Central Bedfordshire
Safeguarding Children Partnership

Child Safeguarding Practice Review

Baby Harry (pseudonym)

Independent Reviewer: Kevin Ball

Date: Final Version – April 2025

Contents

1. Introduction & background to the review

1.1. This summary report sets out the findings and learning from a Child Safeguarding Practice Review (CSPR) commissioned by Central Bedfordshire Safeguarding Children Partnership (the Partnership). It is intended to build on learning identified at the Rapid Review stage. While the quality of the Rapid Review was commended by the national Child Safeguarding Practice Review Panel[1], the Partnership chose to commission a proportionate independent review as an opportunity to capture further opportunities for improvement.

1.2. In February 2024 a six-month-old child, who for the purpose of this report will be known as Baby Harry, tragically died. Abuse and neglect were suspected, resulting in a Police investigation.

1.3. In brief, learning identified at the Rapid Review stage touched on the following areas:

- The quality and effectiveness of pre-birth assessments and the need to remain focused on the child's experience and day to day life, where concerns are apparent.
- The importance of using tools such as genograms and eco-maps to support assessment, analysis, and professional curiosity.
- The role any Children's Centre has in identifying and referring concerns, or non-engagement.
- The importance of checking, assessing, and monitoring bail conditions and bail addresses.
- The positive use of, for example Clare's Law (a Domestic Violence Disclosure Scheme) to assist with the safety of victims and children.
- Queries about how Findings of Fact, from Family Court proceedings, can be used to assist and support safety planning.

1.4. Based on the above points, the Partnership, in collaboration with the Independent Reviewer, determined that further examination of the following two areas may yield additional learning, at a local, and possibly national level:

- Assessment of concerns about unborn children.
- Using Findings of Fact from Family Courts to safeguard all children.

2. Arrangements for the review, including lines of enquiry

2.1. The decision to conduct a CSPR followed the conclusion of the Rapid Review held in February 2024. This decision was supported by the Child Safeguarding Practice Review Panel in March 2024. The following steps were then taken:

- The Partnership appointed Kevin Ball[2] as the Independent Reviewer.
- An initial Review Panel was convened in May 2024 which confirmed the local arrangements for the review.
- Review Panel meetings involving representatives from relevant agencies were held in July and September, to support the smooth and timely completion of the review.
- Seeking information reports from relevant agencies involved with the child and family was an important step, to allow agencies the opportunity to formally reflect on their involvement with the children; as such, relevant agencies submitted information reports against the agreed lines of enquiry.
- Information requests about research, literature and/or the operational use of Findings of Fact were made to the NSPCC Information & Library Service[3] and Cafcass (Children & Family Court Advisory & Support Service).

[1] Child Safeguarding Practice Review Panel is established under the Children & Social Work Act 2017.

[2] Kevin Ball is an experienced independent consultant, chair, reviewer, and scrutineer. He is a member of the Child Safeguarding Practice Review Panel's pool of reviewers available for national reviews.

[3] The NSPCC Library & Information Service is the only UK library that specialises in safeguarding, child protection, child abuse and neglect. It contains over 45,000 resources, provides free, direct access to online publications, including case reviews, research, training resources,

- A multi-agency workshop was held in July 2024 facilitated by the Independent Reviewer. In addition to the practitioner perspective being captured via single agency reporting, the workshop allowed a further opportunity to gain practitioner views.
- Family members were offered the opportunity to contribute to the review, but no response was received.

2.2. The following services and agencies have contributed to this Review:

Central Bedfordshire Council Children's Services	Bedfordshire, Luton & Milton Keynes ICB & GP
Cambridgeshire Community Services	Bedfordshire Police
East London NHS Foundation Trust	Luton & Dunstable Hospital
Central Bedfordshire Pathfinder Legal Services Ltd	-

2.3. The following full lines of enquiry were agreed as needing to be explored by the key agencies involved;

Key Line of enquiry 1: Assessment of concerns about unborn children:

a) What worked well, and what could have been better about the pre-birth assessment carried out in 2023?

b) More systemically, what blocks and barriers exist (policy, procedure, people, practice) that make it harder for all professionals to undertake, participate in, and complete high-quality assessments of unborn children, when concerns become apparent? How do you know these blocks and barriers exist i.e. are they anecdotal or evidence based?

c) Systemically, what works well about current arrangements (policy, procedure, people, practice) when needing to undertake assessments of unborn children, when concerns become apparent? How do you know it works well at a systemic level i.e. anecdotal or evidence based?

d) What can Central Bedfordshire Safeguarding Children Partnership learn from this episode involving Baby Harry, about matters concerning the quality and effectiveness of all pre-birth assessment activity carried out in the area, and when concerns become apparent about the safety and welfare of the unborn child/pregnant mother?

Key Line of enquiry 2: Using Findings of Fact from Family Courts to safeguard all children

a) What current measures or mechanisms are in place that allow Findings of Fact from both Family Court proceedings and Private Law proceedings to be shared with third parties, allowing the sharing of information about actual or likely risk to be appropriately disclosed to other relevant agencies should concerns about a child's safety or welfare arise?

b) What blocks or barriers might exist to prevent the strengthening the law, policy, procedure, or practice in the sharing of information about Findings of Fact with relevant and interested parties?

c) What opportunities exist to strengthen arrangements?

3. Concise account of relevant information & key events

3.1. In February 2024, Baby Harry, aged just over six months, was found floppy and unresponsive by Paramedics, having been called to attend the home address of Adult A. It later transpired that Baby Harry had become unwell at another address, but was transferred by the adults caring for him at the time, back to the home address of the

video and audio recordings, textbooks, journal abstracts and reports from organisations and government (grey literature), provides a unique collection of case reviews and NSPCC research, and offers a specialist enquiry service to help find resources.

grandmother of Adult A. The results of the initial scan and postmortem suggest abuse and non-accidental injury which ultimately contributed to him being pronounced dead a few hours later. The circumstances surrounding Baby Harry's tragic death, which including alleged deceit by the adults involved in Baby Harry's care that day, are being investigated by Bedfordshire Police.

3.2. Baby Harry's mother experienced a difficult childhood herself, having been subject to a Child Protection Plan as a young child due to concerns about emotional abuse. There were further contacts and assessments throughout her own childhood and into adolescence. This was as a result of concerns about emotional abuse, witnessing domestic abuse and neglectful home conditions.

3.3. Baby Harry's mother had formed a recent close relationship with Adult A. On the day that Baby Harry died, his mother had asked Adult A to look after Baby Harry for a few hours at the family home of Adult B (whilst the mother went out with Adult B's partner). Adult B and his partner had legal restrictions in place preventing each of them access to their own children following their children being removed from their care. In addition, Adult A had Findings of Fact made against him from a previous relationship involving children, furthermore just a few weeks prior to his relationship with Baby Harry's mother, Adult A had been in a relationship with another woman who had a young child; this relationship ended following an alleged assault on the child by Adult A and an information request by the woman using the Domestic Violence Disclosure Scheme. This ultimately resulted in bail conditions made against Adult A to not have contact with under 16-year-olds. In addition to the restrictions on these adults, Baby Harry's father also had Findings of Fact made against him from a previous relationship too. It is unclear whether the mother was aware of the full extent of all this information about Adult A, Adult B and his partner and Baby Harry's father at that time. It has also become apparent that some members of the mother's own family, including a small network of other associations, consisted of individuals where there was a history of domestic abuse, coercion and control, drug use and adults who posed a risk to both vulnerable adults and children. All this information was gathered through the Rapid Review process.

3.4. Prior to the tragic events of that day, concerns about the mother's ability to care for a new-born child had been identified. These were first noted in March 2023 by the Midwifery Service, responsible for supporting the mother through her pregnancy. Her attendance at ante-natal appointment was good and she engaged well with the Midwife from the specialist team supporting young mothers; she had been identified as vulnerable due to her young age and history. Appropriately, the Midwifery Service made a referral to Central Bedfordshire Children's Services in March 2023. Given the concerns identified by the Midwifery Service, Children's Services carried out a multi-agency pre-birth assessment between March and May 2023. The conclusion of the assessment was that the mother should access support, via a universal offer, at a local Children's Centre for parenting support; a referral to the Children's Centre was made. After Baby Harry's premature birth, and, following the closure of the Child in Need episode of assessment activity in May 2023, a Health Visitor from Cambridgeshire Community Services carried out a home visit, and no concerns were noted. Once Baby Harry was discharged, Health Visitors completed a visit, and Nursery Nurses completed weight checks; no concerns were noted. During this time there was no information to indicate the mother was in a relationship with any adult of concern. The offer of support from the Children's Centre was not taken up by the mother, but no further contact by agencies was undertaken.

3.5. All children and adult subjects of this review are white – British, with English being their first language. The review has kept in mind the nine protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Due to increased vulnerability from these characteristics, individuals are afforded greater protections through legislation thereby reducing any attempts to discriminate against them or treat them unfairly. Other than Baby Harry's young and vulnerable age, no characteristics were considered relevant to this review despite his mother's young age.

4. Findings & analysis

1. Detailed Information Reports have been submitted by key agencies involved with Baby Harry, and those agencies best placed to respond to the two key lines of enquiry. This is in addition to information provided by the NSPCC Information & Library Service and Cafcass.

2. Consideration of the nine protected characteristics (age, gender, race, disability, religion or belief, sexual orientation, gender reassignment, marriage or civil partnerships, pregnancy, and maternity) highlight there is no evidence of any discrimination against the mother or Baby Harry during any agency contact or involvement. It is understood that Baby Harry's father had not been involved or had contact with the mother or Baby Harry – but he was excluded from the pre-birth assessment based on the mother's wishes.

3. Both Adult A & Adult B had experienced adversity during childhood, with there being concerns about drug use, drug dealing, domestic abuse, and criminal behaviour. The presence of these two adults in the mother's life and her network of associates was potentially knowable, had a thorough pre-birth assessment and network mapping exercise been completed. However, their close involvement in the mother's life which subsequently led them to be involved in Baby Harry's care on the day of his death, was not something that could have been known about or predicted.

4.1. Line of enquiry 1: Assessment of concerns about unborn child:

4.1.1. Research[4] reminds us of the importance of providing the right support for women during, and after, pregnancy. This is especially important for those women who are younger, and who have experienced adverse childhood experiences, and who may have limited support networks '*… Young mothers up to the age of 25 are at particular risk of poor mental health, up to 3 years after birth. Untreated perinatal mental health problems affect maternal morbidity and mortality …*'; but also, for children themselves '*… infant mental health is crucial to the long-term development of good mental, physical and emotional health, and wellbeing throughout the whole life course. An infant's early social and emotional development is vital to his, or her, mental and physical wellbeing through childhood, adolescence, and adulthood, and those early social and emotional experiences with parents play a crucial part in this process …*'. Research[5] also reminds us about the significance of recognizing and responding to the vulnerability of babies under 12 months of age. On this basis, assessing future parenting capacity, levels of need, and risk to babies prior to birth can be critical aspects of safety planning for any new born child.

4.1.2. It is important for this review to acknowledge positive aspects of practice and identify what worked well as a result of agency contact between March and May 2023. In this respect:

- Concerns about Baby Harry's mother's capacity to be a parent were identified at an early stage of the pregnancy by all professionals,

- A timely referral was made by the Midwifery Service to the Maternity Safeguarding Team and the Central Bedfordshire Integrated Front Door (Multi-Agency Safeguarding Hub). This was then passed on to Central Bedfordshire Children's Service for an assessment. The threshold for carrying out an assessment was agreed by all professionals.

- The mother benefitted from the consistency of Midwifery care; this was provided by having the same Midwife throughout her pregnancy.

[4] HM Government, Early years high impact area 2: Supporting maternal and family mental health, Updated 19 May 2021.

[5] Child Safeguarding Practice Review Panel, Annual Report 2022/23: Patterns in practice, key messages and 2023/24 work programme, January 2024, HM Government.

- The Health Visiting Service was notified effectively about the pregnancy, and the mother was placed on an Antenatal Targeted List. This resulted in an allocation of a Health Visitor to complete an antenatal visit prior to birth. The purpose of this visit is to introduce the 0-19 service offer in the local area, assess the health needs for the family, support parents and families with their preparation for the new baby and to enable an early assessment of women and families in regards to the presence of any perinatal ill-health and risk.

- Children's Services made timely decisions to allocate the work, to enable a specific and distinct pre-birth assessment to be carried out; this was allocated to an experienced Social Worker who was also supported by an experienced Manager. A multi-agency Pre-Birth Planning Meeting was held in April 2023 and a Pre-Birth Tracking meeting held in May 2023, in line with protocol.

- Positively, given the early referral in the pregnancy, sufficient time was available for a full and thorough assessment to take place.

- Baby Harry's mother engaged well with the Midwifery Team for ante-natal care, and the Children's Services Social Worker during the assessment process.

- Sufficient background information about both pre-disposing and situational risks was available, and this was examined. These included records of the family history held by Children's Services, local intelligence held by the Midwifery Team about the immediate family network and Police National Computer (PNC) checks of all the adults living in the household. No information of concern was raised through these checks.

4.1.3. Children's Services – which took the lead for the pre-birth assessment, have recognised that as a multi-agency partnership *'… information known about [the mother] and her family was not critically analysed or evaluated. Some areas of concern were identified, but there was a lack of risk assessment, curiosity, or challenge …'*. More broadly, across services involved with the family, areas where practice did not work so well, and where learning has been identified, include;

- All home visits and meetings by Children's Services with Baby Harry's mother were completed in her father's home. This meant that the mother was never seen alone and never given the opportunity to share her personal views in respect of; the relational dynamics between her, the child's mother, her father, and other family members. As a result of this, these factors were therefore not fully examined. This was an important aspect that needed full exploration given the mother's own childhood experiences, the impact of her own mother's history (Baby Harry's grandmother), her father's background (Baby Harry's grandfather), and their involvement with Children's Services in the past.

- The mother's own thoughts, feelings and understanding about her pregnancy in the context of her own childhood were not fully explored. There was, as a result, no in-depth consideration about what this would mean to her as a new, and young parent, and therefore no assessment of vulnerability or risk. On this basis, Baby Harry's presence (once born) and his day-to-day experiences were not fully considered.

- Some professionals' meetings i.e. a Pre-Birth Planning Meeting in April 2023 and a Pre-Birth Tracking meeting held in May 2023, were held using a hybrid approach - participants from Children's Services attended in-person and Health professionals attended virtually. Whilst virtual attendance can bring efficiencies, there was a sense that in some instances they might have been unhelpful due to connection disruptions and distractions, and diverted people's attention away from a more focused discussion.

- Continued concerns raised by the Midwifery Service about the mother being young, and needing parenting support, plus concerns about the maternal grandfather of the unborn and the extended family being well

known to another Children's Services, do not appear to have been triangulated, processed, or further assessed; there was no further challenge or escalation about this by the Midwifery Service.

- The relationship between Baby Harry's mother and father, which was brief and ended prior to Baby Harry's birth due to alleged domestic abuse, was not explored. This was because she did not want him to be involved in Baby Harry's life; and as a result, seeking his contribution to the pre-birth assessment never occurred; he was never contacted, and his views never sought.

- Professionals focus was very much on the immediate and presenting issues rather than asking more probing and potentially challenging questions as part of the assessment activity. Immediate risks were identified and explored e.g. risks from dogs in the house, and Baby Harry's grandmother's history impacting on her ability to support; this was despite there being limited contact. These factors appear to have been given greater weight than other important factors e.g. the challenges of parenting a newborn in a busy household, and the extended networks involved with the mother.

- The assessment did not gather information from all potential professional sources e.g. the GP, who held critical information about serious maternal ambivalence to the pregnancy. This ambivalence was not picked up by the Midwifery Service in discussions with the mother and, as a result, the information was not available to be shared with Children's Services. An ecomap/cultural genogram would have helped professionals map family members and other networks (personal & professional), and on which the assessment could then progress. Information about wider networks of people connected to the family was not followed up or examined. This was subsequently noted by the Police *'… A more holistic and bespoke multi-agency strategy may have afforded the mother greater protection and awareness of entering new relationships and the risks those individuals presented, by having access to Baby Harry. Bespoke and holistic risk assessments in these circumstances would have assisted in the interpretation, grading, monitoring, and reviews of those risks to maximise safeguarding of both, Baby Harry, and the mother, thereby enabling compilation of multi-agency strategies specific to each case. The background of the adults featured within this review clearly demonstrate cyclical and generational patterns of abuse, with common factors and triggers present in each of Adult A's relationships that should have alerted partners to risks of child abuse. The current practice of risk assessments being completed in isolation and reactively, as opposed to 'seeing the bigger picture', fails to afford vulnerable people and children the safety measures commensurate to their needs …'.* Whilst the mother was discussed at a Pre-Birth Tracking meeting Luton & Dunstable Hospital note, the *'… multi-agency approach allows all professionals working with the family to understand where the assessment process is and some of the decision making that has taken place during the work be carried out with a family. It was during this forum the safeguarding midwife raised concerns about the grandfather of unborn, and the extended family, being very well known to [another Children's Services and resulting in a request for] … Central Beds to seek this information urgently …'.* The full extent of this information was not made clear.

- There was no critical challenge within the Children's Services management system about the deficits in the pre-birth assessment report; this was compounded by limited management curiosity, support, and challenge during routine supervision. Additionally, other professionals accepted Children's Services decision to close their involvement with Baby Harry once the assessment had concluded; there was no evidence of any dissent, and no challenge by professionals from other agencies to this decision. Other agencies and professionals did not have sight of the full and final pre-birth assessment report. Independent review of the pre-birth assessment report confirms the above findings.

4.1.4. No one factor has been captured about the reasons why the quality of the Pre-Birth Assessment was not to the standard hoped for by Children's Services. As noted in another recent CSPR[6] completed for Central Bedfordshire Safeguarding Children Partnership, this review reminds us of the human fallibility about the assessment task, and that no system can fully eliminate risk. In this scenario, an over-optimism bias that the mother had been compliant during the assessment process, had appeared to have a safe support network around her, and recognized the obvious and immediate risks i.e. dogs and the grandmother's history, were likely factors which then resulted in a limited analysis and/or minimization of potential risk.

4.1.5. The review has captured information about what, more generally works well; these are current arrangements for carrying out pre-birth assessments, and include:

- The Pan Bedfordshire Guidance in relation to Pre-Birth Planning and Assessments: This is clear, comprehensive, and accessible. As the guidance is Pan Bedfordshire this supports more effective and consistent working across the Boroughs that are part of the Bedfordshire area i.e. Central Bedfordshire, Bedford Borough & Luton Borough).

- Routine screening questions used by the Midwifery Service enable the early identification of actual or potential vulnerability or risk; topics asked about include, for example, questions on domestic abuse, previous contact with Children's Services, social concerns, mental health, alcohol, and substance misuse.

- Review of historical hospital records in relation to safeguarding to help identify any previous concerns raised is good practice by the Community Midwifery Team.

- There are Bedfordshire Hospitals guidelines in place to help practitioners and support practice, these include – Guideline for antenatal referral, Guideline for antenatal pathway and risk assessment, Teenage pregnancy Guideline and Safeguarding children policy.

- The Luton & Dunstable Hospital has a specialist Community Midwifery Team in place to care for teenage and vulnerable families. There are clearly defined criteria for referral, these are to help other staff within maternity to understand when families would benefit from this support.

- The number of information sharing forms generated by maternity staff would demonstrate a good understanding of how to identify concerns. All Information Sharing Forms are reviewed and triaged by a Safeguarding Midwife to ensure the correct care pathways are followed, and any further referrals required are completed.

- The integration of multiple services i.e. Midwifery, secondary healthcare, works well and supports the early recognition of risks.

- Antenatal Cause of Concern notification forms completed by Midwifery Service are sent to the Health Visiting Service; this is to notify of any concerns that are identified at booking or during the pregnancy journey of expectant mothers.

- Whilst antenatal home visits to all pregnant women were not offered at the time by the Health Visiting Service, they are now. Each woman under the care of the Liberty Community Midwifery Team will have a home visit completed in the antenatal period.

[6] Central Bedfordshire Safeguarding Children Partnership, March 2024, Daniel & Sophie CSPR

- A Pre-Birth Tracking meeting is held monthly as well as Pre-Birth Planning Meetings (held within the first 20 days of the assessment) – both enable timely and effective information sharing. The Pre-Birth Tracking meeting is a multi-agency professional forum which discusses families of unborn children that are currently having contact with Children's Services. The mother was discussed at this forum.

4.1.6. The review has highlighted blocks or barriers that might exist at a more systemic level or where policy, procedure or practice can be strengthened, particularly in respect of the Pan Bedfordshire Guidance for Pre-Birth Planning and Assessments. While the guidance is good, there are three areas where it could be strengthened:

- **Contingency Planning**: Based on the events of this case, further guidance in relation to contingency planning would be of benefit. For example, the choice made by the mother to not attend or follow-through the offer of support at a Children's Centre could have been questioned, given her initial agreement to the offer. The mother's parenting capacity had been untested, and concerns remained but there was no consideration given to what actions could have been taken e.g. to accompany her to the first session given her young age and assumed confidence levels. This might have helped her overcome any initial anxiety about attending the Centre. A protocol or working agreement was not in place in Central Bedfordshire for Children's Centres to follow up or refer back to Children's Services parents who have undergone a Pre-Birth Assessment but had not accessed the support given that they had originally agreed and consented to do so. Extending the Guidance to cover contingency planning, for example, the first four weeks of the new-born's life, might potentially be helpful.

- **Tracking & monitoring:** The current guidance contains no mention about the monthly Pre-Birth Tracking meeting. Guidance about expectations, attendance, information sharing, and decision making would usefully strengthen the multi-agency approach to unborn children where there are concerns. This should include an expectation about the Pre-Birth Assessment report, coordinated and completed by Children's Services being shared with relevant partner agencies to allow everyone access to the same information and analysis. This could then be used by the multi-agency network to make informed decisions about next steps i.e. case closure, targeted support, or safety planning. Sharing the finalised Pre-Birth Assessment report would also allow all partner agencies to add curiosity, challenge, and scrutiny. Whilst this may increase the workload of that forum, it should promote more robust discussion and decision making – thereby strengthening safeguards for newborn children. Additionally, expectations about searching for, and tracking, information as part of this forum could be reviewed. Two examples are noted, firstly from Luton & Dunstable Hospital who comment on challenges they face, '*… accessing information on fathers / partners is very difficult, as fathers are not linked to their children in the same way on hospital systems as mothers and babies. Information was shared by the Community Midwife* [through local intelligence rather than information recorded on the database] *… that the father of the unborn had three other children with two other women, however links through the hospital system could not be made and we did not have enough identifiable information about the father of the unborn to search the system appropriately …*', and secondly, Children's Services being able to request information from other local authorities where information was subsequently known to be held. Setting an expectation that the allocated Social Worker responsible for leading the Pre-Birth Assessment attends Pre-Birth Tracking meetings would also support multi-agency discussion and decision making.

- **Under 20's Support Pathway:** There appears to be some uncertainty about the use of the Under 20 Support Pathway Referral Form which was not utilised or completed in this situation. Whilst positive steps were taken to make timely referrals, the review has highlighted a need for this to be reviewed and clarified, especially in the context of the mother not following through the offer of support via the Children's Centre and no further professional involvement.

Learning points
Mapping family and disclosed network associations as part of the information gathering aspect to Pre-Birth assessments is a critical activity, which then allows discussions and explorations about what these might mean to the pregnant woman. Core questions to accompany these discussions might include – have any of these individuals ever had contact with the Police, might you be concerned about any of them caring for your baby, and are you aware of them having drug/alcohol use problems, mental health difficulties or being abusive? Sharing network information with multi-agency partners during the assessment phase may elicit further information.
Sharing information, including assessment reports, with multi-agency partners allows and encourages a more rigorous analysis through triangulation of information, and in turn, more informed and stronger decision making. Being open and receptive to scrutiny and challenge can help with the assessment of risk and problem solving.
Young mothers, and fathers, may lack the confidence to push themselves into unfamiliar situations, for example attending a support group, especially if they have had negative previous experienced of 'professional contact'. Supporting young parents to engage with offers of support, may yield benefits as time passes.
When concerns have been expressed by the professional network about a child's safety, welfare or developmental needing support, and a parent has agreed to access support offered, but subsequently declines or does not engage in the offered support, all agencies should consider the need to re-refer the matter to the appropriate agencies, i.e. the offer of support via a Children's Centre not being followed through.
All professionals involved in working with, and support, young parents under 20 years of age need to be familiar with the Under 20's Support Pathway as a means of ensuring timely and effective intervention to young parents.

4.2. Line of enquiry 2: Using Findings of Fact from Family Courts to safeguard all children:

4.2.1. This line of enquiry is relevant because the two adult individuals who had been given care of Baby Harry on the day of his death, each had either legal restriction in place preventing them access to their own children or Findings of Fact made against them. Adult A had a Findings of Fact made against him during Family Court proceedings. Additionally, Baby Harry's father had a Finding of Fact made against him in previous Family Court proceedings. While the details of these Findings of Fact against each adult do not need to be listed in this report, it is highly relevant information for the purposes of this review. The matters that resulted in these legal decisions could affect the safety and welfare of all children who may encounter these individuals. It is information that had Baby Harry's mother been fully apprised of, may have resulted in her altering her decision about whether to leave Baby Harry in their care. Whilst it is acknowledged that it is impossible for any professional to predict or know about all new relationships that might be formed, had this information been available to agencies working with Baby Harry and his mother, either during the pre-birth phase or within his six months of life, it had the potential to alter the professional view about the level of risk Baby Harry may have faced once born.

a) What current measures or mechanisms are in place that allow Findings of Fact from both Family Court proceedings and Private Law proceedings to be shared with third parties, thereby allowing information about actual or likely risk to be appropriately disclosed to other relevant agencies should concerns about a child's safety or welfare arise?

4.2.2. A fact-finding Hearing is a separate Hearing or sometimes held within a final Hearing within the Family Court, which aims to establish the truth of allegations made by one or both parties; these then become Findings of Fact and usually relate to harm suffered by a child as a result of the care given, or events witnessed or experienced. They can then be used to support risk assessment, safety planning and decision making by all professionals involved in a child's life who are party to those proceedings. Local Government Lawyer (a website for lawyers and legal professionals working in the public sector) cite Lord Justice Peter Jackson who said, *'… Welfare decisions made by the family court are based on an assessment of the relevant facts. In care proceedings, facts establishing the threshold are a precondition to making any order at all. … Depending on their gravity, findings of fact may be highly relevant to, or even determinative of, the welfare decision, not only in the proceedings in which they were made, but also in other proceedings about the same child or proceedings about different children …'*[7].

4.2.3. Cafcass represent the interests of children and young people in Family Court cases in England. They independently advise the Family Courts about what is safe for children and what is in their best interests – this includes children whose parents are divorcing or separating through private law or in care proceedings where the local authority has serious concerns about the safety or welfare of a child, through public law; they also support children through adoption proceedings. In this respect, Cafcass are uniquely placed to know about fact finding hearings and Findings of Fact as well as the relevance of information about the actual or potential safety and welfare of other children who may come into contact with the individuals and, not just those subject to the immediate legal proceedings.

4.2.4. Cafcass advise that family law proceedings are held in private. Therefore, Findings of Fact, and all information and documents in public or private proceedings in relation to children are not automatically shared with other agencies. They note that Practice Direction 12G which supplements the Family Procedure Rules Part 12, Chapter 7 deals with the communication of information relating to proceedings concerning children (see Appendix 1). These rules allow Cafcass to share judgments with the Police, but they rely on the Police requesting disclosure of the information as Cafcass does not automatically share information. Cafcass Family Court Advisors/Guardians can make referrals to the local authority where they have safeguarding concerns about the child or connected children. Both the sharing of information with the Police and the making of a referral to the local authority require a proactive step and will be solely based on children known to be either at risk or the likelihood of risk, at the time of the legal proceedings taking place. This would not account for children who may be at risk in the future and who are not yet known. It is therefore not clear how agencies reliably and consistently share this potentially highly relevant information to safeguard children when, perpetrators of abuse or neglect, are not the biological parents. Beyond the steps outlined above relating to Practice Direction 12G, there appears to be no other mechanism for information sharing, particularly in relation to Findings of Fact, to be shared with third parties.

b) What blocks or barriers might exist to strengthening law, policy, procedure, or practice to sharing information about Findings of Fact with relevant and interested parties?

4.2.5. Beckett Chambers Barristers comment on whether there would be a benefit to Findings of Fact made in public law family proceedings being centrally recorded and accessible to safeguarding professionals[8]. They argue that the key determining factor may be the burden of proof, which for the local authority being the lead agency in public law proceedings, is the balance of probabilities. They comment *'… The civil burden of proof in family courts means that findings of fact can be made in instances where the police do not proceed with a criminal case where of course the criminal standard of 'sure' or 'beyond reasonable doubt' must be met for a conviction to be secured. These findings are recorded on individual local authority case files, but they are not centrally recorded by courts and therefore very serious findings can be made by a family Judge which do not follow the perpetrator and they may go on to harm another child …'*. They go on to reflect on the benefits of the current Disclosure & Barring Service (DBS)

[7] Local Government Lawyer: Family court has jurisdiction to review its findings of fact, says Court of Appeal, August 14, 2019

[8] Becket Chambers: Should the findings made in family courts be accessible to safeguarding agencies? 27 January 2023

which was introduced following the 2004 Bichard Inquiry as a result of the murders of Holly Wells and Jessica Chapman. The DBS system now allows information about previous allegations (which did not meet the threshold for a criminal conviction) made against members of the children's or adults workforce to be logged on Police intelligence and reporting systems. This can be shared when prospective employers or relevant bodies make a request for a DBS check. Beckett Chambers Barristers suggest that a database for Findings of Fact made in family law proceedings, if accessible when requesting a DBS check could help protect children and vulnerable adults. Of that suggestion, this review argues that while extremely useful, it would have limitations because the database would only be accessible when someone was making an application for a DBS check to be undertaken – most often when connected to employment. It would not provide for situations, as occurred with Baby Harry and his mother, where-by acquaintances provide childcare or form a relationship with a parent, neither situation needing a DBS check.

4.2.6. One factor which is likely to undermine such a move to create a centralized database, or more targeted sharing of Findings of Fact is likely to be the challenge that findings were made against a civil burden of proof i.e. the balance of probabilities, rather than beyond reasonable doubt – especially if there has been no opportunity for defense by the individual concerned. A Finding of Fact has the potential to undermine and jeopardise criminal proceedings when the prosecution is attempting to prove deliberate and malicious assaults upon children. Conversely, there is potential for information to be disclosed during family proceedings that would assist criminal proceedings in respect of culpability of perpetrators to prove/disprove their involvement. However, currently such information cannot be used as evidence unless investigators are present during those proceedings and can provide witness testimony to that effect. The exchange of information between the Civil/Family/Criminal courts would require a change in legislation to enable sharing of information between professionals for the purpose of promoting the welfare and protection of children from significant harm.

4.2.7. Another factor which may be seen as problematic relates to the privacy of such information; deciding who Findings of Fact are shared with, and the most appropriate mechanism to do so. The concept of confidence, confidentiality and transparency was examined by the President of the Family Division in 2021 and who noted[9] '*… It is necessary to draw a distinction between 'fact-finding' judgments and other Family Court judgments …*'. Tight control of sensitive and confidential information generated from Fact Finding Hearings remains important.

c) What opportunities exist to strengthen arrangements?

4.2.8. Based on a focused review of information available, arguably opportunities do exist to strengthen arrangements.

4.2.9. One recent example which highlighted the sharing of Findings of Fact from private law proceedings having a positive impact on public safety and confidence, can be seen through the *Re X (Disclosure to Social Work England: Findings of Domestic Abuse)* [2023] EWHC 447 (Fam) . This case concerned the mother of a 10-year-old child, who made allegations of domestic abuse against the child's father; this resulted in the Judge making Findings of domestic abuse against the father, who was employed as a Social Worker. Initially, these Findings were not shared with the social work regulator, Social Work England however, on Appeal, the initial ruling was over-turned by the Royal Court of Justice in February 2023.

4.2.10. Preliminary review of this judgement, along with an analysis of it produced by Woods (2023)[10], indicates that firstly, the welfare and interests of the child(ren) concerned in the proceedings, is likely to be relevant when

[9] Judiciary UK, Sir Andrew McFarlane, President of the Family Division, 28th October 2021. Confidence and Confidentiality-Transparency in the Family Courts

[10] Woods, Lianne, 14 March 2023, UK Human Rights Blog, Crown Office Row, Is Sharing Caring? Disclosures from the Family Courts to Professional Regulators

determining an application for disclosure to the Police, but also the welfare and interests of other children generally. This is important in the context of this review; that the likelihood of those individuals who have had Findings of Fact made against them, often due to domestic abuse or other abusive behaviour, go on to form a relationship with the parent of another child unconnected to the primary case, can never be discounted. In turn, this may result in other children being at risk. It is inconceivable and unrealistic to consider that any local authority party to any Family Court proceedings, and who would be aware of Findings of Fact made on any one individual, could remain alert to the movements of that adult, new relationships they may form, and risks to children, beyond the individual memory of the workforce. A more robust, systematic, and reliable mechanism must be achievable. Additionally, the judgement and analysis also refer to *'… the public interest in the administration of justice. Barriers should not be erected between one branch of the judicature and another inimical to the overall interests of justice …* [and] *… the desirability of cooperation between various agencies concerned with the welfare of children …'*. Therefore, attempts to strengthen information sharing on this particular issue should not be placed in the 'too difficult pile' by any agency or national body that might be well placed to influence improvements and have leverage.

4.2.11. This review argues that Practice Direction 12G which supplements the Family Procedure Rules Part 12, Chapter 7, can be strengthened. By amending the Practice Direction, it could provide the route and mechanism for information about Findings of Fact to be shared by Cafcass with the Police, automatically, and for it to be retained on the Police National Computer (PNC)[11].

4.2.12. In the same way information is disclosed by the Police in either a Clare's Law application (Domestic Violence Disclosure Scheme - DVDS) or a Sarah's Law application (Child Sex Offender Disclosure Scheme), and the 'right to ask - right to request' principle, this review argues that there is benefit to information about Findings of Fact made in Family Court proceedings also being made available to any applicant seeking information via one of these Disclosure Schemes. This would fit, and align with, the spirit of such disclosure schemes, be a targeted information share with the relevant audience that is likely to benefit from such information, and only be shared when and as needed, by a relevant body that is subject to strict guidelines about how sensitive information is shared. Police Forces are conversant with disclosing other intelligence held about individuals, and non-conviction related information via the Disclosure & Barring Service's enhanced disclosure scheme, and a similar set of guidelines[12] could be applied. It would also align with the detail set out in statutory guidance[13] about information sharing, multi-agency collaboration and cooperation and the shared responsibility to keep all children safe. Indeed, one adult female associate of Adult A, another parent, successfully made a Clare's Law application resulting in information being shared with her that prompted her to leave a recently formed relationship because of the information that was given to her. Whilst this example did not include Findings of Fact as part of that disclosure, it does highlight that in this set of circumstances, the sharing of relevant information following an appropriate request, did result in a positive outcome. The College of Policing[14] state *'… Information which may be disclosed includes convictions and out-of-court disposals for violent offences and/or information about the person's behaviour which reasonably leads the police and other safeguarding agencies to believe that the person poses a risk of harm to the potential victim …'*. While not a failsafe remedy due to the proactive nature of needing to request information, the proposed remedy of using the PNC and Disclosure Schemes may be reasonable and proportionate, with the benefits to adult victims of domestic abuse and children being immeasurable.

[11] Home Office: Code of Practice for the Police National Computer (PNC) and the Law Enforcement Data Service (LEDS), 23 February 2023 *'… Data stored on PNC or LEDS should only be created or entered for law enforcement, other policing or safeguarding purposes …'*.

[12] Home Office, Statutory Disclosure Guidance To Chief Officers of police on providing information for inclusion in enhanced criminal record certificates Fourth edition, February 2024.

[13] Working Together to Safeguard Children, 2023, HM Government.

[14] College of Policing: Domestic violence disclosure scheme (Clare's Law) - 14/10/2021

5. Conclusion

5.1. This focused and proportionate Child Safeguarding Practice Review has examined the contact of agencies with a six-month-old child who tragically died in February 2024. The review has benefitted from information being submitted by a range of key agencies involved with the child and family. Although being contacted on two separate occasions, family members did not respond to letters inviting them to contribute to the review.

5.2. The review has built on the learning captured by the Partnership from the Rapid Review phase and identified further insights into what areas of policy, procedure and practice worked well during the Pre-Birth Assessment stage of concerns first being identified, through to also identifying where arrangements can be strengthened. The review has also examined specific issues relating to how information about Findings of Fact, issued through the Family Court system remain, often, tightly restricted, and not shared. Such arrangements, the review argues, do little to help safeguard children who may have contact with adults who may still present a risk but who are unconnected to the original Finding of Fact made.

5.3. Individual agencies that have contributed to this review have identified learning and improvement action for themselves; this review concludes with recommendations for the Partnership.

6. Recommendations

6.1. Individual agencies that have contributed to this review have each, where necessary, submitted their own learning and associated action plan as a result of recommendations they have identified themselves. The following recommendations are for the Central Bedfordshire Safeguarding Children Partnership;

6.2. In respect of pre-birth assessment activity:

a) The Partnership should continue to build on the recommendation (recommendation 5) recently made in the Daniel & Sophie CSPR (March 2024) about promoting awareness about the Pan Bedfordshire Procedure and Guidance in relation to Pre-Birth Planning and Assessments.

b) The Pan Bedfordshire Procedure and Guidance in relation to Pre-Birth Planning and Assessments should be strengthened to include:

   i. Greater reference to contingency planning and different scenarios where this may be applicable,

   ii. The need to share with relevant multi-agency partners the completed Pre-Birth Assessment report to aid multi-agency discussion, scrutiny and decision making,

   iii. The contributions to multi-agency assessment, information sharing and decision making of the Pre-Birth Tracking Meeting.

   iv. Guidance (including procedural aspects that refer to continued responsibilities to safeguard and promote the welfare of children) regarding follow-up by the Children's Centres where parents of newborns or children under two years of age, have been offered opportunities to attend for support, and these have not been followed through particularly when support is not accessed.

6.2. A multi-agency protocol should be developed that supports the re-referral back to an appropriate agency, when parents who originally consented to seeking and engaging with additional support, fail to do so.

6.3. The Partnership should raise awareness and understanding about the Under 20's Support Pathway with key agencies and professionals.

6.4. In respect of Findings of Fact being used to safeguard all children;

a) The Child Safeguarding Practice Review Panel have highlighted in the response letter to the Partnership that they have regular contact with the Ministry of Justice and the President of the Family Division. Following discussion with the Child Safeguarding Practice Review Panel about this review and its findings, the Partnership should request the Child Safeguarding Practice Review Panel formally take this matter forward with both the Secretary of State for the Ministry of Justice and the President of the Family Division.

b) The Partnership should also directly contact the Secretary of State for the Ministry of Justice and the President of the Family Division, advising them of the findings and recommendations of this review, and seek a response.

c) The following recommendations are offered as a potential remedy to the current situation:

- Practice Direction 12G which supplements the Family Procedure Rules Part 12, notably the entry which refers to communication of information with a Police Officer for the purpose of a criminal investigation (third from last): this should be amended to reference information being shared with 'Chief Officers of Police', as defined under the Police Act 1996, and with the purpose of information being communicated '*for the purpose of a criminal investigation*' but also extended to include '*and for the purposes of sharing information to promote public safety*'. Chief Officers of Police may then delegate the responsibility of this action to their Disclosure Units.

- Information from Findings of Fact made in Family Proceedings should be added to the Police National Computer (to become the National Law Enforcement Data Service) to allow any Police authority the ability to access relevant information on the same basis as the current Domestic Violence Disclosure Scheme (Clare's Law) and the Child Sex Offender Disclosure Scheme (Sarah's Law) operates. Information from Findings of Fact should then be shared using the same principle of '*Right to ask – Right to know*'. This principle allows Police to make disclosures using their own initiative about safety to other members of the public, which would include children.

- A formal response to the above recommendations should be shared back to the Partnership, by those it has been shared with i.e. the Child Safeguarding Practice Review Panel, the Secretary of State for the Ministry of Justice, and the President of the Family Division. If the decision is taken not to pursue the concept of sharing of Findings of Fact with the Police from Family Courts or not to strengthen Practice Direction 12G, the rationale should be provided to the Partnership to allow learning; this should be published alongside this report when it is also published. This will allow greater scrutiny and challenge given the likelihood of such a scenario, as outlined in this review, occurring again.

Appendix 1: Practice Direction 12G, Communication of information, Family Procedures Rules, Ministry of Justice.

A person specified in the first column of the following table may communicate to a person listed in the second column such information as is specified in the third column for the purpose or purposes specified in the fourth column

A party	A lay adviser, a McKenzie Friend, an Independent Domestic Violence Adviser or	Any information relating to the proceedings	To enable the party to obtain advice or assistance in relation to the proceedings

	Independent Sexual Violence Adviser, or a person arranging or providing pro bono legal services		
A party	A health care professional or a person or body providing counselling services for children or families		To enable the party or any child of the party to obtain health care or counselling
A party	The Child Maintenance and Enforcement Commission, a McKenzie Friend, a lay adviser or the First-tier Tribunal dealing with an appeal made under section 20 of the Child Support Act 1991		For the purposes of making or responding to an appeal under section 20 of the Child Support Act 1991 or the determination of such an appeal
A party or other person lawfully in receipt of information	The Secretary of State, a McKenzie Friend, a lay adviser or the Upper Tier Tribunal dealing with an appeal under section 24 of the Child Support Act 1991 in respect of a decision of the First tier Tribunal that was made under section 20 of that Act		For a purpose connected with an appeal under section 24 of the Child Support Act 1991 in respect of a decision of the First-tier Tribunal that was made under section 20 of that Act
A party	An adoption panel		To enable the adoption panel to discharge its functions as appropriate
A party	A local authority's medical adviser appointed under the Adoption Agencies Regulations 2005 or the Adoption		To enable the medical adviser to discharge his or her functions as appropriate

	Agencies (Wales) Regulations 2005		
A party	The European Court of Human Rights		For the purpose of making an application to the European Court of Human Rights
A party or any person lawfully in receipt of information	The Children's Commissioner or the Children's Commissioner for Wales		To refer an issue affecting the interests of children to the Children's Commissioner or the Children's Commissioner for Wales
A party or any person lawfully in receipt of information	The Welsh Language Commissioner		To refer an issue so that the Welsh Language Commissioner can consider whether to institute or intervene in legal proceedings or to assist a party or prospective party to legal proceedings.
A party, any person lawfully in receipt of information or a proper officer	A person or body conducting an approved research project		For the purpose of an approved research project
A legal representative or a professional legal adviser	A professional indemnity insurer		To enable the professional indemnity insurer to be notified of a claim or complaint, or potential claim or complaint, in relation to the legal representative or a professional legal adviser, and the legal representative or professional legal adviser to obtain advice in respect of that claim or complaint
A legal representative or a professional legal adviser	A person or body responsible for investigating or determining complaints in relation to legal representatives or professional legal advisers		For the purposes of the investigation or determination of a complaint in relation to a legal representative or a professional legal adviser
A legal representative or a professional legal adviser	A person or body assessing quality assurance systems		To enable the legal representative or professional legal adviser to obtain a quality assurance assessment
A legal representative or a	An accreditation body	Any information relating to the	To enable the legal representative or professional legal adviser to obtain accreditation

professional legal adviser		proceedings providing that it does not, or is not likely to, identify any person involved in the proceedings	
A party	A police officer	The text or summary of the whole or part of a judgment given in the proceedings	For the purpose of a criminal investigation
A party or any person lawfully in receipt of information	A member of the Crown Prosecution Service		To enable the Crown Prosecution Service to discharge its functions under any enactment
A party or an adoption agency	An adoption agency	Any information relating to the proceedings	To enable the sharing of relevant information between adoption agencies for more effective undertaking of their functions