Central Bedfordshire
Safeguarding Children Partnership

Child Safeguarding Practice Review

Daniel & Sophie (pseudonyms)

Independent Reviewer: Kevin Ball

Date: March 2024 – Final Version

Contents

1. Introduction & background to the review

1.1. This summary report sets out the findings and learning as a result of 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 and highlight further opportunities for improvement.

1.2. In June 2023 an 8-month-old child died, and abuse and neglect were suspected. A range of agencies had been involved in the child's life, having also had considerable previous involvement with an older sibling. For the purposes of this review, the child that died will be known as Daniel, and the older sibling that will be known as Sophie.

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 June 2023 This decision was supported by the Child Safeguarding Practice Review Panel[1] in July 2023. The following steps were then taken:

- The Partnership appointed Kevin Ball[2] as the Independent Reviewer.
- An initial scoping meeting was held in July 2023 during which arrangements for the review were confirmed. A briefing session for single agency authors was also provided by the Independent Reviewer.
- Review Panel meetings involving representatives from relevant agencies were held in July, September, and November, to support the smooth and timely completion of the review.
- Seeking information reports from relevant agencies involved with the children and family was an important step, to allow them the opportunity to formally reflect on their involvement with the children; as such, relevant agencies submitted information reports against the agreed lines of enquiry.
- The Independent Reviewer was provided with a comprehensive set of relevant documents to examine from Bedford Borough Children's Services, Luton Borough Children's Services, and the Probation Service, these included; Child in Need documents, Child Protection reports & plans, and OASys reports (Offender Assessment System reports).
- A multi-agency workshop was held in December 2023 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 during the later stages of the Police investigation.

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

Central Bedfordshire Council Children's Services	Bedford Borough Council Children's Services
Bedford Hospital	Bedfordshire, Luton & Milton Keynes ICB & GP
Pre-School facility	Luton & Dunstable Hospital
Luton Borough Council Children's Services	Bedfordshire Police
Cambridgeshire Community Services	Central Bedfordshire Community Services
East London Foundation Trust	The Probation Service

2.3. A comprehensive set of key lines of enquiry were agreed as needing to be explored by key agencies involved;

[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 national reviewers.

a. What sources of information were used to understand and assess significant male partners in the mother's life. How effectively was this information used to determine what risks they may present to both children, but also risk to the mother?
b. What sources of information were used to understand and assess the mother when conducting assessments about her role as a parent? How effectively was this information used to determine what risks she may present to the children, but also how effectively she was able to protect herself from the children's father, and any other significant male partners?
c. What was the quality and effectiveness of assessment, planning, intervention, and review for the periods when Daniel's older sibling, Sophie, was subject to a Child in Need Plan, and then a Child Protection Plan? What worked well about the single agency, and multi-agency, arrangements during these periods? What challenges, problems or difficulties were encountered, and what can be learnt from these?
d. What was the quality of transfer and hand-over arrangements between one local authority Children's Services and another, but also between localised health service providers? How was risk and safety planning communicated? How effective was information sharing i.e. quality, timeliness, response, shared understanding? What worked well, and what can be learnt to strengthen arrangements for the future?
e. Given the known history, what actions or arrangements were considered, and followed through, to understand any risks that Daniel might face from the point of the pregnancy being booked?
f. Two specific incidents of physical injury have been identified, one in November 2022 and the other in March 2023, both concerning Sophie. What actions were taken as a result of these two incidents? How were threshold criteria interpreted, what was the quality of decision making and response to these two incidents? What can be learnt from this episode?
g. How are professionals that conduct home visits to see children and families supported to be professionally curious about the children's daily lived experience and any adversity or harm they may experience, but also assess home conditions and the living environment?
h. How clearly and effectively do agencies records, assessment reports and plans, reflect the daily lived experiences, and voices of, both children?
i. How clearly and effectively do agencies records, assessment reports and plans, reflect issues of race, ethnicity, and culture?
j. What was the impact of Covid-19 on your agency's contact and involvement with these children and the family?

2.4. For the purposes of this over view report, these key lines of enquiry have been distilled into emerging themes. However, in taking a reductionist approach and distilling information it is important to acknowledge that a considerable amount of detail has, inevitably, been omitted from this report. As expressed above, the benefit of allowing each agency the opportunity to formally reflect on the more detailed aspects of contact has also encouraged learning – the detail therefore, has not been lost.

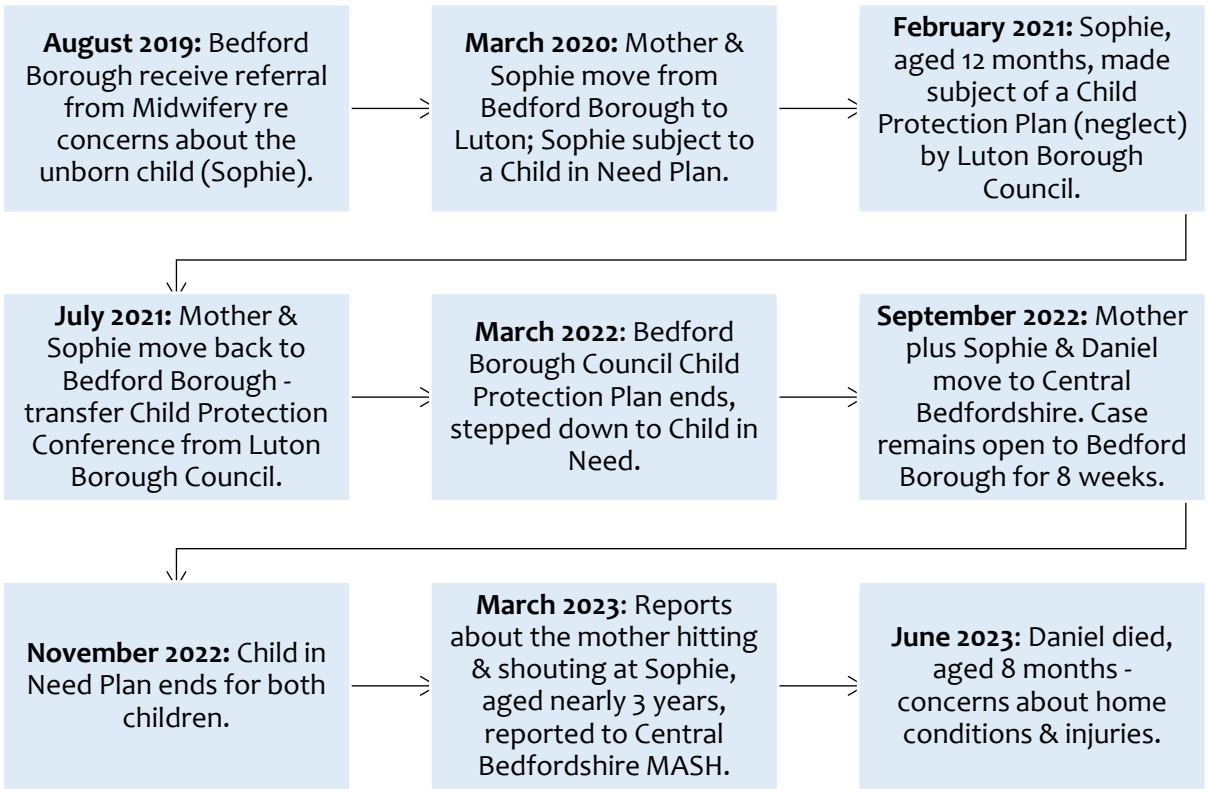
3. Concise account of relevant information & key events

3.1. An extensive multi-agency chronology was compiled for this review. The following information is relevant:

- Information from agency records highlights that the mother experienced significant difficult times prior to becoming a teenage parent; notably, experiencing abuse & neglect as a child, being exploited in later childhood, drug and alcohol misuse, self-harming, and a breakdown of the relationship with her mother.
- The children's father also had a history which indicates concern, notably, being a former child in care, having a diagnosis of attention deficit hyperactivity disorder (ADHD), drug using, being involved in gangs, and criminality. Another of the mother's male partners had similar difficulties, namely serious mental health difficulties, involvement with gangs and criminality.

- There is a pattern of the mother being inconsistent in her engagement with professionals for issues relating to the children's welfare, with appointments being attended on a regular and scheduled basis i.e. antenatal, but then not consistently attending or engaging with others i.e. GP, pre-school, health visiting.
- Concerns about both Daniel and Sophie fluctuated. There were sufficient concerns prior to each of their births, for the respective local authority Children's Services to make them subject to Child in Need processes during the pregnancy. However, there is also a clear pattern of there being 'no concerns' about the children, and positives being noted i.e. meeting developmental milestones, and good attachments.
- The mother moved three times during the timeframe under review, all within the Bedfordshire region (between Bedford Borough, Luton Borough, and Central Bedfordshire). Whilst this did not impact some services that cover all three authority areas e.g. Cambridgeshire Community Services and Bedfordshire Police, it did impact on which of the three different Children's Services had contact with the family, and held case responsibility.
- There is a dominant theme of the mother continuing her relationship with the children's father despite there being a) legal restrictions about him having contact with the mother and children, and b) the mother being advised about the risks to herself, and her children, of maintaining a relationship with him. Concerns about the relationship emerged within three months of Sophie being born, with controlling and coercive behaviour being cited, alongside a deterioration in the mother's mental health; this was in tandem with concerns about the father's mental health also worsening, particularly in relation to his ADHD. Following a GP assessment at this time, the mother was diagnosed with post-natal depression in June 2020.

Figure 1: Summary timeline of key events



4. Findings & analysis

1. Detailed Information Reports have been submitted by key agencies involved with Daniel and Sophie. From the comprehensive key lines of enquiry which are set out above, the review has distilled information into themes which highlight further opportunities for learning and improvement. Themes examined are:

- The assessment of risk and safety planning.
- Children in need of support, or at risk, transferring across organisational boundaries.
- Knowing and understanding the child's day to day experiences.

4.1. The assessment of risk and safety planning

Statutory guidance[3] states,

'… No system can fully eliminate risk. Understanding risk involves judgment and balance. To manage risks, social workers and other practitioners should make decisions with the best interests of the child in mind, informed by the evidence available and underpinned by knowledge of child development …'.

4.1.1. Individually, the children's mother and their father, each had difficult childhoods, experiencing abuse and neglect alongside other considerable adversity. When translated into assessing current risk and parenting ability these difficulties can be categorised into those factors that are currently presenting themselves as a concern, for which it may be possible to manage i.e., situational risks, and those where there is less likelihood of effecting change and which are more historical and biographical in nature i.e., pre-disposing risks[4]. There is a considerable body of research[5] that helps us appreciate the impact of adverse childhood experiences on individuals and it is important that all professionals involved in working with vulnerable parents are aware of such pre-disposing factors. Exploring and understanding the impact of these pre-disposing factors can help professionals gain a better insight into the quality of parenting likely to be offered to children. The combination of pre-disposing vulnerabilities and situational risks for both parents are acknowledged, to a greater or lesser extent, and explored in documents that have been provided by Bedford Borough Children's Services and Luton Borough Children's Services i.e. Child in Need Plans, Child Protection Plans, and assessment reports. There is however, very limited consideration or assessment about how the trauma each of the parents are likely to have experienced, impacted on their parenting capacity, and how that might influence the style of professional intervention[6]; practitioners at the multi-agency workshop recognised this gap.

4.1.2. It is argued that risks from the children's father (known to be in a relationship with the mother since the beginning of 2019) were thoroughly assessed, and known about by the key agencies, to a greater or lesser extent, during agencies time of involvement with both Sophie and Daniel. Records about the father noted in June 2023[7] *' … The nature of the risk to known individuals (i.e. intimate partners) in general is of coercive sexual behaviour/rape, sexual assault, violence, threats/intimidation/harassment, seeking revenge, and psychological / emotional harm. …The nature of the risk to female children under the age of 18 (i.e. partners/girlfriends) is coercive sexual behaviour/rape, sexual assault, violence with or without weapon, physical injury, threats/intimidation/harassment, and emotional harm. [he] may also pose a risk of serious harm to male children under the age of 18 who are connected to any partners. The nature of this risk would be violence with or without weapon, threats, emotional harm. Risk of*

[3] Working Together to Safeguard Children, 2018, p. 31, HM Government.

[4] A model for risk assessment as proposed by Brearley in 1982, as cited in Risk in Child Protection, Calder, M., 2016, Jessica Kingsley.

[5] 1) Adverse childhood experiences: What we know, what we don't know, and what should happen next, Asmussen, K., Fischer, F., Drayton, E., & McBride, T., February 2020, The Early Intervention Foundation. 2) Adversity & Trauma informed practice: A short guide for professionals working on the front line, Brennan, R., Bush, M., & Trickey, D with Levene, C. & Watson, J., June 2019, Young Minds.

[6] a) Guidance: Working definition of trauma-informed practice, published 2 November 2022, HM Government, & b) Research in Practice.

[7] The Probation Service Information Report & OASys report (Offender Assessment System report) by the National Offender Management Service.

accidental physical harm to his own children … should they be present during situations of conflict, in addition to the potential psychological/emotional harm of witnessing conflict … The nature of the risk to the public is that of violence, physical injury, threats/intimidation, and emotional harm ….' The level of risk posed was judged to be medium to high. Records confirm that this information was not only correctly identified by the Probation Service but also shared with Bedford Borough Children's Services; and that the Probation Service continued to be involved in the child protection or Child in Need processes by attending a number of meetings - this is good practice and indicates an acknowledgement about the level of risk posed but also by maintaining involvement there is a level of ownership about safety planning.

4.1.3. The presence of a second adult male who posed an equal risk to both women and children has emerged. Probation Service records show that, in April 2023, the risks to women and children were similarly thoroughly assessed as either medium or high in general, but that they had no knowledge of this second adult male having any connection to the mother in the weeks prior to the incident in June 2023; on that basis the Probation Service had no information to share with partner agencies and it is apparent that a number of agencies were not aware of the possibility of this second males presence in the mother's life – with some uncertainty about their associations remaining. It does however serve as a further example of how the mother could become involved with adult males that were high risk. It therefore emphasises the need for the multi-agency network to maintain a close eye on the children's day to day experiences and the judicious use of intelligence as a way of strengthening safety planning.

4.1.4. Whilst it had been possible to have a sound idea of the risks posed to the children from their father, information reviewed indicates there was considerably less focus on the level of physical risk the mother might pose to the children. It is important to acknowledge that neither of the males known to be associated with the mother were present at the time of Daniel's death – both were in prison; the mother is the only suspect in the Police investigation. There is no serious professional curiosity about the mother being a possible risk and source of harm through commission i.e., physical harm; assessments tend to focus on the mother failing to do something i.e., an act of omission, such as failing to maintain a safe distance from the father whilst on bail, or failing to attend appointments or engage in services. Practitioners attending the multi-agency workshop acknowledged the greater focus being on risks posed by adult males rather than the mother.

The quality & effectiveness of risk assessment & safety planning whilst living in Bedford Borough

4.1.5. The Child in Need and Child Protection frameworks provide insights from a multi-agency perspective, into the quality and effectiveness of risk assessment and safety planning. Bedford Hospital provided Midwifery care to the mother during both pregnancies. As part of the transfer from the Luton & Dunstable Hospital to Bedford Hospital relevant information was shared about history and risks. During the second pregnancy with Daniel, the Midwifery Service demonstrated good practice by recognising risk factors at the point of booking; the mother had booked the pregnancy late, she was no longer in a relationship with father of unborn and would not share his details, she was living in temporary accommodation but supported by an extended family member, plus Sophie was already open to Children's Services and on a Child in Need Plan. This information was correctly shared with Bedford Borough Children's Services. Two areas of learning have been highlighted; firstly, a copy of the pre-birth assessment was not shared with the Midwife, despite it being known at the time that the unborn was subject to statutory processes through the Child in Need framework, and secondly; there is ambiguity in regards to completion of a multi-agency pre- birth plan, as per procedural guidance[8], when a case is at CiN - this was not completed in preparation for Sophie's birth.

4.1.6. Positively, Bedford Borough Children's Services have highlighted that information was sought from different professionals, at different times to understand the risk the children's father posed to the mother and children; their involvement was pivotal in coordinating the multi-agency plan. This included the father's Social Worker from the Leaving Care Team in Luton, Probation Service and existing documents held by the Council. Review of these documents from 2019, 2021 and 2022 confirms this, but also verifies that different professionals did either attend

[8] Bedford Borough, Central Bedfordshire, and Luton Safeguarding Children Partnership Procedures – section 9.5, Multi-agency Pre-Birth Plan.

or provide reports as follow-on activity, thereby appropriately remaining involved in the safeguarding process. Of note, the mother's vulnerabilities were also considered during the Child Protection and Child in Need Planning processes (with evidenced input from the multi-agency network), with queries raised about the mother's '*… ability to be transparent with professionals … ability to protect her children from the risks posed by the father …* [and having] *misled the professionals initially ….*' This was based on the mother reportedly having regular telephone contact from the father whilst he was in prison contrary to her stating that the relationship had ended.

4.1.7. A Complex Case Discussion was held in recognition of a notable development in August 2021; the concern being that the father was likely to have broken bail conditions to not have contact (being out of prison at this time) and the mother had not abided by a working agreement in place to not allow contact, thereby placing Sophie at risk of harm from domestic abuse incidents. The inclusion of this episode, or exploration of it with the mother, was then not subsequently considered in the Child & Family Assessment conducted in July 2022, prior to Daniel's birth later that year. Neither health professionals e.g. Health visiting, or Probation Service colleagues informed the Social Worker conducting the assessment about this episode. At the point of the July 2022 Child & Family assessment, the children's father had returned to prison and the risks were therefore played down, given his inability to physically access the mother and children. The likelihood of her seeking another relationship to support her with a second child were also not explored.

4.1.8. Additionally, gaps in respect of a pre-birth assessment by Bedford Borough Children's Services during the pregnancy for Daniel (from January 2022) have been identified, noting '*… There is recording of a diagnosis of Post Natal depression after the birth of Sophie. This does not appear to be referred to or considered in the assessment for unborn Daniel or in the consideration of what support the mother would need in November 2022 …. There is limited analysis and understanding of what the impact of her own experiences and her relationship would have on her children in terms of her own emotional stability and resilience. There is little consideration as to what coping mechanisms, she had available to her and in relation to her being a young parent ….*' An important task such as a pre-birth assessment would be carried out over several visits, to allow time to fully explore relevant issues but also allow the worker to assess capacity to parent and capacity to change over time, track and compare responses to questions and be more informed about the consistency of parental response and readiness to becoming a parent. These visits, and accompanying analysis would, ideally, be reflected in the report. The overriding narrative in the reporting focuses on the immediate and presenting circumstances; it does not, for example, explore the mother and father's own experiences of being parented themselves, the impact of mental health, substance misuse or domestic abuse. The concern about post-natal depression following this second birth, is not explored, nor picked up by Cambridgeshire Community Services until the 12-week development check, post birth. These are important factors to understand during any pre-birth assessment, as it allows a more informed assessment of both risk and protective factors. Exploration of these issues is extremely limited in the Child & Family Assessment. It is argued that the term 'pre-birth assessment' has been used in a more mechanistic way to show that an assessment, prior to birth, has taken place. Whilst all assessments of risks to children should include a thorough and systematic exploration of history and pre-disposing circumstances, there is a particular need to focus on parental history and experiences during a pre-birth assessment when concerns relate to an unborn child. Review of the Pan Bedfordshire Procedure and Guidance in relation to Pre-Birth Planning and Assessments shows comprehensive guidance, and which clearly suggest to those professionals involved in such assessment activity that there is a need to move beyond the more immediate and presenting issues and that which may be captured via a 'single assessment' mindset, into a much more exploratory way of assessing. Exploration of this topic at the multi-agency workshop highlighted a need to remind all practitioners about the guidance available and ensure it is being applied when faced with concerns about a child's safety and welfare during pregnancy.

4.1.9. These matters are then not followed through or fully recognised at the point of Bedford Borough Children's Services transferring the case to the Central Bedfordshire Children's Centre in November 2022 with Bedford Borough Children's Services noting; '*… At the time of closing the case in November 2022, it appears the mother was focused on being a mother and not interested in another relationship. As the father was in prison, risks to the children and the father was assessed as low …* [however] *… there is limited revisiting and analysis in the pre-birth assessment*

of the mother's childhood and previous experiences and how this may be relevant for having another child when Sophie was only [two years old]. *There is key information not known or provided to the social worker that would be pertinent to the assessment. There is no consideration of possibility of post-natal depression and how that would impact on both children. There is no detailed exploration as to what day to day support would look like in* [the local area] *from family and who and what was available to the mother. The continued narrative about father as the primary risk to the children and the mother perhaps overrode consideration for different hypotheses. … a referral to Central Bedfordshire Children's Services at the time of the decision to close to Bedford Borough Council and their involvement in that would have been important. There was also a change in all professionals supporting the family because of the move. This impacts on what can be identified as risk and change because workers have no previous history with an individual and it is therefore more difficult to readily identify ….'*

The quality & effectiveness of risk assessment & safety planning whilst living in Luton Borough

4.1.10. Luton Borough Children's Services had a significant amount of involvement with the family between March 2020 and July 2021. The Child in Need and Child Protection frameworks applied in Luton provide insights from a multi-agency perspective, into the quality and effectiveness of risk assessment and safety planning. As well as the handover of Sophie being a Child in Need from Bedford Borough Children's Services, records highlight a further nine separate referrals to Luton Borough Children's Services over the timeframe the mother and Sophie lived in Luton. These referrals related to domestic disputes between the mother and father, drug use and drug dealing allegations, dirty home conditions, male offenders being in the family home, the father breaching bail conditions and being in the family home, and in one incident threatening behaviours resulting in the Police moving the mother and Sophie to a hotel for their own safety. Some of the referrals were anonymous, and some resulted in a Strategy discussion taking place. Episodes also included the mother and Sophie moving out of Borough to a refuge in two different areas. Following the seventh referral, Sophie became subject to a Child Protection Plan in February 2021, which was then reviewed in April 2021 (with input from the multi-agency network), and then transferred to Bedford Borough in July 2021.

4.1.11. Luton Borough Children's Services have identified considerable learning as a result of their involvement and interventions, notably relating to the timeliness of response to identified risks, challenges faced during the Covid-19 pandemic, and the need to use chronologies much more to inform risk assessment and timely decision making. Luton Borough's Children's Services involvement was pivotal in coordinating the multi-agency plan. Of interest, one reference in May 2021 from a practitioner to a manager highlighting a common, and stubborn challenge faced by many, *'… I have completed a virtual child protection visit to the mother today as advised … I am concerned that the mother is not being honest about the father and I have a feeling that she is seeing him. She is denying this and I have no evidence but I am really uneasy about it. She is now living in Bedford; Bedford have refused the case and I am concerned that my input is not enough. She is not engaging with the Health Visitor or the Children's Centre … She is not engaging with emotional wellbeing support or domestic abuse support. If she doesn't engage with this, she is just more vulnerable to maintaining a relationship with him, more so now she is living independently*. … [an extended family member is also concerned about the mother having contact with the father] *… I am getting worried that we are sitting on an incident waiting to happen. Where do we stand with some unannounced visits or welfare checks out of hours? Or do you have any other advice? I have not had any other feedback from management since Bedford refused the case ….'* This direct reference highlights three issues; a) the positive recognition about risks posed by the father, b) appropriately so, acknowledgement about the mother being vulnerable and at risk, but no mention about the impact on the situation on Sophie, and c) a level of despair by the worker about what to do. The situation was finally resolved due to the transfer being accepted by Bedford Borough Children's Services but does reflect a frustrating period for workers to be holding and managing risk at a distance.

4.1.12. The issues highlighted about risks posed by the mother are somewhat considered by Luton Borough Children's Services, commenting *'… reference to the mother's own propensity for violence is touched upon in the Bedford Borough Single Assessments and … includes historic instances of violence from the mother, reflecting she received 'several fixed term exclusions in school for aggressive behaviour towards fellow pupils' … the mother's step father had 'physically restrained* [her] *as she was causing damage to the property and acting aggressively towards her*

younger sibling [in 2014] *.... The date and nature of this behaviour would helpfully have been explored to understand the possible triggers, seriousness and what the mother's response was to any support offered. The mother was only 18 when she became pregnant, so these incidents might have been relatively recent and live … her record includes more recent instances of alleged and threatened violence* [July 2020] *… 'fighting with the father ... assaulting the father ... running up the road to chase after him and the child was home alone ... threatening to burn the caller's house down …'.* The incidents are not however, linked together to form a coherent whole picture about the level of risk, in her own right, she may pose – the narrative continues to focus on adult males. There is an acceptance that she will always gravitate back to being in a relationship with the father, and that this is the greatest risk factor.

4.1.13. In terms of risk the mother may have presented, Cambridgeshire Community Services as an agency that had continuity of agency involvement (although practitioners would have changed when locality changed) despite the mother moving across local authority boundaries, note *' … appropriate screening around mental health and family circumstances was carried out at an antenatal visit by the Health Visitor in December 2019 and it is documented that no recent or past events had occurred that may impact on parenting ability. However, it is evident in the records that there were several vulnerabilities for the mother, namely needs around historic mental health issues, parental conflict, and childhood adversity but it is not evidenced in the records as to how these vulnerabilities were factored into assessment completed by the Health Visitor. New birth visits for* [both children] *did not highlight any concerns around maternal mental health. The mother's attachment with her children was noted as positive in the health records ….'* The mother accepted a referral to the specialist Perinatal and Infant Mental Health Champions however her presentation did not suggest that she needed urgent mental health specialist input. She failed to engage in efforts for further assessment and was therefore removed from the waiting list, and *'… Although denied by the mother, … there are a number of references about the mother using drugs in her health records as well as her limited insight into the impact of domestic abuse in her relationship with the father on her child(ren). Her engagement in different programmes to help with this was inconsistent …'.* By not evidencing how the mother's vulnerabilities were factored into assessments by the Health Visitor, plus the mother's inconsistent engagement with support programmes the potential for 'starting again,' despite the agency continuity.

4.1.14. As these issues were not explicitly examined by one authority, they were not transferred in any handovers from either Bedford Borough to Luton Borough or through to Central Bedfordshire Children's Services. The enduring narrative, or bias, towards the greatest risks to the children being from the adult males in the mother's life, is maintained throughout all the agency submissions to this review. In part, this is appropriate given their respective histories, however it is argued that there was sufficient information about the mother to raise the profile of risk she too may have posed. This gap was acknowledged by those attending the multi-agency workshop.

The quality & effectiveness of risk assessment & safety planning whilst the children lived in Central Bedfordshire

4.1.15. Central Bedfordshire Children's Services had relatively limited contact with the mother given her move to the area in September 2022. Practice relating to the quality and effectiveness of the case transfer from Bedford Borough Children's Services is examined below in section 4.2, however there are two specific incidents which occurred whilst both children were living with their mother in Central Bedfordshire, that warrant closer examination.

- Firstly, in November 2022 Sophie (aged 33 months) was reported by the Children's Centre as having a black eye. On seeking advice from the Bedford Borough Social Worker that Sophie should be taken to the GP, the GP examined Sophie with the mother, and was satisfied with explanation of the child accidentally walking into a piece of furniture (there is some uncertainty about the age of the bruise). The GP has reflected that it was not clear from the notes whether the Social Worker was asking for the review out of concern about the management of the injury or from a safeguarding element and that knowing this would have been helpful. The Bedford Borough Social Worker emailed the Children's Centre Manager to advise of this. It was noted during the exchange *'… that there are no concerns usually for mum's care of the children, there has never been a risk/concern re physical harm from her to the children …'* This episode occurred at the time that the services being offered to the family were being stepped down from Child in

Need to Early Help/Universal Services. Given the history of involvement it is arguable that, although a sensible course of action was taken in response to the bruise, a more robust response was also justified i.e. a formal referral/notification to Central Bedfordshire MASH so that a multi-agency perspective could have been taken – thereby allowing a fresh look at the history and circumstances; this is especially so if the request made of the GP was more about assessment of the injury from a safeguarding perspective. One hypothesis being considered at the time was that the mother had moved area to distract professionals and avoid scrutiny, in which case, it was a successful strategy. As will be examined in section 4.2 below, given the complete absence of a formal transfer, or notification from Bedford Borough to Central Bedfordshire, no professionals in Central Bedfordshire (aside from the Children's Centre) had information about the mother – the GP therefore would not have known about any statutory involvement at-all and was, in some respects, making decisions without relevant contextual information. Added to this, it does not appear the Health Visitor was spoken with either, thereby severely limiting the wider perspective.

- Secondly, in March 2023 reports about Sophie (aged nearly 3 years) being hit by her mother on the way to the Pre-School provision, were received by Central Bedfordshire Children's Services. The mother was contacted by a Central Bedfordshire Social Worker to gain her account of the incident; she declined a Child and Family Assessment but agreed to re-engage with the Children's Centre. Due process was followed in terms of multi-agency checks being completed, including with the Police, which did reveal full and relevant historical and contextual information, risks, and vulnerabilities - although it is noted that there was a delay of seven days in obtaining information from Bedford Borough Children's Services.

4.1.16. Whilst it was acknowledged that the children's father was in prison, and that there were factors of concern, this appears to have led to a judgement about the mother not being in a new relationship, which then equated to there being no risk of abuse; this judgement had the effect of closing the process. Given the seriousness of the reports about Sophie being hit by the mother, which were judged to be credible, plus the information received from multi-agency checks, there was more than sufficient information to justify convening a Strategy discussion[9] – this did not happen though, no one spoke with Sophie about the incident, and there was no challenge about the decision to take no further action. A number of contributory factors have been put forward, and include;

- The reports of the incident were submitted by members of the public rather than professionals – this may have, unwittingly, impacted on the evaluation of risk and lowered it by the source of referral somehow being less authoritative.
- The use of the term 'physical chastisement' to describe the incident may have minimised the mother's behaviours, thereby shifting the narrative from one about an 'assault' to one about a parent controlling and managing a child's behaviour.
- The child's Pre-School provision did not see any marks or injuries on Sophie. They also described good attachment between the mother and Sophie and positive engagement by the mother with staff. This may have reduced the level of professional concern.
- An error of professional judgment (and sympathy bias) influenced by '*… not wanting to label the mother and her parenting capacity negatively due to the past safeguarding issues, and to take into account the positive information secured on the mother's parenting ….'* This may have led to over optimism and minimisation.

4.1.17. From their analysis of this episode Central Bedfordshire Children's Services have reflected '*… practice, action, and intervention* [fell] *short of expected policy/procedure. An extensive audit of decision making (Contact and Referrals for children aged three and under that do not progress to assessment) has been undertaken since this incident. This has not revealed that other errors of judgement of a similar nature or overall issues with the quality of information gathering and decision making. … It is however notable that MASH processes do not involve multi-agency evaluation of the information secured by Children's Services. Rather, information is sought and provided and analysis*

[9] Strategy discussions are convened under section 47 of the Children Act 1989.

and decision making is taken by the CBC Children's Services Access and Referral social workers and managers. This means that there is not multi-agency evaluation of information and collaborative decision making. This is deficit in current arrangements. … Additionally, the CBC Assessment and Referral Service is very lean in terms of team manager capacity, with one team manager managing, leading and quality assuring most of Contact and Referral decisions. It is appropriate for managers and practitioners to be specialist in this area of work, as this builds skills and knowledge through experience and targeted CPD. However, continuously processing large amounts of complex child safeguarding information, including large amounts of text, some of which is low quality … is very challenging and high risk ….' Actions have been identified by Central Bedfordshire Children's Services to strengthen arrangements.

4.1.18. The above findings remind us of the human contribution to the task of keeping children safe, that the assessment of safety and risk is a fallible process and that '*no system can fully eliminate risk*'[10]. Factors such as 'decision fatigue'[11], bias in different forms (e.g. sympathy bias, gender bias, non-professional referral bias[12]), the use of language to describe events or behaviours being open to interpretation (e.g. use of the phrase physical chastisement versus hitting or assault), plus dealing with complexity, all potentially have a cumulative impact on assessment and decision making.

Learning points
Gaining knowledge, through assessment activity, about how earlier life experiences which are likely to have been traumatic, affect current functioning as an adult, and especially as a parent, are important steps to evaluating risk to children.
Research[13] into other case reviews and tragedies highlights the use of working agreements with parents as a means of encouraging compliance, having limitations, and should not be relied on as the sole safety measure.
A child's first year of life is so uniquely vulnerable, not just because of the baby's complete dependency, but also because studies show that children are at most risk of fatal or severe injury in their first year. When concerns exist, pre-birth assessments, whenever possible, need to be planned, be multi-disciplinary, engage with the parents and provide a sound, objective analysis of information gathered. They need to explore the past, to inform the future. Risk cannot be properly evaluated without robust, yet sensitive professional curiosity and authoritative practice. Such assessment activity cannot be completed in one visit by any professional.
The formation of bias (e.g. sympathy, gender, non-professional referral) is often an unconscious process that can unwittingly creep into one's practice. It can be offset, or neutralised, by good quality reflective case oversight, through for example, individual or group supervision.
Victims of domestic abuse can find it difficult to leave an abusive relationship. In part, this may be due to ongoing, yet subtle, coercive, and controlling behaviours by the perpetrator towards the victim – much of which might remain hidden from the professional network. Being professionally curious, and alert to the reasons why

[10] Working Together to Safeguard Children, 2018, p. 31, HM Government.

[11] Decision fatigue – the complexity of decision-making can be increased further by many sequential decisions having to be made in a single day, potentially resulting in depletion or 'decision fatigue', referenced in Clinical Judgement and Decision-Making in Children's Social Work: An analysis of the 'front door' system Research report, April 2014, HM Government.

[12] Child Protection in England, National review into the murders of Arthur Labinjo Hughes and Star Hobson, Child Safeguarding Practice Review Panel, 2022, HM Government.

[13] Complexity and challenge: a triennial analysis of SCRs 2014-2017, March 2020, p. 152, Brandon, M., Sidebotham, P., Belderson, P., Cleaver, H., Dickens, J., Garstang, J., Harris, J., Sorensen, P., and Wate, R., HM Government.

a victim of an abusive relationship might maintain contact with someone who is abusive is important, even more so, when small children are part of the dynamic.

Dealing with inevitable levels of uncertainty, whilst hoping for certainty, can be hugely challenging and stressful for practitioners and first line managers working in child protection. Holding this psychological tension can impact decision making, especially when flooded with referrals, information, risks, and decisions on a day-to-day basis. Research[14] suggests that some may resolve this tension by '*an irrational belief in the possibility of a rational preference*' – a belief that, with enough information, enough practice wisdom and experience a 'right' answer or decision will somehow emerge. Ensuring sufficient capacity within the decision-making process, which is supported by allowing reflective space for those dealing with this emotional tension, is critical to reducing the burden.

Whilst it is acknowledged that women are at much greater risk of assault and violent crime than men[15] where a mother's history clearly shows she has experienced significant abuse, neglect, and trauma in her own past, it will be important to assess her parenting capacity as much as the father/adult male. Exercising healthy scepticism and thinking the unthinkable is an important part of protecting children from harm. In such scenarios it will be important to be mindful about developing bias towards victims of abuse and distorting, or minimising, risks to children based on the stereotyping of men being abusers.

4.2. Children in need of support, or at risk, transferring across organisational boundaries

Research[16] reminds us about the importance of working together,

'*… Effective communication between agencies is particularly important when working with families with a history of transience or mobility. Where families move … it is vital that their needs, risks and history are shared with the receiving area to facilitate continuity of service and prevent drift. Where families move between areas, it is necessary for agencies to revisit and clarify responsibilities to avoid families slipping through the net …*.'

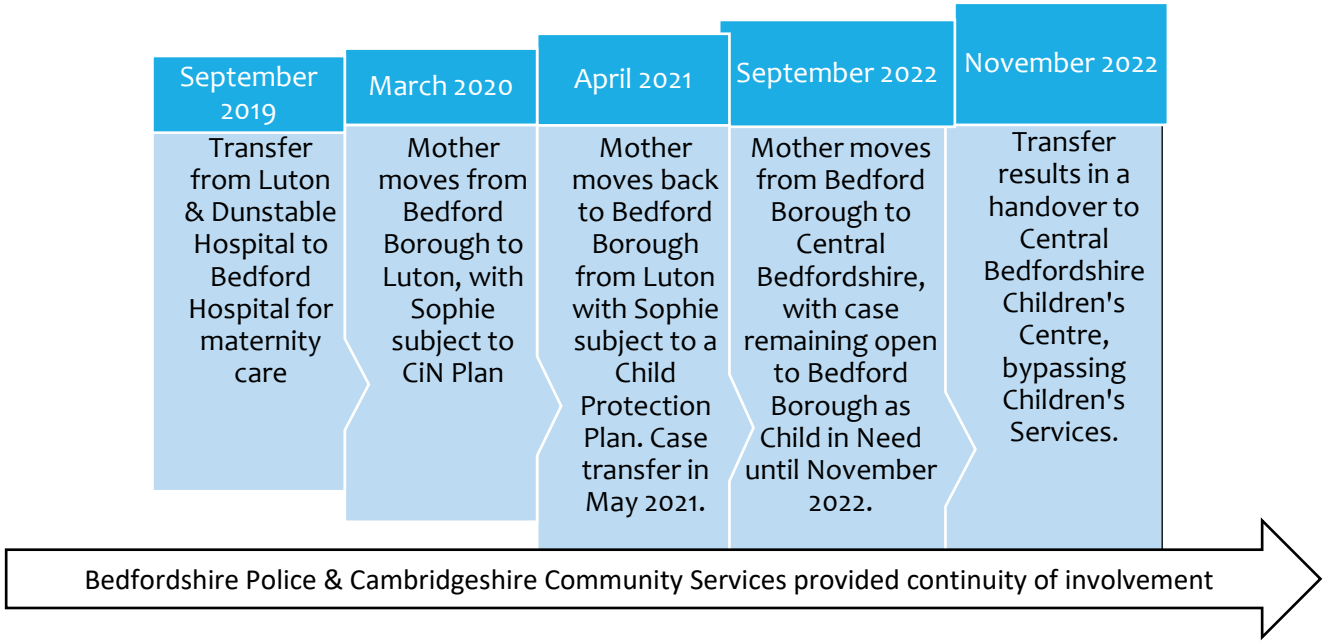
4.2.1. In this case there were several transfers that occurred. From a system thinking perspective transfers are the handover of professional responsibility and accountability for measures that either support or protect a child from harm on a temporary or permanent basis. The objective of any handover is the accurate and reliable communication of information, whether that be an internal exchange from one team to another or across organisational boundaries, with the goal of ensuring continuity of care. In this case, handovers took place in the context of practice frameworks such as Child in Need Plans or Child Protection Plans being in place, and there being a statutory requirement to maintain levels of support and protection for the children. These transfers are set out below in Figure 2.

[14] Beckett, C., Risk, Uncertainty and thresholds, in Calder, M., Contemporary risk assessment in safeguarding children, p. 42, 2008, Russell House Publishing Ltd.

[15] Thiara, R., & Radford, L., Working with domestic violence and abuse across the life course: Understanding good practice, 2021, Jessica Kingsley.

[16] Learning for the future: Final analysis of serious case reviews, 2017 to 2019, p.75, 2022, HM Government.

Figure 2: Key points of transfer



4.2.2. The transfer of information from Luton & Dunstable Hospital to Bedford Hospital for maternity care in September 2019 is reported to have been effective and efficient. Whilst part of the same NHS Trust, the Hospitals occupy different geographical sites and have different Midwifery Services. Database systems across the two sites are not connected, despite being within the same NHS Trust. The use of email, followed up by telephone discussion and the supply of documentation show an effective handover about the mother, '*… a vulnerable families Midwife at Bedford received a verbal handover from the specialist Teenage Caseload Midwife at L&D which was then followed up by an email handover. This included copy of the antenatal booking form which had information on father to unborn …, his address, DOB, ethnicity, contact details, that he had been present when they completed booking, they had been in a relationship for 3 months, pregnancy was unplanned, he was unemployed and this was his first baby. Also, that he was known to youth offending and adult prison for drug related issues, domestic violence, robbery, and witness intimidation, he was also a previous looked after child. The email also included a copy of the information sharing form and multiagency safeguarding hub (MASH) referral which gives very good clear information that the unborn is already open to children's social care in Bedford borough for a pre-birth assessment ….*' What makes this particularly good practice is the verbal follow up between Midwives, the clarity of transfer information and the recognition of risk factors. This positive practice continued throughout their involvement during both pregnancies.

4.2.3. The transfer of responsibility from Bedford Borough Children's Services to Luton Borough Children's Services in March 2020 whilst Sophie (aged 1 month) was subject to a Child in Need Plan has highlighted learning. Bedford Borough Children's Services note '*… there is evidence that key information and documents were shared with Luton when the transfer was undertaken ….* [However] *There is no specific handover discussion documented between the two local authorities which arguably would have been beneficial ….*' Luton Borough Children's Services had noted that the 2019 Single Assessment and 2020 Child in Need Plans were shared by Bedford Borough Children's Services in a timely and effective manner, however a 20-day delay in Luton Borough Children's Services accepting the transfer cannot be accounted for; a delay of 20 days is potentially very significant in terms of safety planning and managing risk to a child. Sparse notes of a handover by phone with a recommendation for the Plan to continue have been confirmed but beyond this it has not been possible to gain any further understanding about the quality and effectiveness of the handover as the worker no longer works for the Borough. Whilst it is noted that an introductory meeting between the parents and new worker is not recorded as taking place, it is also noted that there was no obvious review of '*… the indicators of risk, or [agreement] which Local Authority was case responsible, from which date … It is not clear whether a safety plan was requested, or outstanding assessments such as the Probation Service Oasys assessment of father; Bedfordshire's Pre-Birth Assessment, or any other assessments or plans*

completed, were requested … [the input from the father's] *Personal Adviser was not pursued or assessments requested as they might have been to enhance understanding of her risks, vulnerabilities and what had, and what had not worked so well in supporting her ….'* Whilst Luton Borough Children's Services have not been able to account for many of these issues noted, it is important to acknowledge that this handover took place at the precise time of Government advice, and then lockdown restrictions coming into force due to the Covid-10 pandemic; and as such, may have been a contributory factor.

4.2.4. The transfer of responsibility from Luton Borough Children's Services back to Bedford Borough Children's Services in April 2021 whilst Sophie (aged 14 months) was subject to a Child Protection Plan also highlights learning. Bedford Borough Children's Services comment *'… A year later concerns had escalated and Sophie was subject to a Child Protection Plan. Given this was a move back to the local authority they had been open to and there was evidence the child was suffering or likely to suffer significant harm, a reflective discussion between the two local authorities would have been important. This could have focused on continuity, key issues as well as the challenge of changing boroughs and workers from all relevant agencies. It is clear that expected practice regarding child protection transfers was followed … It is those systemic and reflective conversations that appear to have not explicitly taken place. However, there are timely transfers with expected documents and workers attending key meetings around the transfer process ….'* Luton Borough Children's Services have noted that, whilst subject of a Child Protection Plan, Sophie moved across Boroughs but initially not to a permanent address; that of an extended family member for four weeks. Record keeping around this time has been identified as a concern, with there being limited records about transfer communications and actions taken, however, there was a delay in advising the receiving authority (Bedford Borough) by four weeks until a degree of certainty had been obtained from the mother about the permanence of the move. Whilst the mother's uncertainty about the move was a potential distraction from alerting the receiving authority, there is no record held by Luton Borough Children's Services which indicates to Bedford Borough Children's Services/MASH that any notification or phone calls were made advising them of a child at risk, moving to their area. This does not conform with the expectations set out in a regional protocol[17] that the receiving authority should be notified within 24 hours about a child moved across borders – whether temporarily or permanently. Records indicate there were two opportunities to notify Bedford Borough Children's Services; firstly, at the point she moved to live with an extended family member; and then secondly, following a Legal Gateway Meeting held two week later – neither opportunity was taken, instead it being delayed by a further two weeks until early May 2021. Additionally, it seems that Bedford Borough Children's Services would also not accept case management responsibility as it was unclear whether the move was permanent. The positive use of escalation to Head of Service level in Luton to intervene, appears to have resolved matter – although this still resulted in delays. Current risks, history and safety planning were then formally discussed in a handover meeting that took place a further four weeks later and the end of June 2021. From this point forward records indicate the handover to be complete with Bedford Borough Children's Services fully engaged. This was at a time when Covid-19 restrictions were steadily being lifted.

4.2.5. The transfer of responsibility from Bedford Borough Children's Services to Central Bedfordshire Children's Services between September and November 2022 whilst both children were subject to Child in Need Plans has highlighted important learning. At this time Sophie was 2½ years and Daniel 2 months old. The Bedford Borough Social Worker made a direct approach to the Central Bedfordshire Children's Centre in respect of support needed for the mother and children given their move across the local authority boundary area, and whilst still being subject to a Child in Need Plan. The Children's Centre assumed that a transfer Child in Need meeting had been arranged and contact had been made with the receiving authorities Children's Services – neither had happened and effectively, the Children's Centre were offering services in a vacuum with no appropriate oversight. Good information sharing had however taken place between the Bedford Borough Social Worker and the Children's Centre otherwise; information about risks, needs and areas for support were detailed. Bedford Borough Children's Services have reflected *'… The step-down in November from CiN to Universal services involved no transfer or*

[17] The East of England region Children's Services joint protocol on children subject to child protection plan moving between local authority boundaries, version 6, 05/07/2021.

notification to Central Bedfordshire Children's Services … it was stepped down without detailed contingency planning and no discussion with the local authority Children's Services ….'

4.2.6. Cambridgeshire Community Services maintained their agency involvement throughout the transfers; they have noted '*… It is apparent from review of records that the CCS Transfer Movement in and Out pathway was generally followed well with regards to handover between Health Visiting Teams (verbal hand over and written summary undertaken with each move), contact with the mother, and telephone contact/virtual contact or home visits being undertaken. There were instances whereby the mother had not responded to Health Visitor attempts to contact, and thus opportunistic visits were undertaken successfully, demonstrating application of professional judgement in line with the Pan Bedfordshire Guidance on Children and Young People Who Are Not Brought to Appointments (WNB). … In June 2020, the mother and Sophie moved to Luton with the father. There was some uncertainty around whether Sophie remained subject to a Child in Need plan, or whether the family had been stepped down to Early Help. The allocated Health Visitor made several calls/emails to partner agencies (Social Care; Children's Centre) to enquire as to the plan of support for the family, it was not until 23rd September 2020 that the family were confirmed to be open under Early Help. In the interim time, the Health Visitor undertook contacts and visits as per the Universal Partnership Plus level service offer in place at this time. This was good practice given the ambiguity of the multi-agency assessment at the time. … A further delay in undertaking contact as per the CCS Transfer Movement in and Out Pathway took place when the mother, Sophie and Daniel moved to Central Bedfordshire. … During this time, Sophie and Daniel were subject to a Child in Need plan which ended at the meeting in November 2022 …'.* These reflections highlight that, although the Health Visitor made attempts to clarify whether the children were subject to a Child in Need Plan having transferred to Luton, there was a significant delay in confirming arrangements (3 months), and no evidence to suggest escalation was considered. Additionally, there was no challenge or request for confirmation about Central Bedfordshire Children's Services being notified of a Child in Need transfer in September 2022, instead it reinforced the direct approach by Bedford Borough Children's Services to the Children's Centre. Currently, there is a regional protocol[18] which provides procedural guidance about the transfer of Child Protection cases, but this does not include those children that are subject to Child in Need Plans. The use of challenge and escalation could therefore have been stronger by Cambridgeshire Community Services.

Learning points
When a family transfer across local authority boundaries and are subject to formal, statutory processes such as Child in Need, information should always be shared by the departing authority with the receiving authority prior to any local services being offered. This supports better management of risk and support but also allows resource management to be targeted to those most in need. Verbal handovers, as well as document exchange, are likely to result in better quality transfers.
Research[19] highlights an important factor when handing over case responsibility '*… there is a distinction to be made between information-sharing and effective communication. For this reason, it is vital that a case handover discussion occurs between the outgoing and receiving authority ….'* Unreliable communications can result in missing information, unnecessary information, inaccurate information, poor or variable quality of information, misunderstandings, failure to carry forward necessary tasks or activities that compromise or undermine the professional role to keep children safe. An effective handover consists of three distinct elements; 1. A period of preparation by those workers handing over responsibility to new workers e.g. collating information, ensuring chronologies are up to date, evaluation of risk and safety factors, to offer a coherent package of information to handover.

[18] The East of England region Children's Services joint protocol on children subject to child protection plan moving between local authority boundaries, version 6, 05/07/2021.

[19] Learning for the future: Final analysis of serious case reviews, 2017 to 2019, p.76, 2022, HM Government.

2. The actual handover, during which departing workers and receiving workers communicate and exchange task-relevant information, but also check the quality of information exchanged, the meaning of information and language used so that safety and risk are understood in context, and being clear about next steps needed to ensure continuity of safety and support.
3. Cross-checking of information by the receiving workers, as they assume responsibility for the task, to ensure a full understanding of relevant issues, and following up any outstanding issues.

Where families move between local authority areas it is important to ensure an effective transition. Local authorities could consider creating an acknowledgement of receipt email when the case is picked up by the receiving authority. Local authorities should ideally ensure that a verbal handover discussion occurs between the outgoing and receiving authority.

It is noted that the East of England Protocol 2021[20] currently targets children subject to Child Protection processes. It is very procedurally based and does little to guide expectations about the quality of handovers, nor does it refer to children subject to Child in Need Plans or processes. An opportunity exists to refresh and strengthen this guidance to reduce the likelihood of transfer errors occurring or distractions caused by individual case complexities, and including those children subject to Child in Need processes.

4.3. Knowing & understanding the child's day to day experiences

Practitioners need to ensure the voice and lived experiences of the child runs through everything they do and that the child's perspective is clearly visible throughout any assessment that affects them and taken into account no matter what their age or ability to communicate directly. Ask yourself: 'Do I understand what this child's life is like, what do they do each day? How do they feel about their lives, how would they want things to change?[21]

4.3.1. Arguably, assessing a child's life and their day-to-day experience requires an understanding about their identify – who they are, and what has happened in their lives. Knowledge about their ethnicity is one such aspect which, it is argued, impacts identity, culture, and parenting. Records reviewed indicate very mixed recording and understanding about ethnicity but also the children's day to day experiences.

4.3.2. Bedford Hospital have recorded the mother's ethnicity as White British during both pregnancies and the father's as White/Asian. The Police have no mention of ethnicity. Cambridgeshire Community Services highlight that although questions about religion were not asked of the parents, the ethnicity of Sophie and Daniel is recorded as mixed White & Asian, with the mother recorded as White and father as White/Asian. The Probation Service comment that there are either no records or incomplete records about race, ethnicity, and culture, highlighting a gap in their work assessing the father. The Pre-School setting have recorded details about ethnicity, religion and languages spoken. Bedford Borough Children's Services have either not recorded, or inaccurately recorded ethnicity throughout their assessment work. The mother's ethnicity and faith are not consistently recorded in Luton Borough Children's Services records. Sophie is recorded as 'English,' 'British,' 'White and Asian.' Sophie's father is recorded to be British English White and Asian by Luton Borough Children's Services, who also note '*… Exploration with the mother, of her own race, ethnicity, and cultural considerations, and what it meant for Sophie being dual heritage, was not explored in Sophie's record. It is not clear if this is attributable to the frequent changes of Coordinator / Social Worker; the frequent referrals which took precedence; the family moving and transferring across Local Authorities, or a combination of all of these making the management of Sophie, during Covid-*

[20] The East of England region Children's Services joint protocol on children subject to child protection plan moving between local authority boundaries, version 6, 05/07/2021.

[21] Voice of the Child Practitioner Briefing, 23/03/2023, Bedford Borough, Central Bedfordshire, and Luton Safeguarding Children Partnership Procedures.

19 in the words of her Family Safeguarding Social Worker, 'chaotic from the start'. Central Bedfordshire Children's Services or Children's Centre have not recorded ethnicity.

4.3.3. Some specific examples have been cited by key agencies involved which either demonstrate attempts to know and understand the children's daily experiences, or highlight where, in future, opportunities may arise; these include,

- Bedford Borough Children's Services have reflected that home conditions have been clearly recorded, with no concerns being noted; review of records confirms this to be the case as well as indicators of risk being clearly detailed, however there is much less analysis about the children's lived experiences or day to day life, '*… What appears to be absent from the Bedford work is the further analysis of not just observing children in the here and now but considering what the impact of trauma on adults could have for their attachment to their child and subsequent parenting …'*.

- Cambridgeshire Community Services have reflected a mixed picture about how well the children's lived experiences were captured. Given the Services role, they are ideally placed to assess the children's development alongside their presentation, environment, and any risks they may face. There is, for example, no record of Daniel's sleeping space ever having been seen, though Sophie's cot in her mother's room was seen during a visit in May 2021 (when Sophie was 14 months old) and no concerns were raised about these arrangements. On several occasions Sophie and Daniel were seen and again, no concerns were raised about their cleanliness or dress. A consistent understanding about the relationship between the children and the parents is not captured, with limited observation of the interactions between the mother and children occurring, in part caused by virtual meeting, the mother failing to attend meetings, or non-engagement with professionals. During home visits some Health Visitors documented home conditions; the use of the term '*moderate clutter'* has been used, and this is open to interpretation, highlighting a gap in an agreed and common language for staff to use when describing the home environment. Similarly, on another visit another worker described the home as '*sparse … but clean and tidy … and no records regarding any baby equipment or toys observed in the home ….'* Health Visiting records comment on the parents being '*… warm, loving and nurturing ….*' The use of Day in the Life tools[22] that cover various ages and stages has been noted as applied, which very helpfully capture a child's experiences; these are promoted by Bedford Borough, Central Bedfordshire, and Luton Safeguarding Children Partnership.

- The Police response to an incident in November 2021 (when Sophie was 21 months old) where officers were responding to an assault incident '*… and where Officers encountered what they considered to be unsanitary conditions within the home. Those concerns were duly recorded on the officer's body worn video and relevant referrals were made to highlight those concerns. Although the incident fell below an immediate risk where Officers could have considered Police protection powers, the level of concern/risk identified was proportionate and the reporting officers considered the response to this incident looking from the children's perspective ….'* Although referred, Bedford Borough Children's Services did not seek or request the video evidence to assist with any assessment of the incident. As the Police note '*… the use of body worn video to see things from an objective viewpoint and the value of capturing 'unseen' issues can add significant value to decision making and supporting the voice of the child ….'* Images taken by the Police were used to significant effect during the multi-agency workshop to promote discussion about thresholds, decision making, and assessing safe sleeping arrangements.

- Of 18 visits made to see Sophie during Luton Borough's Children's Services involvement, including assessments, CiN and Child Protection Plan; 10 visits were completed virtually, and 8 were face-to-face. Two visits were unannounced. Sophie was seen during all these visits in the presence of her mother. A number of positive observations were made by the worker and recorded; examples include, '*… Sophie was*

[22] A day in my life - Practice guidance tools, Bedford Borough, Central Bedfordshire, and Luton Safeguarding Children Partnership Procedures

happy and content … in good spirits … happy child and crawling around the home …pretty healthy baby who was dressed in clean clothes there were age appropriate … favourite toy giraffe … good sleeper … well dressed and inquisitive … comfortable and settled with her mother and no sign of distress … appropriate toys and clothes were seen … mother was seeing to Sophie throughout the call and making sure she was safe … appeared quiet and shy and just looked at the screen … happy and relaxed in her mother's care …'. Home conditions were described as '*a bit messy – not a big concern … Home conditions appeared to be clean … accommodation appeared clean and tidy … Flat a bit messy and needed a tidy up … flat was a bit untidy… bedroom cluttered with clothes and bathroom messy ….'* Over the course of reviewing the case notes, the Information Report author noted the slight deterioration in the descriptions of home conditions – these might have been usefully analysed and questions asked about the apparent decline. It was also noted a lack of consideration about male partners in the home during home visits. Recordings detail what Sophie was eating during visits. Alongside these positive features, Luton Borough Children's Services have identified areas that could have been stronger, one issue being '*… greater reflection upon her experience of witnessing, hearing, and potentially being directly exposed to the domestic abuse which was so clearly a part of her lived experience* [given the number of referrals] *… referrals made reference to worries about Sophie … A challenge for the Social Worker was the mother's minimisation and outright denial of the referrals. The mother could not be relied upon to accurately articulate Sophie's authentic lived experiences, as she repeatedly prioritised the needs of the father ….'*

- In response to the allegation of abuse in March 2023 (when Sophie was 2 years, and Daniel was 6 months old), Central Bedfordshire Children's Services recognise that by not pursuing the allegations, not undertaking a Child & Family Assessment, and not seeking Sophie's views, the opportunity to understand the child's day to day life was not taken. Central Bedfordshire Children's Services have identified that four home visits were completed by the Children's Centre. As the remit of the work by the Children's Centre was under an Early Help umbrella practitioners would not routinely look in bedrooms or fridges, unlike expectations if children were subject to Child in Need or Child Protection Plans. No concerns were detailed as a result of the four visits with the home environment being described as '*a bit untidy*,' and the mother's interaction with the children was warm and attentive.

4.3.4. Research[23] discusses the challenges created by Covid-19 and the proximity of workers to children and families, complicating the assessment task. Covid-19 did impact the delivery of some services, as highlighted below;

- For Bedford Hospital, providing Midwifery Services home visits were not standard practice, although during Sophie's pregnancy home visits did take place at an extended family members home. However, during Daniel's pregnancy, the mother came to the GP practice to see the Community Midwife, as a result of Covid-19. This meant that the mother and Sophie were not seen in the home context.

- For Cambridgeshire Community Services, new birth visits were prioritised above other Universal contacts within their continuity planning during Covid-19. Sophie's 4 and 6 month contacts as per the Universal Partnership Plus pathway were completed by phone in June and August 2020 respectively before a home visit a few days later. A transfer in contact was made via video call in July 2020 and the Health Visitor documented that Sophie was seen '*bright and alert, smiling and cooing*' in a clean and tidy living room. It does not appear that Covid-19 was a factor in the missed contacts between November 2021 and October 2022. Sophie's 9–12-month development review was undertaken by telephone as the mother declined video contact, reporting no connectivity/wifi on her phone, which will have limited the practitioner's ability to understand Sophie's voice through observation and interaction – although at this time, Sophie was not

[23] a) Ferguson, H., Pink, S., Kelly, L., The Unheld Child: Social Work, Social Distancing and the Possibilities and Limits to Child Protection during the COVID-19 Pandemic, *The British Journal of Social Work*, Volume 52, Issue 4, June 2022, Pages 2403 - 2421, b) McFadden, P., Ross, J., MacLochlainn, J., Mallett, J., McGrory, S., Currie, D., Schroder, H., Nicholl, P., Ravalier, J., Manthorpe, J., COVID-19 Impact on Children's Social Work Practice and Social Worker Well-being: A Mixed Methods Study from Northern Ireland and Great Britain during 2020–2022, The British Journal of Social Work, 2023.

subject to a Child in Need or Child Protection Plan. For Cambridgeshire Community Services the Covid-19 pandemic did not appear to have a significant impact on contact and involvement with the family but did result in some standard practices being completed in a different way.

- The impact of Covid-19 for Bedford Borough Children's Services has been considered; '*… When Sophie was open to Bedford virtual visits took place from April to June 2020. CIN review meetings took place face to face … It is positive that the CiN reviews for Sophie were face to face as this indicates that they were identified appropriately regarding risk …. When the case returned to Bedford in May 2021, all the visits and reviews took place face to face …*'.

- Luton Borough Children's Services recognise that the impact of Covid-19 did affect visiting, which for their involvement coincided with the beginning of the first national lockdown. As previously noted, of the 18 visits during the timeframe, 10 were completed virtually. Clearly virtual visiting did limit the extent of information gathered, such as observing the child's interactions, assessing whether there was any smell of drugs, and restricting the ability to build a rapport. When questioned about working arrangements during this time the Team Manager reflected the situation that many were dealing with '*It was a challenging time to work in. There were 1000s of people dying every day, and this caused anxiety … We did all that we could to keep a focus on safeguarding ….*'

Learning points
Police body worn video can provide extremely useful information for other agencies, especially so when working with parents that may deny or limit engagement with professionals.
Accurately identifying and recording not only children and parent's ethnicity, but other protected characteristics – age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, race (including colour, nationality, ethnic or national origin), religion or belief, sex, sexual orientation (Equality Act 2010), is an important early step to better understanding what their individual needs might be.
Tools such as 'A day in my life' can be very useful as a way of practitioners recording the child's lived experiences. The tools are designed to be used alongside parents or with children (where age and developmentally appropriate). They consist of a list of questions, or prompts, to help shape your understanding of their lived experience. They can act as a starting point for a conversation or as a useful list of questions to help form a view of the day-to-day care of a child. They can highlight areas of strength in the parenting and areas in need of development. Tools such as this, but also others like the Graded Care Profile 2, which is designed to support practitioners exercise curiosity and form judgements about neglect, can help practitioners gain confidence but also discuss difficult subject matter with parents/carers.

5. Conclusion

5.1. This CSPR has examined the contact of agencies with two children between 2019 and 2023; the review was triggered by the tragic death of the youngest child, who died aged 8 months old. It has benefitted from information being submitted by a number of key agencies involved, all of whom have reflected on their involvement with the children and their parents.

5.2. The review has identified that no one agency could have predicted the tragic outcome for the 8-month-old child. The focus of agency concern mostly centred on the male adults in the children's lives, but who were, for the greater period, absent due to being in prison; risks the children's mother may have posed to the children's safety

were not assessed in any detail. This review, alongside single agency analysis, has captured considerable learning for all partner agencies.

6. Family contributions to the review

6.1. Daniel and Sophie's mother and father were each offered the opportunity to contribute to the review; both chose not to take up this offer. An extended member of the children's family was also offered the opportunity, and did meet with the Independent Reviewer and the Business Manager for the Central Bedfordshire Safeguarding Children Partnership. Alongside hoping that learning from Daniel's tragic death can be used to make improvements to services for other children that may experience similar circumstances, four main points were expressed by the member of the family. Firstly, a clear view that both children should have remained subject to the Child in Need framework when transferring from Bedford Borough to Central Bedfordshire Children's Services, and not closed; secondly, that professionals would have had to work really hard at times to engage the children's mother in a meaningful way and that due to handovers and transitions between different workers this would have made it more challenging for professionals to maintain her engagement; thirdly, a sense that professionals would only have been told what the mother thought they wanted to hear, and the need for professionals to be more curious and rigorous in their assessments and interventions; and finally, the use of a Working Agreement with the mother by Luton Children's Services was seen as having a positive impact, and helped provide some 'rules' and structure for the mother to follow, and meant that extended members of the family were aware of expectations.

7. Recommendations

7.1. 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;

1. Disseminate the learning from this review to the workforce in all three local authority areas involved in this review.

2. To refresh and update the East of England region Children's Services joint protocol on children subject to child protection plan moving between local authority boundaries, version 6, 05/07/2021, and to include children that are subject to Child in Need processes. Further guidance should also be provided that sets minimum expectations about the quality of transfers.

3. Promote the use of 'day in the life' assessment tools to help practitioners of all disciplines, gain a better understanding about a child's experiences, and the quality of care they are receiving from parents/carers.

4. All practitioners, but especially those working in settings that deal with referrals about risks to children's safety and welfare i.e. Multi-Agency Safeguarding Hubs, should be reminded about the importance of assessing a child's age and stage of development to make an informed decision about whether a child for whom concerns have been raised, are spoken with to gain their views.

5. All three Partnerships (Central Bedfordshire, Luton & Bedford Borough) should promote awareness about the Pan Bedfordshire Procedure and Guidance in relation to Pre-Birth Planning and Assessments. Use of the guidance (frequency and quality) should be monitored and scrutinised on an annual basis.