2.24 At the first court hearing, Ruby was made the subject of a time limited child arrangement order in favour of Mr. and Mrs. Anderson, supported by an interim supervision order to the local authority. This meant that Mr. and Mrs. Anderson now shared parental responsibility for Ruby with her parents. Theo was made the subject of an interim care order and placed with Mr. and Mr. Anderson. Arrangements were made for the children to have supervised contact with their parents.

2.25 Because Theo was now a looked after child, Mr. and Mrs. Anderson were to be assessed as foster carers for the first time. They received a fostering

[7] See Section 3e) Parental cannabis misuse as a feature of family life

allowance and ‘items …to support the placement’. Theo was not, however, allocated an independent reviewing officer as would have been expected. The local authority attributes this to human error.

2.26 The children’s guardian did not challenge the absence of an independent reviewing officer. There is a policy expectation within Cafcass that contact should be made with the independent reviewing officer service when a child becomes looked after. This did not happen in Theo’s case but, as the responsible manager had left the service before the Cafcass individual management review was undertaken, the reason is unknown. Cafcass has now embedded a letter to independent reviewing officers in Business Services Standard Operating Procedures at the start of Cafcass’ involvement in public law proceedings. This is intended to help counter any delay in a local authority providing the details of the allocated independent reviewing officer by establishing a connection and sharing the children’s guardian’s details.

2.27 At the second court hearing, it was agreed that the children should remain with Mr. and Mrs. Anderson while assessments were being completed. Theo’s interim care order was replaced with an interim supervision order and a time limited child arrangement order. This meant that Mr. and Mrs. Anderson had now acquired parental responsibility for both children, shared with Ms. Taylor and Mr. Walker.

2.28 Within the local authority, casework responsibility for the children was jointly allocated to social worker 1 and to social worker 2. Social worker 2 had initially been given the task of completing a ‘social work assessment’. When social worker 1 began a period of statutory leave, however, social worker 2 was allocated sole casework responsibility. Both social workers contributed to care proceedings in their early stages. Notably, one social worker was only recently qualified and the other had no previous experience of statutory social work with children.

2.29 *While decisions about Ruby’s and Theo’s family lives were being determined by the court, the national news was dominated by coronavirus/Covid 19. By the time of the second hearing, infections were widespread and ‘non-essential contact and travel’ had been curtailed.*

2.30 Three days after the second court hearing, the children’s child protection plans came to an end. This action was broadly in line with multi-agency procedures at the time. Since then, however, the safeguarding children partnership has updated child protection procedures. It is now the general expectation that children who are the subjects of interim supervision orders should have active child protection plans until proceedings are concluded[8].

[8] See section 3f) Increasing the level of multi-agency work in care proceedings

2.31 *Less than two weeks later, schools in England closed to most children. People were instructed that they must stay at home except for very limited purposes.*

2.32 The increasing prevalence of Covid 19 made this an extremely worrying time for all members of the community, with serious disruption to everyone's lives at home; in education; and at work. Public health measures, combined with the increased incidence of illness in the community, had a significant impact on how agencies were able to fulfil their statutory and non-statutory functions. Those various effects are described below.

2.33 The children's health visitor 1 was part of the designated 'home visiting team'. This allowed health visitors, in personal protective equipment, to continue to visit vulnerable children. Other health visitors undertook a safeguarding reporting role, writing reports based on the visiting health visitor's records and participating in multi-agency meetings. This approach had the advantage of providing continuity of in-person care to children and families but meant that the home visiting team did not directly contribute to safeguarding planning.

2.34 For Ruby and Theo, welfare visits and developmental assessments continued as before. Both children appeared to be well and to be making satisfactory developmental progress. Health visitor 1 was also in a position to support Mr. and Mrs. Anderson.

2.35 For social work practitioners and managers, there was a huge change in their working arrangements. Workers were home-based, with limited access to office space and to the formal and informal support systems to which they were accustomed. A 'workflow step' was introduced to clarify contact arrangements with children and their families. Managers made efforts to hold virtual support sessions but, as with the requirement to complete covid risk assessment documents, these could be experienced as cumbersome to workers already struggling to manage their casework responsibilities. Child protection conferences and reviews were held virtually, with parents joining through mobile phones.

2.36 In substance misuse services, only high-risk drugs users[9] and those where safeguarding concerns were identified continued to be seen face-to-face. As Mr. Walker was not living with his children at this point and his cannabis use was 'low risk', his appointments were by telephone. This meant that Mr. Walker's drug use was 'generally self-reported', with practitioners having 'no ability to visually assess his presentation'[10].

2.37 For the couple's housing association, while some practical support was provided to the most vulnerable tenants, contact was almost entirely by

[9] Mainly those on opiate substitute therapy
[10] Substance misuse services IMR

telephone. As the housing association understood that there were no children living with Ms. Taylor and Mr. Walker, they were not identified as a vulnerable family.

2.38 All probation offices were closed. Only specified individuals were required to report to the office. Mr. Walker’s order was coming to an end as lockdown began. His remaining sessions took place by telephone. Mr. Walker’s probation practitioner continued trying to keep in touch with children’s social care, but return communication was poor.

2.39 All Cafcass offices closed to the public and the majority of staff began working remotely. Parents and carers were offered the option of using video link or telephone contact in place of some face-to-face meetings.

2.40 In this case, the situation was complicated by the personal circumstances of the children’s guardian who was ‘shielding’. This meant that, even as restrictions reduced, the children's guardian was unable to return to in-person meetings. In the event, the children's guardian met parents on one occasion only, when they attended the second court hearing. All other contact with the children, parents and family members was by ‘video-link’ or telephone. Cafcass has indicated that there should have been more explicit discussions between the children's guardian and her manager to understand how ‘shielding’ arrangements affected practice.

2.41 At what was a crucial point in planning for the children ‘the myriad protective systems and services designed to detect, prevent and respond to maltreatment’[11] were severely disrupted. As a consequence, as face-to-face contact with families reduced or ceased, professional’s dependence on parents’ ‘self-reporting’ correspondingly increased.

2.42 In the family proceedings court, in-person attendance was generally substituted by participation by telephone. This allowed legal matters to continue without delay. It was, however, a completely new experience for all parties. Such an unfamiliar working environment had the capacity to distort participant’s customary roles and routines in what had previously been a highly predictable setting. This was challenging both for professionals who were sometimes ‘in attendance’ through computer technology and for parents who were relying on their mobile phones to stay in touch with proceedings. The usual potential for discussion and negotiation within the court building was also eliminated.

2.43 *Approximately seven weeks after lockdown began, people who could not work from home were now able return to work but they were to avoid public transport. Masks were to be worn in enclosed spaces.*

[11] NSPCC, 2020

2.44 Around this time, the first of only two virtual child in need meetings took place. No agreed notes were produced.

2.45 Soon after that meeting, social worker 2 provided the court with an inconclusive assessment of parents' capacity to care for the children, with no proposals for final care plans. In conversation with the reviewer, social worker 2 described her uncertainty about what was required in terms of a 'social work assessment' and of the difficulty she experienced gaining sufficient clarity from managers to guide her. Her recollection was that she was to 'provide a fresh pair of eyes'.

2.46 The issue of social worker's access to manager's advice and guidance was highlighted separately by another member of staff who expressed concerns about the limited support being provided to inexperienced workers and about the quality of supervision generally.

2.47 Even without the complications of Covid 19, completing a good quality social work assessment for court is a complex task, particularly where there is no established relationship with parents. It requires a structured approach; sufficient time; consultation with partner agencies; and, particularly for a social worker inexperienced in this area of work, active managerial support.

2.48 It is plainly very difficult to complete such a task within the tight timescales of care proceedings under the Public Law Outline process. This reinforces the importance of pre-proceedings as the opportunity to complete assessments and to determine whether parents can be supported to achieve and maintain changes[12]. A short extension to the period to complete the social work assessment was later agreed by court.

2.49 The second child in need meeting was also held virtually. This appears to have been mainly an 'information-sharing' meeting. It was noted that Ms. Taylor had had a positive test for cannabis use and that Mr. Walker was due to have a test in two weeks' time. There is no evidence that the long-term plan for the children was discussed.

2.50 *A system of 'local lockdowns' was now introduced in England and new health and safety guidance on operating 'covid securely' was published.*

2.51 Around this time, social worker 2 was absent from work for six weeks due to illness. Six weeks is a significant period in the context of care proceedings. During social worker 2's absence, no social work visits to the children or parents took place and no child in need meetings were held. Casework responsibility remained in social worker 2's name. The task of completing an

[12] See section 3c) The effective use of pre-proceedings

updated assessment, however, was allocated to an agency social worker (social worker 3).

2.52 The local authority acknowledges that, while the pandemic created 'unique' pressures, 'more could have been done to 'work' the case and to formulate the final care plan with partners.' It also notes that, since then, 'high-level reporting on long term absences has been established to support contingency planning'.

2.53 *Increasing numbers of covid restrictions were eased.*

2.54 Social worker 3's assessment began before social worker 2 returned to work. Social worker 3 observed outdoor contact sessions and undertook a number of 'support' sessions with the couple. Social worker 3 concluded that Ms. Taylor and Mr. Walker had shown that, with time and support, they could make changes. She recommended a return of the children to their parents' care, phased over six months. Notably, under this proposal, reunification would not be achievable within the court timetable.

2.55 Meanwhile, on her return to work, social worker 2 made an unannounced visit to the family home. She had been looking forward to seeing the couple as she felt that she had a good relationship with them. Ms. Taylor and Mr Walker, however, would not allow her access. They were 'verbally abusive' to her and were 'shouting out of the front bedroom window'.

2.56 Just as the final social work evidence was due to be filed, social worker 2 and her practice supervisor discussed 'case progression'. This is the first reference in the information provided to the review which describes active oversight of social work care planning and case management[13]. The record of discussion refers to 'limited visits to the family home and … attempts to undertake unannounced visits (being) met with a refusal of entry and hostility from parents.' Parents were said to have denied Ms. Taylor's drugs' use, while Mr Walker minimised his. 'Parental dishonesty' was also said to be 'making assessment of management of risks increasingly difficult'.

2.57 Children's social care has confirmed that no proposals in respect of care planning were discussed during this meeting and that 'specifically, there is no detail regarding a possible reunification plan'. The local authority states: 'The file does not clearly explain how the plan for reunification was solidified in the mind of the social work team at this time'.

d) <u>The case for reunification is made and accepted by the court</u>

[13] Some documents are countersigned by a manager/managers but the level of scrutiny/follow up conversations are unclear.

2.58 The next court hearing was pivotal. This hearing was also virtual, again with parties participating by telephone.

2.59 Theo and Ruby's final care plans recommended child arrangement orders to Mr. and Mrs. Anderson, together with 12 month supervision orders to the local authority. At the same time, the local authority planned that there would be 'a slow transition for the children to return to parents' care'. The rationale for this was that Mr. Walker and Ms. Taylor 'had not yet had the opportunity to fully demonstrate their ability to meet the children's needs and to protect them from harm'. The children's care plans were endorsed by a team manager and a head of service.

2.60 The anticipated advantage of these plans was that the children's move could be incremental over four months, with opportunities to draw a halt to the process if necessary. The disadvantages, however, were not recognised. The most important of these was that there would be no legal oversight of decisions about where the children would live permanently. The granting of child arrangement orders in the context of uncertainty about the final outcome could also have left parents, family members and the children with tricky legal issues to manage in future.

2.61 The local authority's final social work evidence to the court was strongly informed by social worker 3's positive assessment. Parents were said to have 'engaged well with services and demonstrated their ability to meet all the needs of the children'. The evidence to support that statement was, however, weak[14].

2.62 The children's guardian accepted the local authority's view that parents had made 'good progress'. She had no objection in principle to the children returning to parents. She wanted proceedings to be completed, however, only when long-term plans for the children could be determined. To resolve this, the children's guardian suggested reducing the proposed period of reunification while, at the same time, extending the proceedings to allow 'close monitoring' until the final hearing. If reunification were not successful, the court could then consider whether to make orders in Mr. and Mrs. Anderson's favour. The children's guardian suggested that the children could be 'rehabilitated back to the care of their parents within a six-to-eight-week period'.

2.63 Although social worker 2 disagreed with the children's guardian's proposal, the children's guardian's acceptance of the reunification plan reinforced her own view that the children might live with their parents. Cafcass, however,

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[14] See Section 3a) The quality of 'parenting assessments'/'social work assessments'

suggests that the children's guardian's position should have been more challenging of the local authority's proposals and that the plan for reunification could have been considered with more 'respectful scepticism'[15].

2.64 On the day of the hearing, all parties agreed that the children should return to their parents' care. There were, however, two issues on which agreement could not be reached. Those were the period required for transition and the question of whether, as the local authority had proposed, drugs testing of parents should continue. The court was required to adjudicate on those matters.

2.65 In respect of the transition period, the local authority's arguments in support of the 4 month plan were rejected by all other parties. Legal representatives for Ms. Taylor, Mr. Walker, Mr and Mrs Anderson and the children's guardian argued that, in the context of the agreement that the children should live with parents, there was no justification for the effective delay built into the local authority's plan.

2.66 In respect of drugs testing, the local authority referred to Ms. Taylor and Mr. Walker's lack of candour to date and queried whether, in the absence of testing, their word could be trusted. Counsel for parents argued that reunification was essentially an 'unconditional' position and that 'until very recently' parents' drugs use had not been deemed a bar to the children going home. The children's guardian was described as being 'neutral' on this point. The court's legal advisor asked the justices to take into account specific legal precedent.[16]

2.67 After deliberation, the court determined that the children's guardian's suggestion of an eight week rehabilitation plan was 'reasonable and proportionate'. And so, to allow the transition plan to take effect prior to final disposals, the court also ordered a four month adjournment in proceedings.

2.68 On the matter of drugs testing, the court acknowledged that evidence from additional drugs test would be beneficial. Such evidence, however, 'would not be necessary to ensure that proceedings were concluded appropriately'. As a result, the court did not order drugs testing to continue.

2.69 The children's social worker was disappointed and frustrated by both outcomes. She continued to believe that a more prolonged period of moving to live with Ms. Taylor and Mr. Walker would have been in the children's best interests. She also felt that the decision not to order further drugs testing removed a source of reliable information through which the local authority

[15] Cafcass IMR
[16] Re H-L (A Child) [2013] EWCA Civ 655

could monitor and challenge the couple's drug use. Social worker 2 had the impression that other parties in court viewed the local authority's position as being overly cautious.

2.70 The children's guardian was satisfied that the proceedings had been extended to accommodate a shorter transition period. She did not appreciate at the time, however, that drugs testing was not to continue. The children's guardian's recollection of events is that she had positively supported continued testing which she considered 'essential to ensure ongoing scrutiny of the parents' substance use and their parenting capacity'[17]. She believed that there was a consensus among parties that drug testing would continue, with or without an order. She was 'neutral' only as to whether legally an order was necessary.

2.71 The evidence from court records, however, supports the local authority's understanding of the outcome. In conversation, the children's guardian reflected on the factors which might have contributed to her forming a different interpretation of the same judgement. These included her inexperience at that point as a children's guardian and difficulties in managing the 'remote' nature of the proceedings. The discrepancies between Cafcass and the local authority in respect of their expectations of drugs testing were not revealed during subsequent communication between them.

2.72 Notably, prior to the court hearing, parents had expressed a preference for an extended period of reunification. In discussion with the reviewer, Mr. Walker recalled that the couple had asked if the children could be returned separately, starting with Theo, as he and Ms. Taylor were concerned about how they would manage with both at once. Mr. Walker said that he did not know why this request had been refused. Parents' suggestion was also recorded in Theo's final care plan, where it is described as 'realistic'. The children returning separately to parents' care did not, however, feature in the 16 week transition plan presented to the court.

2.73 Following the court hearing, a revised transition plan was provided to parties. This was a simple document, detailing the expectations of increasing contact between children and parents, until the children would be entirely in their care. There were to be weekly 'unannounced visits' by children's social care.

2.74 That level of visiting is consistent with the children's social care risk mitigation tool (Covid 19) which stated: 'Ruby and Theo can be seen via video calls.

[17] Cafcass IMR

However, due to the children returning home, weekly unannounced face to face visits will be undertaken'.[18]

e) The children return to their parents' care

2.75 The absence of multi-agency engagement with the court processes is seen within the various responses to the decision that the children should return to parents. It was, for example, Mr. Walker rather than children's social care, who informed his substance misuse practitioner that consideration was being given to the children coming home[19].

2.76 Similarly, it was only on receiving the invitation to attend a virtual strategy meeting that health visitor 1 became aware that the decision had been made that Ruby and Theo would be going to live with their parents[20]. By the time that the resultant child protection conference was held, the transition plan was already in its fifth week of operation and the children were living primarily with their parents.

2.77 The child protection conference did not include all interested parties. Ms. Taylor was unable to participate due to 'childcare' issues. Mr. and Mrs. Anderson had not been invited, despite them having parental responsibility for both children and being actively involved in the transition plan. There was no representation from substance misuse services. Ms. Taylor and Mr. Walker's housing association had not been notified of the children's move to their home address and the children's guardian was unaware that a conference was taking place.

2.78 The social work report to conference reflected the optimistic views already presented to court. The children were made subjects of child protection plans in line with the then local safeguarding children partnership procedures for children returning home as subjects of interim supervision orders.

2.79 The outstanding issues were noted to be uncertainties about parents' cannabis use and the possibility that home conditions would deteriorate when parents had full time care of their children. It was reported that there were 'no longer concerns around domestic abuse'. It would not have been obvious to a reader, however, that the children had not been seen in their parents' care since the transition plan had begun. The social work report was endorsed by a manager.

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[18] See Section 3h) Reunifying children with their parents

[19] See Sections 3e) Parental cannabis misuse as a feature of family life and 3g) Reunifying children with their parents during care proceedings

[20] Local procedures at the time required child protection plans to be reinstated if children, who were subjects of ISOs, were returning to parents' care during care proceedings.

2.80 Within the child protection plan which followed, the social work visiting schedule was set at a lower level of frequency than had been outlined in the transition plan. This suggests that a weekly visit by children's social care was considered to be more than adequate. Monthly safeguarding visits by the health visitor were to continue, although these would now be by health visitor 2 in whose area parents lived.

2.81 *Around this time, the second 'lockdown' came into force in England. There was recent evidence confirming that most children would not become seriously unwell as the result of a Covid 19 infection. Parents were advised, however, that, 'if they were worried about their children, especially those under 2, then they should seek medical advice'.*

2.82 Just over a week after the children were made subjects of child protection plans, police officers attended the family home. Ms. Taylor had called 999 to report someone 'banging at the door'. Officers understood that the person at the door was there 'to collect or enforce a drug debt owed by Mr. Walker'. When police arrived, Ms Taylor told the officers that there were children in the house. Officers did not, however, check their welfare. Intelligence was submitted but no child details were recorded and children's social care were not informed. In the circumstances of this case, that gap was significant.

2.83 The police officer who attended has not been able to provide information to the review. Police checks have confirmed, however, that there was a 'flag' at the address to indicate that there were children in the household who were subjects of child protection plans. The review queried whether this would, or should, have been known to the officers at the time.

2.84 Further investigations have revealed that the control room operator responding to an emergency call has time only to complete checks relating to officer's safety, as 'the urgency is to get an officer to the scene'. The fact that there was a child protection flag at the address would not have been known, therefore, to the officers who were to attend. Once the incident is allocated, responsibility is handed over to the officers to deal with events as they see appropriate. The attending officer could have requested further checks, but there is now no additional means of knowing why this did not happen on the night.

2.85 The police have already recognised, however, that there are potential gaps in control room responses. In order 'to support control room staff in recognising and appropriately dealing with vulnerability', therefore, the possibility of introducing a specialist vulnerability detective sergeant to control room operations is understood to be currently under consideration.

2.86 The police and the local authority have recently successfully ‘tested by dip sample’, the robustness of the system which ‘flags’ addresses where children are the subjects of child protection plan.

2.87 The day after police were called to the house, Ms. Taylor and Mr. Walker came to the social work office with the children. Social worker 2 was, of course, unaware of events the previous evening. This was the first time since the transition plan began that a professional had seen the children in their parents’ care. It was also the day before the children were to move to live with their parents on a full time basis. Notably, despite the previous emphasis on the home environment; no professional had been inside the home to check on conditions for the children’s eating, sleeping and playing.

2.88 The period when the children lived with Ms. Taylor and Mr. Walker is considered in Section 3h) ‘Safeguarding the children following their return to parents’.

f) <u>The emergency response</u>

2.89 Six weeks after the children returned full time to their parents, the ambulance service received a call in the early hours of the morning to say that Theo was not breathing. When they arrived, Mr. Walker was trying to resuscitate Theo with cardiopulmonary resuscitation. Within ten minutes of the emergency call, the ambulance service had informed the police that Theo was in cardiac arrest. Theo was taken quickly to hospital, following a pre-alert to the emergency department.

2.90 It was established that Theo had been a looked after child earlier in the year and that he was now the subject of a child protection plan. The ambulance crew advised hospital staff that home conditions were ‘unkempt’ and ‘possibly smelled of cannabis’. Theo’s clothes were soiled.

2.91 Theo died soon after arriving at hospital. Ruby was taken into police protection and returned to Mr. and Mrs. Anderson’s care. The following day, she was seen by a consultant paediatrician and a child protection medical was completed. Ruby appeared fit and well, with no obvious injuries.

2.92 The ambulance service response was considered as part of the combined health response to the rapid review. No specific learning was identified. No issues were found in response time; decisions about treatment; conveying Theo to the hospital; or the timings of transfer to the appropriate emergency department. The rapid review report finds that there was evidence of good interagency working and compliance with internal processes.

2.93 Police and health professionals alerted the coroner who agreed that a ‘Home Office post-mortem’ examination of Theo should be carried out.

2.94 After the public holidays, relevant notifications were sent out about Theo's death and arrangements were made for Ruby to return to the hospital for a skeletal survey. She had no internal injuries. Cafcass was also informed of Theo's death.

2.95 Theo's post-mortem found no signs of underlying disease or conditions that could have contributed to his death. He was found to have injuries which were 'abusive and inflicted'. Police investigations continued. Ms. Taylor and Mr Walker were subsequently arrested in connection with Theo's death. Police bail conditions were imposed to prevent them from having contact with Ruby.

2.96 Planning for Ruby's future continued within the established care proceedings.

3. Learning and Recommendations

3.1 Ms. Taylor and Mr. Walker were responsible for Theo's death. They have been convicted and sentenced for that crime. Theo was, however, a very young child whose parents were known to have posed a risk of significant harm to him and who, it had been agreed, required legal intervention to keep him safe. Professional interventions should have protected him.

3.2 The most significant professional decision for Theo was that he and his sister should live with their parents. Analysis of practice throughout the period of this review suggests, however, that the safeguarding environment in which that decision was made had been incrementally weakened by the decisions, actions, circumstances and events which preceded it.

3.3 The details of Theo's experience during the last weeks of his life were described during his parents' criminal trial. Most of what was exposed, however, was unknown to professionals working with the family at that time. The review has found, nevertheless, that safeguarding practice during that time was inadequate. This will be addressed below.

3.4 The learning which follows has been agreed by the review panel which has also endorsed the recommendations for the safeguarding children partnership.

3.5 To emphasise the cumulative effect of decisions and actions, learning is presented mainly in chronological order.

a) The quality of 'parenting assessments' / 'social work assessments'

3.6 The terms 'parenting assessment' and 'social work assessment' are often used differently in different local authorities. Their general purpose is,

however, to determine whether parents are able to demonstrate both motivation and ability to provide good enough care for their children, while considering the children's ages and developmental needs. Parenting assessments are almost always completed by the local authority as a single agency. These assessments, unlike social work assessments, are often undertaken by workers who do not hold a social work qualification.

3.7 Two parenting assessments were completed during the period covered by this review. Both were conducted when the child or children were recognised as being at risk of, or as having suffered, significant harm. On the first occasion, Ruby was the subject of a pre-proceedings plan as well as a child protection plan and on the second occasion, both Ruby and Theo were the subjects of care proceedings.

3.8 The evidence indicates that parents engaged well with both assessments and that they impressed as open and responsive with the workers involved. Key elements of both assessments, however, relied on parents' self-reporting[21].

3.9 The combined parenting/social work assessment which underpinned the local authority's care plans for Ruby and Theo reported that home conditions, which had been problematic, had improved. It was, however, acknowledged that this might be difficult for parents to sustain with a small child and a baby in the house. The couple's drug misuse was described mainly in terms of the quantity of cannabis that the couple were consuming. Too much weight was given to their expressed intentions to reduce their cannabis use. The report lacked an objective evaluation of the degree to which their habitual misuse might be resistant to change.

3.10 The significance of everyday examples of satisfactory parenting was over-stated, while a number of concerns relevant to the couple's capacity to care for their children were not addressed. At the same time, more negative inference could have been drawn from the couple's previous reluctance to work with services; from their misrepresentations of their drug use; and from their abusive response to the social worker. Most strikingly, parents were not asked to explain what went wrong when they were caring for Ruby, and so no insight is offered as to how they expected to avoid similar difficulties in future.

3.11 Both assessments reached optimistic conclusions about parents' capacity to provide the children with the care they needed. Both assessments proved to be inaccurate. Although there is reference in the first assessment to consultation with agencies, neither assessment included the active participation of multi-agency partners.

3.12 On completion, copies of the assessments were not shared with partners. Partners, however, did not challenge this, which suggests that 'not sharing'

[21] See Section 2a) for details of the first parenting assessment.

was common practice. The local authority acknowledges that this has been the case.

3.13 The local authority reports that significant steps have been taken 'to strengthen quality and consistency of practice and provide robust well-balanced assessments.' These include the creation of a "Parenting Assessment and Family-Time Team" and the adoption of a specific assessment framework.

3.14 Given the extent to which parenting assessments can influence decisions with serious safeguarding implications, the safeguarding children partnership needs to be confident that the conclusions of local authority parenting assessments are well founded; informed by the active involvement of partner agencies and subject to internal scrutiny by managers.

3.15 It should also be assured that there is a clear process for sharing information and that there are opportunities for challenge within the professional group working with the family.

3.16 *Recommendation 1: The safeguarding children partnership should undertake a multi-agency audit of recent parenting assessments to evaluate:*

i. the quality of analysis and conclusions;
ii. the involvement of partner agencies;
iii. evidence of scrutiny by managers; and,
iv. the effectiveness of information-sharing and professional challenge.

b) Recognising the difference between 'family arrangements' and being looked after

3.17 Many children live with close relatives under private or informal family arrangements, with no involvement of, or need to involve, children's social care. When Ruby lived with her parents, for example, Ms. Taylor and Mr. Walker often asked family members to look after her. Those were family arrangements.

3.18 When children live in family arrangements, the local authority has no specific responsibility to provide financial or other support to the family. When children's social care becomes involved in a decision about a child going to live with family members to keep them safe, however, then consideration should be given as to whether that child should be looked after.

3.19 On two occasions during this review, children's social care made arrangements for Ruby to stay with Mr. and Mrs. Anderson. In the first instance, this was because professionals had concluded that Ruby could not remain with her parents, principally because of the conditions in the home. In the second instance, Ruby went to live with Mr. and Mrs Anderson, initially for

four weeks, as an outcome of a Public Law Outline review meeting. This arrangement was subsequently extended twice in similar circumstances.

3.20 The impact of not considering whether Ruby should be looked after was most significant on the second occasion. At that point, had Ms Taylor and Mr. Walker agreed to Ruby becoming accommodated under Section 20 of The Children Act 1989; Ruby would have become looked after and Mr. and Mrs. Anderson would have been assessed as foster carers (kinship/connected carers). Ruby would also have been allocated an independent reviewing officer to ensure that her care plan was appropriate and was being progressed. Mr. and Mrs. Anderson, if accepted as foster carers, would have benefitted from financial, practical and emotional support from the local authority.

3.21 If parents had not agreed to Ruby becoming looked after, the local authority would have had to re-evaluate its legal options at that point. Instead, Ruby lived full time with Mr. and Mrs. Anderson for six months before care proceedings were issued.

3.22 Meanwhile, practitioners from partner agencies were under the impression that Ruby had been removed from her parents' care. Ms. Taylor and Mr. Walker understood that the local authority intended to recommend to the court that Ruby remain with Mr. and Mrs. Anderson.

3.23 Not recognising the significance of the local authority's involvement in Ruby going to live with family members was therefore a serious gap in the local authority's practice, both legally and in terms of its responsibilities to expedite an appropriate permanence plan for the infant Ruby.

3.24 The local authority has accepted that Ruby's living arrangements 'should have been treated as a placement'. The evidence from practitioners and managers across the partnership suggests, however, that similar misunderstandings as to what constitutes family arrangements have been common. The local authority is of the view that increased oversight of children in pre-proceedings or 'on the edge of care' means that this error is less likely to occur in future. The evidence which underpins this conclusion, however, is unclear.

3.25 *Recommendation 2: The safeguarding children partnership should require the local authority to provide evidence of its improved practice, since 2020, in distinguishing between 'family arrangements' and 'placements'. The report should include details of: work undertaken with professionals; information provided to connected persons caring for other people's children (kinship carers); and, how the impact of changes has been measured. The report should be received by the safeguarding children partnership by the end of June 2024.*

c) The effective use of pre-proceedings

3.26 Ruby was the subject of formal pre-proceedings under the Public Law Outline on two occasions.

3.27 Research in Practice describes pre-proceedings 'in their widest sense' as being 'any activity to support children and families and prevent harm prior to issuing care proceedings.[22] In this case, however, use of the term pre-proceedings refers to that smaller proportion of work during which the local authority formally considers whether, with the right support, parents can make and sustain the kind of changes that will keep their children safe in their care or, if this cannot be achieved, an application should be made to the family court to seek an alternative permanence plan for the child.

3.28 On the first occasion, Ruby's pre-proceedings plan came to an end following a positive parenting assessment. Care proceedings, at that point, were averted.

3.29 On the second occasion, Ruby being moved to live with family members should have offered the local authority an opportunity to conduct 'a full and proper and thorough assessment of the case'[23]. There is evidence, however, that Ms. Taylor and Mr. Walker were unwilling to engage with assessments and interventions that might lead to Ruby returning to their care. In those circumstances, the local authority concluded that care proceedings should be issued.

3.30 No sustained progress was made to that end, however, during most of the six months which followed. Instead, there is a sense that the fact that Ruby was 'safe' actually reduced the local authority's momentum to 'get match fit and ready for the process'[24]. This was complicated by Ms. Taylor's pregnancy. It was also exacerbated by the attendant lack of urgency in bringing care planning for unborn Theo into the legal framework.

3.31 This meant that, by the time that it issued proceedings, the local authority was not adequately prepared to put plans for permanence before the court. This then led to pressures within care proceedings to undertake assessments which should have been completed earlier.

3.32 Had Ruby become looked after when she went to live with Mr. and Mrs. Anderson, as discussed earlier, some of the factors contributing to this delay might have been identified and resolved at an earlier stage.

[22] Research in Practice describes this being recognised in statutory guidance, Court orders and pre-proceedings for local authorities (DfE, 2014), which emphasises the importance of early help services and of continuing support to children and families, if necessary, under a child in need or a child protection plan.
[23] President of Family Division, Re-launch of PLO 2023 (Webinar)
[24] Ibid.

3.33 The local authority acknowledges weaknesses in the pre-proceedings process as it operated at this time. Since then, the terms of reference for the relevant decision-making panel (the scrutiny panel) have been updated. The scrutiny panel considers the progress being made by children in a wide range of circumstances, including children for whom pre-proceedings are recommended and those for whom the decision about whether to issue care proceedings is required.

3.34 The local authority is satisfied that this revised process has improved the timeliness of legal interventions, increased legal and senior manager scrutiny and ultimately has led to better outcomes for children. The safeguarding children partnership, however, should be assured that this is the case.

3.35 *Recommendation 3: The safeguarding children partnership should require the local authority to provide evidence of the improved effectiveness of pre-proceedings work with children and parents, since the period covered by this review. This should include evidence of both appropriately diverting children from proceedings and where this has not been possible, securing timely permanence plans. The report should be received by the end of June 2024.*

d) Concealed pregnancy

3.36 When Ms Taylor attended for an emergency booking appointment with unborn Theo, her pregnancy was found to have been 'concealed'.

3.37 A number of safeguarding partnerships have developed stand-alone guidance in respect of concealed pregnancies[25]. Examples describe the implications of concealed pregnancy as 'wide-ranging', including risks to mother and child during pregnancy; the potential for unassisted delivery; and a possibly negative impact on maternal bonding with the newborn. Concealed pregnancy has also featured in a number of serious case reviews[26].

3.38 Although the reasons for concealing Ms. Taylor's pregnancy could have been material to assessments of parents' capacity to care for Theo, there is no record that this was explored. Opportunities to consider the significance of Ms. Taylor's late reporting of her pregnancy were further limited by the delays in child protection processes which followed.

3.39 In conversations with the independent reviewer, both parents denied that they had 'concealed' Ms. Taylor's pregnancy, although Ms. Taylor acknowledged some delay in reporting it. She recalled asking Mr. Walker if he thought it was the right time to have another child, but he 'got angry' as he thought she 'didn't want him' (that is, Theo). After that, Ms. Taylor said she stopped talking to Mr.

[25] Example of LSCB practice guidance (2019) in respect of concealed pregnancies
[26] NSPCC National case review repository/search results

Walker about the pregnancy[27]. Mr. Walker said that he had no recollection of anyone asking why the couple had not revealed their pregnancy sooner.

3.40 This review was commissioned in the context of the safeguarding children partnership's experience of examining and responding to safeguarding practice with babies. Specifically, between 2018 and 2021, the safeguarding children partnership conducted several multi-agency reviews following serious harm experienced by babies under the age of 1. Since then, and since Theo's death, the safeguarding children partnership has taken significant steps to support keeping babies safe. These include:

i. Developing and implementing a partnership strategy to support the safety of babies (Feb 2021)[28];
ii. Publication of learning from reviews (June 2021)[29];
iii. A Stakeholder Conference to share that learning (July 2021); and,
iv. The adoption by the Safeguarding Children Partnership of 'promoting and improving the safety and welfare of babies' as a key priority and the appointment of a strategic lead. The Keeping Babies Safe Strategic Group remains an active element of the safeguarding children partnership.

3.41 An evaluation and impact report in respect of the safeguarding children partnership's keeping babies safe strategy was published in 2023. That report highlights the development of a universal risk assessment tool to be used within the partnership 'to reinforce the intrinsic vulnerabilities of babies and to support practitioners to identify vulnerabilities within the family'. It is noted that the tool can be adapted for use in the ante-natal period.

3.42 There are helpful references to the potential significance of concealed pregnancy in the documents above as well as it being directly named as an issue within the local safeguarding children partnership procedures. The review panel acknowledged, however, that there would be merit in reviewing/revising the safeguarding children partnership's current guidance in this area.

3.43 *Recommendation 4: The safeguarding children partnership should revise its procedures and guidance in respect of concealed pregnancy.*

3.44 *Recommendation 5: The safeguarding children partnership should update its Keeping Babies Safe Strategy and guidance for the use of the 'Every Baby*

[27] On having sight of the notes of her conversation with the independent reviewer, Ms. Taylor asked that her reported view be expanded to include: 'A concealed pregnancy would not have been possible as we were seeing the Social Worker regularly at this time. Nor would I have wanted to hide it, as all I ever wanted was to have children'.
[28] 'Three Steps for Baby Safety'
[29] 'Promoting the Safety of Babies, Learning from Reviews'

Matters' assessment tool to include the vulnerabilities associated with concealed pregnancy.

e) Parental cannabis misuse as a feature of family life

3.45 Since estimates began in 1995[30], cannabis has consistently been the most used illegal drug in England and Wales. In 2022, approximately 7% and 16% of adults aged 16 to 59 years and 16 to 24 years, respectively, reported having used cannabis. Many people may use cannabis safely and with minimal effect on their everyday lives. Problematic cannabis use is, however, a significant adverse factor in the lives of many families involved with children's social care. In this case, Ms. Taylor's and Mr Walker's cannabis use had been a cause for concern since Ms. Taylor was pregnant with Ruby.

3.46 Mr. Walker was known to have a significant history of using different types of drugs, including taking amphetamines and smoking heroin. In conversation with the independent reviewer, Mr. Walker described the association between his drug misuse both with his past poor mental health and with his conviction for domestic violence related offences.

3.47 Mr. Walker told the independent reviewer that he had been using cannabis since he was nine years old. He described finding it difficult to function without ready access to cannabis to help with his anxiety and to give him energy. Mr. Walker also talked about his experience of cannabis increasing in potency during the years that he was a 'daily user'. Significantly, the potency of cannabis has been found to be associated with the highest levels of risks to mental health to people like Mr. Walker who are regular users[31] and who begin using in adolescence.[32]

3.48 Ms. Taylor was also known to have used cannabis frequently as a young teenager. Ms. Taylor told the independent reviewer that her cannabis use had become 'a habit' and 'normal'. She described having built a tolerance to the drug, so that it was 'just like having a fag'.

3.49 As already noted, the couple's cannabis use was identified as a risk factor in Ruby's child protection plan. The couple themselves, however, did not acknowledge that their cannabis use was problematic. They continued to deny or to minimise its significance.

3.50 As a result, conversations between children's social care and Ms. Taylor and Mr. Walker, often focused on exhorting the couple to be truthful about their cannabis use rather than on discussing its function in their lives and its potential impact on their parenting capacity. The child protection strategy

[30] Trends in individual drugs use, ONS 2022
[31] UK cannabis market dominated by high-potency 'skunk' | Website archive | King's College London (kcl.ac.uk)
[32] NHS inform

appears to have been, therefore, to continue testing Ms. Taylor and Mr. Walker as an objective measure of their consumption and to encourage them to work with services.

3.51 Ms Taylor has described this as the local authority being prepared to 'work round' their drugs use. Mr. Walker's reported interpretation was that children's social care 'were not concerned about (them) smoking cannabis, as long as they were open about it and did not smoke in the house'.

3.52 In the months before Ruby became the subject of a pre-proceedings plan for the second time, Mr. Walker's probation officer found that he was 'struggling with his emotional well-being'.[33] He had been providing the probation service with 'unfit for work medical certificates'. Mr. Walker's drug use was also increasing. When Ms. Taylor was pregnant with Theo, Mr. Walker's probation practitioner referred him to substance misuse services.

3.53 This was an opportunity to explore more fully the significance of cannabis use in the couple's lives and to understand better its implications for their parenting. A combination of shortcomings in respect of Mr. Walker's assessment and treatment plan and the continuing absence of substance misuse practitioners from multi-agency working, however, meant that this potential for change was not realised.

3.54 Specifically, the assessment by substance misuse services of Mr. Walker's current risk was not robust. Mr. Walker was not challenged about his probation practitioner's suspicion that he was 'playing down his current drugs use' and despite the referral containing the probation service's risk assessment, Mr. Walker's support plan did not reflect the referrer's concerns about domestic abuse[34].

3.55 In addition, there was no communication between substance misuse services and children's social care. Mr Walker's substance misuse practitioner was not invited to participate in child protection planning. As a result, pertinent details held by substance misuse services were not shared with safeguarding partners and information held by partners did not inform Mr. Walker's support plan.

3.56 Two months after referring Mr. Walker to substance misuse services, his probation officer secured an amendment to Mr Walker's community order, replacing his unpaid work requirement with a 3 month drug rehabilitation requirement. At that point, Mr. Walker was offered weekly appointments with substance misuse services.

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[33] Probation Service IMR
[34] Substance misuse services IMR

3.57 Mr. Walker was regularly asked by his substance misuse practitioner about his mental health. Mr. Walker, however, gave false assurances that he was receiving treatment through his GP and so potential problems were not explored further.

3.58 From the time that care proceedings began and child protection planning ended, Mr. Walker's drug rehabilitation requirement was still in place. This period coincided, as already noted, with a dip in communication between the probation service and children's social care. There was still no direct communication either between children's social care and substance misuse services. Substance misuse services were not asked to contribute to the local authority's parenting/social work assessment nor were they asked to provide a report for court.

3.59 When the children's move home was imminent, the substance misuse service became a member of the child protection core group for the first time. This led to an increased focus on safety around drug use. By that stage, however, Mr. Walker's contact with the service was only by telephone. Hair strand testing of parents had been ended and Mr. Walker was reporting reduced drug use.

3.60 Despite the significant change in family circumstances, however, the substance misuse practitioner did not bring the case to supervision within the service. This indicated that it 'did not meet the practitioner's threshold for concern'. As a result, there was no management oversight of the work being undertaken with Mr. Walker and family members. The service's individual management review concluded that practitioners demonstrated 'no understanding of the application of safeguarding training', or of 'the vulnerabilities of babies under the age of one'.[35]

3.61 Since Theo has died, all staff in substance misuse services have attended a learning event on the impact of cannabis on parenting. The service has also provided 'professional curiosity workshops' for staff and enhanced training for safeguarding leads. A structured 'cannabis use' tool has been developed and is now in use across the service.

3.62 Priority has also been given to increasing attendance by substance misuse practitioners at child protection conferences (recently reported to be 96%). This suggests a high level of engagement where the need for their involvement has been identified. Improved participation of partners is also reported by the local authority child protection service.

3.63 Safeguarding and promoting the welfare of children affected by parental alcohol and drug use (2018) recognises that directors of public health as commissioners of alcohol and drugs services are 'important players in the

[35] Substance misuse service IMR

local multi-agency safeguarding arrangements.' As the description of events above indicates, however, this was not evident in this case.

3.64 The guidance goes on to recommend that local areas develop a 'joint protocol' to specify the roles that alcohol and drug treatment services have in safeguarding arrangements. That protocol should also specify how duties and responsibilities for child safeguarding are set out in individual service contracts and how they will be monitored.

3.65 *Recommendation 6:* *The safeguarding children partnership should strongly encourage local public health commissioners of substance misuse services and the local authority to develop a working joint protocol in line with guidance and by June 2024, to report the outcome, with details of anticipated impact.*

3.66 In 2021 -2022, the safeguarding children partnership had as a priority 'reducing the impact of parental substance misuse and parental mental health', based on its learning from rapid reviews and child safeguarding practice reviews. The safeguarding children partnership's Annual Report 2021-2022 describes the enquiries made and actions taken by the partnership during that time. As in this case, audit activity revealed that 'substance misuse was a feature that parents disguised or concealed from professionals carrying out the assessment'.

3.67 Discussion about this particular case in various forums[36], however, suggests that the impact of parents 'disguising or concealing their substance misuse' may have been compounded by 'the normalisation of cannabis as a risk factor'[37]. This contention is supported by the comments of some practitioners who, in the context of what is perceived to be a high level of prevalence of cannabis use in the community, were not confident that they could distinguish between 'acceptable' and 'problematic' cannabis use by parents. This uncertainty has the potential to be a recurring influence on professional judgement unless action is taken to address it.

3.68 The safeguarding children partnership is committed to updating its training, policy and guidance in the light of local and national learning. As a consequence, it is reviewing its current guidelines for gathering information and assessing the needs of children whose parents have drug/alcohol issues. This will include '*better representing the challenges arising from misuse of cannabis and understanding of its impact on parenting (including the challenges to assumptions or values that may be different for cannabis than for class A drugs)*'.

[36] Learning event, individual conversations with practitioners involved with the family and case review panel
[37] Substance misuse services IMR

3.69 The safeguarding children partnership is in the process of 'triangulating' its review with existing agreed protocols and procedures. The newly established joint-area Drug and Alcohol Strategic Partnership and the local Operational Group for substance misuse will also be involved in implementing the learning from this review. This will secure both strategic and operational engagement.

3.70 When multi-agency guidance has been updated, the safeguarding children partnership will seek assurance from partner agencies about the steps that are being taken to update their internal training to reflect this.

3.71 As already noted, Mr. Walker has described his reliance on cannabis in generally positive terms. Ms. Taylor, however, talked about how Mr Walker would become 'angry' when he was unable to obtain cannabis. She described how this would lead to 'arguments' between them which, Ms. Taylor has alleged, often ended in Mr. Walker 'smashing the house up'.

3.72 While Mr. Walker did not acknowledge a link with cannabis supply, he reported that 'arguments' between the couple could start over the 'littlest stupidest things' and could 'carry on for days.' This suggests both that conflict was a regular feature of family life and that it was likely to have been related at least in part to the availability or otherwise of cannabis.

3.73 The couple's cannabis use also left them short of money for essential items. Mr. Walker described borrowing money from his mother. Mrs. Anderson reported that Ms. Taylor asked her for money for baby milk while she suspected that the couple's own money had been 'used to buy drugs.'

3.74 As he has done previously, Mr. Walker denied explicit drugs dealing.

3.75 Notably, the NSPCC has recently published a learning from case reviews briefing[38] in relation to parents with substance use problems. Key elements of the learning from this case are reflected in the NSPCC's summary findings.

f) Increasing the level of multi-agency work in care proceedings

3.76 The evidence of this review is that multi-agency work within care proceedings was very limited and that this was detrimental to Ruby's and Theo's welfare and safety.

3.77 The usual vehicle for multi-agency work with children who are at risk of harm is the statutory child protection process. For Theo and Ruby, their child protection plans came to an end when both children were made the subjects of interim supervision orders. The children were then made subjects of child in need plans.

[38] Parents with substance misuse problems; learning from case reviews NSPCC December 2023

3.78 The change from a child protection plan to a child in need plan is routinely described as 'stepping down'. Theo and Ruby were not, however, children who needed support to promote their welfare and development. They were children for whom the court was satisfied that the threshold of significant harm had been met.

3.79 In discussion among practitioners at the learning event, it became clear that there were various interpretations of the significance of the decision to end child protection planning. For most front-line practitioners working with the family, it signified that there would now be less emphasis on multi-agency safeguarding than there had been previously. For some agencies, 'step-down' was also associated with a reduced level of service provision[39].

3.80 A further issue is the lack of clarity about the intended focus of the child in need meetings. In some records, for example, the meetings are referred to, not as child in need meetings but as 'network' meetings. In any event, only two such meetings took place and no agreed notes were produced.

3.81 As already stated, ending the child protection plan was generally consistent with expectation under safeguarding children partnership procedures as they stood at that time. Procedures anticipated, however, that the court endorsed Supervision Support Plan would provide the framework for multi-agency working. This, however, did not happen. It is also questionable whether the support plan would have been adequate for that task.

3.82 Again, as already noted, local multi-agency procedures now require child protection plans to continue where children are subjects of interim supervision orders until final orders are agreed. For this change in procedures to make a difference in reality, however, there needs to be a change in culture both within the local authority and among partner agencies. There was a clear sense at the learning event, for example, that practitioners and managers from partner agencies held little expectation of being actively involved in 'court work'. Whatever its perceived strengths or shortcomings, this was essentially seen as a local authority task.

3.83 <u>Recommendation 7:</u> *The local authority child protection service, with the participation of key partner agencies, should work with the local authority's legal service to develop and implement a practice model that will enable effective multi-agency work while children are subjects of care proceedings.*

3.84 The review acknowledges the challenges inherent in this recommendation. They have been discussed in detail in review panel meetings. Although 'children in care proceedings' includes children who are the subjects of interim care orders; it is anticipated that the initial focus of this work will be in respect

[39] The Probation Service, for example, allocates qualified officers to parents whose children have a child protection plan but an unqualified worker only to children 'in need'

of children who are the subjects of interim supervision orders. These are the children who will be the subjects of concurrent child protection plans. It will be crucial to the task to identify and manage key points of difference/tensions between planning and review processes.

g) Reunifying children with their parents' during care proceedings

3.85 There is no doubt that children should be able to live with their parents, where those parents, with appropriate support, have the capacity to meet their children's needs and to keep them safe. As already discussed, positive assessments of parents' capabilities to care for their children, in this case, fell short of an adequate evaluation of the risks to which the children would be exposed.

3.86 Ms. Taylor's and Mr. Walker's difficulties and problem behaviours were longstanding. They had not been able to provide good enough care for Ruby during the months that she lived alone with them. The most recent parenting assessment was undertaken when the children were being cared for by family members. There was very limited evidence that the couple had been able to effect changes since they had last cared for Ruby. In addition, both Ruby and Theo were very young children who would be completely dependent on their parents for all aspects of their care. There were many risks inherent in this situation. This was not adequately understood.

3.87 Increasing even the likelihood of successful reunification in those circumstances would have required sustained high levels of support to parents combined with high levels of multi-agency challenge to ensure adequate risk management. The local authority's transition plan did not meet these criteria.

3.88 Neither Ms. Taylor, Mr. Walker, Mr and Mrs Anderson nor partner agencies played an active part in planning for the children's return. Parents did not receive a comprehensive and coordinated package of support. Professionals working with the family were not consulted prior to the proposal for reunification being put to the court. They were not involved in discussion about outstanding risk. They were unaware of the details of the transition plan. The continuing role that Mr and Mrs Anderson would have in supporting parents and in keeping the children safe was unclear.

3.89 Contingency planning was underdeveloped. The transition plan refers to the possibility that the children's move to their parents might be ended should the local authority have concerns at any time. A clearer definition of 'concerns', however, linked to a more explicit range of consequences would have provided clarity to parents and a better foundation for professional judgement.

3.90 There were, then, significant shortcomings both in terms of the assessment of the viability of reunification and in the plan to support reunification once that

decision had been made. Many of the interlinked circumstances which gave rise to this situation have already been identified.

3.91 The local authority does not currently expect practitioners to use a particular evidence-informed framework for return home practice such as the model provided by the NSPCC. The local authority has reported, however, that there has been an improvement in the quality of transition planning since Theo and Ruby went to live with their parents. Given the circumstances of this case, the safeguarding children partnership needs to be further assured that children are now properly protected when they return to parents' care.

3.92 *Recommendation 8: The safeguarding children partnership should complete a multi-agency audit of cases where children were reunified with parents in pre-proceedings or during care proceedings. To reflect the learning from this case, the audit should specifically address:*

i. *the involvement of parents and children, family members and partner agencies in planning for reunification;*
ii. *the extent to which the levels of support and challenge offered/provided are consistent with the level of risk identified; and,*
iii. *the quality of contingency planning.*

Where possible, the audit should also consider the outcomes for children and families at 6 months and 12 months following reunification.

h) Safeguarding the children following their return home

3.93 Events leading to the children's full time return to Ms. Taylor's and Mr. Walker's care are described in Section 2: Case Summary. Analysis of circumstances and events that preceded their move have been provided above. The impact of those shortcomings continued to be felt throughout the time that the children lived with their parents.

3.94 For example, because the risks to the children were poorly understood, practitioners and managers were insufficiently alert to the possibility that the children might experience harm. This was compounded by the absence of regular practical support to parents which limited the opportunities to identify early signs of deterioration.

3.95 Even within that context, however, there were clear deficiencies in safeguarding practice.

3.96 *At the point at which Ruby and Theo returned full time to their parents' care, the second national lockdown in England was in place.*

3.97 It had been agreed that the main forms of safeguarding interventions would be weekly unannounced social work visits, monthly visits by the health visitor and monthly child protection core group meetings. Mr. Walker was also having telephone contact with substance misuse services. His allocated substance misuse practitioner would now be included in child protection processes.

3.98 Two days after the children returned to their parents' care, the social worker visited the children at home. All appeared well, except that Theo had a 'small bump to his head' which parents described as being 'caused by a toy', thrown by Ruby. It is not clear to what extent Ms. Taylor's explanation was interrogated by the social worker during the visit.

3.99 The next day, health visitor 2 made a planned visit to the family home, re-arranged from a proposed appointment eight days earlier. Health visitor 2 described the living area as 'cluttered' but the kitchen, as seen through a doorway, appeared clean and tidy. The family dog was upstairs. Health visitor 2 noticed the bruise to the side of Theo's head which parents again said was caused by Ruby throwing a toy. Health visitor 2 told parents that she would have to speak to the social worker about the bump. Parents said that the social worker had seen the bruise the day before.

3.100 Ms. Taylor and Mr. Walker told health visitor 2 that they were 'struggling to make changes to the routines' that Mr. and Mrs. Anderson had established with Ruby. They said that her potty training had regressed. Ruby had not yet been registered with a local nursery or with a local GP. Although this was technically a 'transfer in visit' by the health visitor, community health services acknowledge that there would have been merit in talking to parents about not shaking babies; safe sleeping and strategies for coping with crying children, which would have been provided at a routine birth visit. Unfortunately, health visitor 2 has not been able to participate in this review and it is not clear from the records whether this happened.

3.101 Later that day, health visitor 2 spoke to the social worker by phone. They discussed their separate visits including information about the bruise to Theo's head. There is no evidence that the explanation given by parents for the injury was explored. There was no reference to the Derby and Derbyshire Practice Guidance on Bruising in Babies and Children (2018) as there should have been. Social worker 2 did not share information about the bruise with her manager and there is no record that health visitor 2 took safeguarding advice. There is no evidence either that the children's guardian was informed. No consideration appears to have been given to referring Theo for a child protection medical.

3.102 The safeguarding children partnership acknowledges that is an example of poor safeguarding practice, irrespective of circumstances which came before.

3.103 Since Theo's death, the safeguarding children partnership has invested considerable resource in work to improve safeguarding practice with babies. As already described, this has included the development, implementation and evaluation of a partnership strategy to support babies' safety. [40] A strategic lead in this area has been retained. As a result, it already has in place a strong framework to promote best safeguarding practice with babies. It is anticipated that the dissemination of learning from this review will reinforce those messages.

3.104 For those reasons, therefore, no new recommendations are made in respect of bruising to non-mobile babies. The lack of professional responses to Theo having a bruise on his head, however, emphasises the importance of clear contingency planning when children who have been removed from their parents' care are returned home.

3.105 The following week, health visitor 2 made two unsuccessful attempts to speak with Ms. Taylor by phone to establish if the children had been registered with a local GP. As the GPs still had no records of the children, health visitor 2 noted her intention to pursue this with parents.

3.106 Around this same time, the social worker made an unannounced visit to the family home. Despite 'knocking on the door for up to ten minutes', the social worker was only able to gain access by phoning Ms. Taylor. Theo had been seen through the window. He was asleep, unattended, on the sofa. Ms. Taylor said that she had been upstairs and had not heard the door. Inside the house, Theo presented as 'slightly groggy' but well. It is not known what discussion took place about Theo's presentation as 'slightly groggy' but it is reported by children's social care that 'discussion took place around associated risks.'

3.107 Ms. Taylor told the social worker that Ruby was upstairs listening to music with Mr. Walker. Case notes indicate that 'this was consistent with what the social worker saw while looking round the house'. It is recorded that Ruby was seen and spoken to during this visit and appeared well.

3.108 *Soon after this visit, the second national lockdown ended and England returned to a stricter three-tier system of restrictions. A few days later, the first Covid vaccinations were given in Phase 1 of vaccine rollout.*

3.109 Almost two weeks later, the social worker made another unannounced visit to the children. Again, there was no reply. Ms. Taylor subsequently said that she was out shopping.

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[40] See Section 3d) Concealed pregnancy.

3.110 Three days after that failed home visit, a 'conference call' child protection core group meeting took place. Health visitor 2 was not able to attend but provided a report including 'a summary of her home visit'. Taking part in the call were Ms. Taylor, social worker 2, and a worker from the substance misuse team. Again, Mr. and Mrs. Anderson were not included. Agency records refer to the children's 'positive development'. No evidence has been provided, however, of discussion in relation to the bruise which professionals had seen. The children were still registered with the GP where Mr. and Mrs. Anderson lived. Mr. Walker was said to be 'engaging with substance misuse intervention' and to have reduced his use of cannabis. That reduction, however, was self-reported. He had told the substance misuse practitioner that he was now only using cannabis once a fortnight, with no adverse impact on his mental health.

3.111 Three days later, Mr. Walker spoke to the substance misuse service by telephone. He reported continuing low-level use of cannabis. It was agreed that the next appointment would be face-to-face 'due to the length of time he had been receiving telephone appointments during the pandemic'.

3.112 The day after Mr. Walker spoke to the substance misuse service, Ruby went to stay with Mr. and Mrs. Anderson for a planned visit. This was a Friday. Theo did not go as Ms. Taylor said that he had a cold and was teething.

3.113 On the following Monday, the social worker sent a message to the children's guardian indicating that 'rehabilitation was going well'.

3.114 On the Tuesday, Ms. Taylor cancelled a pre-arranged home visit from the health visitor as Theo was 'having a Covid test'. There is no record that health visitor 2 talked to Ms. Taylor about how to manage Theo's symptoms or asked how parents were coping with a poorly child. No advice appears to have been given about when, or who, to call for help, particularly since the children were not yet registered with the local GP. The health visitor's appointment was postponed for a week. There is no record of a discussion between the health visitor and social worker about this phone call.

3.115 It was now over a month since the health visitor had seen the children. She did not seek advice from the safeguarding team at that point, which was contrary to the service's expectations where a face-to-face visit could not be arranged due to Covid.

3.116 On the Wednesday, the social worker made an unannounced visit to the family home. This visit was conducted on the doorstep as Mr. Walker said that Theo had covid symptoms and was asleep upstairs. No details of Theo's symptoms were given. It was not confirmed that he had had a positive test.

Mr. Walker was not willing to rouse Theo to allow the social worker to see him. Mr. Walker brought Ruby to the door. She 'seemed well'.

3.117 At some point during this encounter, the social worker saw Ms. Taylor in the street. Ms. Taylor had approached a car and was seen to make some kind of transfer which the social worker thought might have been 'drugs related'. The social worker went towards Ms. Taylor, but Ms. Taylor was on the phone. Ms Taylor looked upset but she 'did not disclose any concerns.'

3.118 There is no reference to the social worker challenging Ms. Taylor about what she had observed. There is no evidence either that this incident was discussed with the social work manager, other members of the core group or the children's guardian. The social worker told Ms. Taylor that she needed to see Theo and did not want this to wait as there was a holiday period approaching. She said that she would contact the family the next day. Ms. Taylor said that the health visitor had arranged to call the following week.

3.119 The social worker did not visit the family as planned. Mr. Walker told the independent reviewer, however, that the social worker had sent them a text suggesting a video-call, but that they 'didn't see it' in time. The social worker did not speak either to the health visitor, a manager, or to Mr. and Mrs. Anderson. She e-mailed her practice supervisor to request a visit by the duty social worker as 'a visit was now overdue', but no other concerns were noted. It was now four weeks since Theo had last been seen by a professional. Four days of public holidays were imminent. A duty social worker visit was not made.

3.120 Of the six children's social care visits that should have taken place during this time; only four were attempted. On one of those four occasions, there was no response at all. On each of the three visits where contact was made, issues arose that warranted further enquiry, but necessary actions were not taken. Managerial oversight of compliance with the visiting schedule was absent.

3.121 Of the two health visits that should have taken place, only one was achieved and the other cancelled by Ms. Taylor. Two phone calls to Ms. Taylor were also unanswered.

3.122 Communication between the social worker and the health visitor was too infrequent to enable them to identify issues which might have been of concern to them both. In particular, there is no record of a conversation between the health visitor and the social worker about Ms. Taylor's and Mr. Walker's claims that Theo might have Covid-19 and so could not be seen.

3.123 Only one 'conference call' child protection core group took place during this period. The substance misuse practitioner was 'attending' for the first time

and the health visitor was absent. Information shared appears to have reinforced the impression of an improving family environment, although there was no objective evidence to support this. There was a continuing drift away from effective evaluation of the risks to Ruby and Theo.

3.124 At the same time, the absence of practice supervision is significant. Had practitioners been provided with the kind of reflective supervision that would have allowed them 'a safe space … to slow down and think, explore possibilities, look for meaning and a way to do their work well'[41], they might have been able to consider alternative interpretations of circumstances and events and to have reached different conclusions about what needed to be done.

3.125 Similarly, more expansive conversations between the children's guardian and the social worker might have led to helpful discussions and a different perspective.

3.126 Most importantly, however, regular and purposeful conversations with Mr. and Mrs. Anderson about the children's wellbeing and safety could have provided a much greater level of insight into what was really happening at home.

3.127 The local authority; the 0-19 service; substance misuse services and, Cafcass have accepted that there were failings in basic safeguarding practice during this period. Each of their individual management reviews describe the improvement actions they have since taken.

3.128 Relevant to safeguarding during this period, the local authority reports that it has: strengthened team management oversight of, and quality assurance in respect of social work practice; relaunched its social work practice model; focussed on work with under 5's in the locality where Theo and Ruby lived with their parents and, instituted improved reporting and tracking of home visits, 'ensuring that children who do not have a visit recorded are followed up in a timely way'. The local authority also reports that workforce development and quality assurance activity have provided 'positive evidence' that practitioners are aware of and implement practice guidance in respect of bruising to infants.

3.129 Community health services report that they have: contributed to the Three Steps for Baby Safety partnership strategy; disseminated learning from child deaths; updated 0-19 service best practice guidance for information sharing between health visitors and GP practices; worked to improve communication across 0-19 children's teams when children are living in different geographical areas and delivered relevant training programmes. An audit of safeguarding supervision is scheduled for March 2024.

[41] Research in practice, reflective supervision resource pack, April 2017

3.130 Cafcass has reported that it has reviewed, updated and reissued its internal policies on seeing children in-person. It has also, among other actions: clarified what is expected of children's guardians when reunification is being considered; implemented public law practice quality standards; developed a public law tool kit; and produced practice guidance notes to support children's guardians to review the wording and accuracy of court orders.

3.131 Some of the steps taken by the substance misuse services to improve its safeguarding practice have already been described. They include: comprehensive assessments with clear goals at the early stages of involvement; utilising the 'Think Family' approach within the service; the production and implementation across the service, of a structured tool in respect of cannabis use; ensuring that staff prioritise attendance in multi-disciplinary meetings and supervision and, making sure that notes of safeguarding meetings and child protection plans are attached to the electronic patient record. The service has also reported that safeguarding level 3 training and 'Keeping Babies Safe' training are now requirements for all practitioners.

3.132 Notably, children's social care and substance misuse services have also worked together to provide specific cannabis use training for staff across social care and early help. This training has been delivered on seven occasions during 2023. Feedback indicates that the course improved participant's knowledge about cannabis and cannabis use, helped them to feel more confident about talking to parents about its impact and increased their awareness of what interventions could be offered.

3.133 In January 2024, the NSPCC published [Returning children home from care: learning from case reviews] based on a sample of case reviews published between 2016 and 2023. The key issues and learning in this case are very similar to those which inform the NSPCC briefing. In particular, the briefing reinforces the need for robust assessments of risk and parenting capacity; action to address parents' difficulties; as well as effective planning, support and 'monitoring' during and after the process of returning a child home. The document also emphasises the need for good information sharing between relevant agencies; of having a joint plan to support the family and of developing a sense of 'collective responsibility'.

3.134 The safeguarding children partnership has shared the NSPCC briefing document with members of the case review panel.

i) Additional safeguarding practice issues identified by the review

i. Working with families who appear to be avoiding contact with professionals

3.135 A significant feature of safeguarding work in this case was that professionals were not always able to engage Ms. Taylor and Mr. Walker in common purpose. Throughout the time that services were involved, access to the family home was consistently hard to achieve and there were concerns about the couple's unwillingness to work constructively with professionals. The couple's inaccessibility to professionals was exacerbated during the review period by Covid 19 regulations and by the practical difficulties resulting from the necessary adjustments to face-to-face working arrangements.

3.136 The reasons Ms. Taylor and Mr. Walker did not engage with services appear to have been varied. Both parents, for example, emphasised the importance of feeling 'listened to' by practitioners and of being able to trust workers to be honest with them and 'not to find fault behind their backs'. When they were suspicious of practitioner's motives, they report, they were less likely to make themselves available.

3.137 At other times, Ms. Taylor was simply 'not in the mood' to speak to professionals because of 'all the arguing' with Mr. Walker. Similarly, there were occasions when they avoided contact because they were using cannabis and the house was in a poor state. In their discussions with the independent reviewer, neither parent referred to denying access to professionals when they said Theo had covid symptoms.

3.138 There were occasions when the couple appeared to have felt positive about their relationships with practitioners. Mr. Walker, for example, referred to workers who 'understood his issues' and Ms. Taylor to a worker who 'wanted what was best for her'. There is no evidence, however, that those relationships were associated with parents being able to work earnestly to make or sustain significant changes. This emphasises that while individual practitioners may be able to make relationships which parents experience as 'good', consistently effective safeguarding practice with children and families requires more.

3.139 The review panel discussed this issue in depth and considered whether partners should undertake specific additional remedial action, such as developing a non-engagement protocol or pathway. This remains an option.

3.140 In the meantime, on a focused visit in 2022, Ofsted found evidence of: social workers and managers with a strong grip of family dynamics and risks; safeguarding work that responds to and addresses concerns; strong multi-agency working reflecting partners' confidence in social workers; and, tailored packages of support to families which illustrate the understanding of domestic abuse, substance misuse and neglect in families and the impact on children. Notably, the report also refers to social workers 'having courageous and honest conversations with families as they seek and build open and trusting relationships with them'. These comments suggest solid safeguarding

practices which make the development of effective working relationships with parents more likely.

3.141 This assurance of an improved safeguarding environment has been strengthened by the most recent Ofsted Children's Services Inspection (January 2024) which rated the local authority 'Good' in all elements. Most significantly for this review, this included the experiences of children who need help and protection.

3.142 The safeguarding children partnership should, nevertheless, ensure that its dissemination of learning from this review highlights the importance of developing relationships with parents which both support and challenge.

ii. Responding to issues of domestic violence and abuse.

3.143 Prior to his relationship with Ms. Taylor, Mr. Walker was known to have abused a previous girlfriend. This resulted in him being assessed by the probation service as being of medium risk of serious harm to intimate partners and to children. Ms. Taylor had also been assaulted by a previous partner. When Ruby was living with her parents, there were two police call outs to incidents of domestic violence. Ms. Taylor and Mr. Walker subsequently denied domestic abuse, although neighbours spoken to by police reported that Ms. Taylor was 'terrified' of Mr. Walker.

3.144 At that point, Mr. Walker was the subject of a community order. As part of that order, he completed a 'Safer Choices' programme. This is focussed on offenders 'at the lower end of the scale' in terms of risk of domestic abuse. The probation service individual management review indicates that attitudes in respect of 'healthy relationships' were not explored with Mr. Walker, despite this being a sentence plan objective. Their individual management review suggests that discussions on this topic may have been hindered by Ms. Taylor accompanying Mr. Walker to many of the supervision sessions and the focus being on the child protection plan.

3.145 When Ruby was living with family members and Ms. Taylor was pregnant with Theo, children's social care and the couple's housing officer made a joint visit to the family home. Professionals observed damage to the family home, suggestive of domestic violence. Ms. Taylor denied abuse by Mr. Walker. Both reported that Mr. Walker had caused the damage 'out of frustration'. No further discussion about that appears to have taken place.

3.146 Ms. Taylor told the independent reviewer that, as far as she knew, children's social care were not concerned about 'the arguments' between Mr. Walker and her. Ms. Taylor remembered that the only occasion when children's social care asked how things were with Mr. Walker, he 'was right next to her' at the time. Ms. Taylor said that she was never seen alone by children's social care

and she did not recall any discussions about whether she and Mr. Walker should stay together.

3.147 In further written comments to the review, Ms. Taylor said that on another occasion Mr. Walker had shut her in a room, and 'wouldn't let the social see (her)'.

3.148 Both Mr. Walker and Ms. Taylor were known to have suffered mental health problems and to have difficulties regulating their emotions, including anger.

3.149 Although incidences of domestic violence were included in the local authority's care applications, it did not form part of the assessments of parenting capacity which followed. A separate report provided by the probation service to the court indicated that, at the end of his order, Mr. Walker's risk of serious harm had not changed. He continued to pose a medium risk both to a partner and to children.

3.150 Details of the nature of the couple's relationship and the extent of their 'arguments' were unknown to professionals.

3.151 Each agency or service completing an individual management review for this review was asked to consider specifically their understanding about domestic abuse issues relating to family members and to describe its impact on practice. A number of services subsequently identified actions which they had taken, or planned to take, as the result of their review.

3.152 These include: mandatory participation in a domestic abuse learning and development programme (Cafcass); training sessions and learning for 0-19 community health services supported by the safeguarding service; specific training for primary care practitioners on domestic abuse and associated risks and impact on children in the household; introduction of improved risk management model which specifically identifies victim safety planning (probation service); and, becoming accredited members of the Domestic Abuse Housing Alliance (housing provider).

3.153 Specialist domestic violence services were not involved in the course of work with the family.

3.154 In 2022, the national Child Safeguarding Practice Review Panel published a briefing paper[42] 'setting out key findings from thematic analysis of rapid reviews and local child safeguarding practice reviews where domestic abuse featured'. The briefing paper also includes examples of practice and recommendations that the Panel believes 'would help local areas develop effective responses to the impact of domestic abuse on serious child safeguarding cases.'

[42] CSPRP Multi-agency safeguarding and domestic abuse (2022)

3.155 The safeguarding children partnership's actions in respect of safeguarding and domestic abuse include:

i. Retaining a strategic lead for domestic abuse who is a member of the Domestic Abuse (and Sexual Abuse) Strategic Partnership to ensure that priorities and work plans align and that there are clear mechanisms for accountability;
ii. Working with safeguarding systems as a whole (including schools) to ensure an effective response to concerns about domestic abuse, alongside work to mitigate pressures from police notification on the 'front door';
iii. Delivering both face-to-face and e-learning in relation to domestic abuse and ensuring that all partner agencies are provided with 'all domestic abuse learning' arising through quality assurance and from case reviews.
iv. Revising its current procedures in respect of domestic abuse. It is expected that this revision will be completed by the end of 2024.
v. Updating its guidance to schools in respect of responding to notifications from the police. This is similar to Operation Encompass and is known locally as 'Stopping Domestic Abuse Together';
vi. Undertaking a 'wholesale review of what an effective domestic abuse assessment tool should look like'. In doing so, the safeguarding children partnership has considered Cafcass and other national/regional resources, as well as referring to the findings and specific recommendations of the Child Safeguarding Practice Review Panel's briefing paper. A draft framework and practice guidance for assessing and responding to domestic abuse incidents have now been developed. It is anticipated that the revised model will be implemented by the end of 2024.

3.156 *Recommendation 9: The safeguarding children partnership should seek a report from its Domestic Abuse Strategy Lead to verify that child safeguarding partners have arrangements in place to deliver an effective local response to domestic abuse. That report should specifically address issues of domestic abuse identified in this review as well as the findings and recommendations of the national panel briefing paper (2022).*

3.157 *Recommendation 10: The safeguarding children partnership should undertake an analysis of the impact of its domestic abuse assessment framework/guidance within 12 months of its implementation.*

j) Closing the learning loop

3.158 The following agencies and organisations contributed to this local child safeguarding practice review: children's social care; 0-19 community health services; community substance misuse services; police; Cafcass; hospital 1;

hospital 2; offender management services (referred to as the probation service in the review); children's social care child protection conference service; ambulance service; GP services and parents' housing provider.

3.159 The safeguarding children partnership has compiled evidence of actions which have been implemented by partner agencies in respect of key learning identified in this review. That document will be published with this review. The following recommendation is designed, however, to capture the outcome of all actions agreed or planned by single agencies as part of their individual management reviews.

3.160 *Recommendation 11 The safeguarding children partnership should, by October 2024, require that agencies and organisations participating in this review provide evidence that changes proposed in individual management reviews have been implemented. Where pertinent, an evaluation of their impact on safeguarding children should be included.*

k) Workforce issues

3.161 Practitioners within the local authority and in Cafcass were inexperienced in their roles. They also report having heavy workloads. As a consequence, they were frequently working to satisfy competing timetables which demanded their attention. Internal communications confirm, for example, the difficulties social work practitioners experienced in meeting court related deadlines. Existing difficulties for staff in every agency were compounded by the challenges of living and working during a pandemic and practising in the context of public health measures.

3.162 Some of the national workforce issues relating to key agencies in this review are outlined below. Questions for the safeguarding children partnership are '*What does it understand about workforce issues in local services and what implications does that have for the safeguarding children partnership's core objectives?'*

3.163 Children's social care: In July 2022, Ofsted[43] described the ways in which the pandemic and its aftermath have exacerbated existing workforce challenges at all levels for children's social care, with implications for sufficiency, stability, and increased pressures for staff remaining in post. Although recruitment and retention of staff was difficult before the pandemic, it notes that, as increased numbers of experienced staff have left the workforce, newly qualified staff are covering a greater proportion of posts, with fewer experienced colleagues to learn from. The report also highlights other issues relating to recruitment in specific circumstances.

[43] HMG: Childrens social care 2022:-recovering from the covid-19 pandemic

3.164 Ofsted's concerns are reinforced by the Institute for Government's performance tracker 2023 which reports that as of 2021/22, staff with less than five year's experience make up 60% of the labour force. High workloads and complaints about local authority social work culture are cited as reasons for staff leaving the workforce.

3.165 Health visiting services: The same performance tracker notes that workforce issues have contributed to proportionately fewer children being seen and reviewed by health visitors under children's early years health programmes. The Institute of Health Visiting (2023)[44] reports an estimated shortfall of 5,000 health visitors in England with 48% of those currently employed indicating that they intend to leave the profession within the next 5 years. That report states that only 6% of health visitors in England work with the recommended average ratio of 250 children per health visitor, 28% have more than 750 children.

3.166 Substance misuse services: In 2023, the NHS benchmarking service reported its National Workforce Census for Drug and Alcohol Treatment and Recovery Services. Most submissions to this survey were from providers delivering community services for substance misuse treatment and recovery services. The exercise revealed vacancy rates among alcohol and drugs workers of between 13% (voluntary, independent, private) to 21% (NHS). Across the sectors, more than 50% staff had been in post for less than 3 years.

3.167 Probation service: Probation services were reunified in 2021. In May 2022, the Chief Inspector of Probation appeared before the Justice Select Committee. He described many services as 'experiencing exceptional staff shortages, with a half of positions in key grades in some areas unfilled'. Staff had told inspectors that their workloads were unmanageable and due to high vacancies at manager level, supervision was also poor. The Chief Inspector reported that this was then reflected in the quality of supervision given to people on probation.

3.168 In addition to information provided above in respect of children's social care, the Institute for Government tracker also evaluates the performance of eight other areas of public service: general practice, hospitals, adult social care, neighbourhood services, schools, police, criminal courts, and prisons. Other sources of information about individual services are also available.

3.169 From a safeguarding perspective, in addition to the significance for agencies, is the extent to which serious shortcomings in any key service are likely to be

[44] The State of Health Visiting 2022

magnified as they impact on others. The safeguarding children partnership has already identified risks associated with workforce issues.

3.170 Since March 2020, at each quarterly meeting of the safeguarding children partnership Executive Board, the statutory partners and relevant partner agencies have been required to provide written reports identifying pressures impacting on safeguarding arrangements within organisations; action being taken to mitigate those pressures and actions which may be required of partner agencies. Workforce issues have been included, at different times, in relation to health visiting, child and adolescent mental health services, social work retention, specialist/named designated posts and specialist police roles. In all cases, agencies have explained what changes are planned.

3.171 The safeguarding children partnership has offered as an example of its scrutiny and action, its response to concerns identified by the Exploitation and Vulnerable Young People's Subgroup about the impact on children of lengthy waiting lists at child and adolescent mental health services. Enquiries were to be undertaken by the relevant service providers and commissioners and the concern was noted on the safeguarding children partnership risk register in June 2020.

3.172 In March 2021 and September 2021, the commissioners reported to the safeguarding children partnership actions that had been taken to address workforce issues as well as changes being made to early intervention services in school, to mitigate the need for more complex services from child and adolescent mental health services.

3.173 In September 2022, the Executive Board reviewed the impact of those changes, acknowledged their positive effects, and, agreed continued arrangements for monitoring by the Exploitation and Vulnerable Young People subgroup with the option of escalation should the need arise.

3.174 Reports from agencies indicate that workforce issues (filling vacancies and, for some organisations, budget pressures on recruitment) have become increasingly prevalent. In December 2023, the Executive Board increased the priority given to 'current pressures reporting' by moving the item to the beginning of its agenda to ensure that any potential impact on safeguarding arrangements is considered in the remainder of its deliberations.

3.175 It has also been agreed that future reporting from agencies should include more explicit consideration of the impact of individual agency pressures on the function of other agencies, particularly in respect of safeguarding arrangements.

3.176 On a more positive note, the local authority has reported the success of its workforce development and recruitment strategy, with a reduction since the review period, in the proportion of social work vacancies from 36% to 25%[45]. 36 more Social Workers are employed in frontline practice and 44 more newly qualified Social Workers have been recruited, with 86% retention rate. The employment of agency staff has reduced the working vacancy rate to 9%.[46]

3.177 Cafcass has also reported that workloads in the organisation, elevated during Covid, have reverted to pre-pandemic levels.

4. Summary of Recommendations

Recommendation 1:

The safeguarding children partnership should undertake a multi-agency audit of recent parenting assessments to evaluate:

i. the quality of analysis and conclusions;
ii. the involvement of partner agencies;
iii. evidence of scrutiny by managers; and,
iv. the effectiveness of information sharing and professional challenge.

Recommendation 2:

The safeguarding children partnership should require the local authority to provide evidence of its improved practice, since 2020, in distinguishing between 'family arrangements' and 'placements'. The report should include details of: work undertaken with professionals; information provided to connected persons caring for other people's children (kinship carers); and, how the impact of changes has been measured. The report should be received by the safeguarding children partnership by the end of June 2024.

Recommendation 3:

The safeguarding children partnership should require the local authority to provide evidence of the improved effectiveness of pre-proceedings work with children and parents, since the period covered by this review. This should include evidence of both appropriately diverting children from proceedings and where this has not been possible, securing timely permanence plans. The report should be received by the end of June 2024.

Recommendation 4:

The safeguarding children partnership should revise its procedures and guidance in respect of concealed pregnancy.

[45] December 2023
[46] December 2023

Recommendation 5:

The safeguarding children partnership should update its Keeping Babies Safe Strategy and guidance for the use of the 'Every Baby Matters' assessment tool to include the vulnerabilities associated with concealed pregnancy.

Recommendation 6:

The safeguarding children partnership should strongly encourage local public health commissioners of substance misuse services and the local authority to develop a working joint protocol in line with guidance and by the end of June 2024 to report the outcome, with details of anticipated impact.

Recommendation 7:

The local authority child protection service, with the participation of key partner agencies, should work with the local authority's legal service to develop and implement a practice model that will enable effective multi-agency work while children are subjects of care proceedings.

Recommendation 8:

The safeguarding children partnership should complete a multi-agency audit of cases where children were reunified with parents in pre-proceedings or during care proceedings. To reflect the learning from this case, the audit should specifically address:

i. the involvement of parents and children, family members and partner agencies in planning for reunification;
ii. the extent to which the levels of support and challenge offered/provided are consistent with the level of risk identified; and,
iii. the quality of contingency planning.

Where possible, the audit should also consider the outcomes for children and families at 6 months and 12 months following reunification.

Recommendation 9:

The safeguarding children partnership should seek a report from its Domestic Abuse Strategy Lead to verify that child safeguarding partners have arrangements in place to deliver an effective local response to domestic abuse. That report should specifically address issues of domestic abuse identified in this review as well as the findings and recommendations of the national panel briefing paper (2022).

Recommendation 10:

The safeguarding children partnership should undertake an analysis of the impact of its domestic abuse assessment framework/guidance within 12 months of its implementation.

Recommendation 11:

The safeguarding children partnership should, by October 2024, require that agencies and organisations participating in this review provide evidence that changes proposed in Individual Management Reviews have been implemented. Where pertinent, an evaluation of their impact on safeguarding children should be included.

Independent Reviewer: Isobel Colquhoun

5. References and Further Reading

Isolated and struggling: Social isolation and the risk of child maltreatment, in lockdown and beyond, NSPCC Evidence team, June 2020

Re: HL (A child) judgment - 13 June 2013 (judiciary.uk)

Pre-proceedings: Messages from research and policy: Strategic Briefing: RIP (2022)

Three Steps for Baby Safety Partnership Strategy to Support the Safety of Babies in Derby and Derbyshire

Promoting the Safety of Babies Learning from Reviews, Derby and Derbyshire SCP 2021

President of Family Division, Re-launch of PLO 2023 (Webinar)

Three Steps for Baby Safety: Evaluation and Impact DDSCP and NHS DDS Integrated Care Board 2023

Drug misuse in England and Wales (2022) - Office for National Statistics (ons.gov.uk)

UK cannabis market dominated by high-potency 'skunk' King's College London (kcl.ac.uk)

Cannabis: NHS Inform

DDSCP Annual Report 2021-2022

Safeguarding and promoting the welfare of children affected by parental alcohol and drug use: a guide for local authorities HMG (2018)

Reunification: an evidence-informed framework for return home practice: NSPCC

Parents with substance misuse problems; learning from case reviews NSPCC 2023

Research in practice, reflective supervision resource pack, April 2017

Multi-agency safeguarding and domestic abuse, Panel Briefing 2 CSPRP (2022)

Children's social care 2022: recovering from the COVID-19 pandemic Ofsted (July 2022)

Performance Tracker 2023: Public services as the UK approaches a general election: Institute for Government

The State of Health Visiting: UK Survey Institute for Health Visiting (2023)

National Workforce Census for Drug and Alcohol Treatment and Recovery Services: NHS Benchmarking Network (2023)

HM Inspectorate of Probation: Press Release (2022)

Derbyshire Ofsted Children's Services Inspection (Jan 2024)

Returning children home from care: learning from case reviews NSPCC (Jan 2024)