Bedford Borough
Safeguarding Children Board

Serious Case Review

Baby Adam

OVERVIEW REPORT

FINAL – UPDATED FOR PUBLICATION

8th May 2019

Lead Reviewer

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Governance

My credentials as an independent author and reviewer are that I am currently working as a freelance Safeguarding Children Consultant after a long career in the public sector. I am registered as a general nurse, children's nurse and health visitor with the Nursing and Midwifery Council. I have prior experience as an independent serious case review author, an author of a number of single agency individual management reviews (health and social care), an independent author of commissioned single and multi-agency learning and improvement case reviews and a number of service reviews.

I declare that I have found no conflict of interest in undertaking this review and am independent to the Bedford Borough Safeguarding Children Board (BBSCB) and partner agencies. The report was commissioned by, and written for, the Board. The report and its findings were accepted by the Board in November 2016.

In reflecting the importance of accountability to the wider public, the report can now be published on the BBSCB website. The delay in publication has been as a result of on-going criminal proceedings, but this has not prevented BBSCB and its partners embedding the learning from the review. In publishing the report, the details of the child and their family, and the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

Catherine Powell
8th May 2019

Foreword

Response from the Chair of the Bedford Borough Safeguarding Children Board

This serious case review was commissioned in 2016 and concerned a serious injury to a baby known in this case review as Adam. Whilst there has been some significant delay in the ability of the Bedford Borough Safeguarding Children Board (BBSCB) to publish the full report due to ongoing criminal proceedings, I would like to reassure all that the messages, key learning points and recommendations from the report have been implemented. In addition, practice briefings were developed for front line staff and learning has been shared in other training.

The delay in publishing this case was due to an ongoing criminal case which was completed in May 2019.

This review has highlighted the importance of maintaining child-centred practice, with a focus on the child and their daily lived experiences. Behavioural observation is a vital mechanism for the assessment of pre-verbal children. Good practice was evident in this case, but this was not consistent throughout the proceedings, which need to reflect the best interests of the child at all times.

This review found some evidence of a culture of silo-working and tensions in professional relationships, due in part to a perceived hierarchy. The reported recent improvements in multi-agency working are welcome but need to be sustained and built on. Sharing the message that escalation and management of concerns is a sign of a well-functioning system, not a failure in professional practice, is critical. As chair of the BBSCB it is my role to ensure that there is effective and on-going improvement in this area that impacts positively on the safe care of vulnerable children.

Jenny Myers
Independent Chair
Bedford Borough Safeguarding Children Board

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1. Introduction

1.1 This overview report sets out the findings of an independently-led serious case review (SCR) commissioned by the Chair of Bedford Borough Safeguarding Children Board (BBSCB). It concerns Adam, a White British baby boy, born to Christian parents, who sustained serious brain trauma at the age of eight months, whilst in the care of his biological father.

1.2 Adam's placement had followed removal from his mother at birth (as she was unable to look after him) and an extended period of foster care. He had been in the care of his father for just four weeks. At the time of his injuries Adam was subject to care proceedings, with an intensive support package in place that aimed to enable him to be united with, and parented by, his father.

1.3 As a result of his injuries, which were found to have been caused by more than one episode of trauma, Adam required emergency admission to a paediatric intensive care unit at a regional hospital. In the course of this review it was pleasing to hear that Adam made good progress in his recovery and, whilst his injuries will have a lasting impact, he is now settled in a stable home.

1.4 At the time of Adam's injuries, and in order to support a period of continuing assessment of his father's parenting, Adam was subject to a s.8 Child Arrangement Order and s.38 Interim Supervision Order (Children Act 1989). This meant that there had been a number of agencies involved in the care and support of Adam and his family. These include; health services, children's social care, legal services, a supervised contact provider, a children's centre and a social housing provider.

1.5 Adam's case was discussed at the BBSCB Serious Incident Review Group (SIRG) on two occasions. After due consideration of the circumstances, the case was deemed to have met the criteria for a SCR, as defined in statutory guidance (HM Government, 2015). This is because Adam had suffered a potentially life-threatening non-accidental head injury and there was a need to review the ways in which agencies had worked together to ensure his safety and welfare[1].

1.6 In undertaking this SCR we have aimed to address the core requirements for the conduct of reviews set out in statutory guidance. These are to:

- understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- be transparent about the way data is collected and analysed; and
- make use of relevant research and case evidence to inform the findings.

  HM Government (2015:74)

[1] Regulation 5 of the Local Safeguarding Children Board Regulations 2006 5(2)(b)(ii)

1.6 There is a requirement that overview reports are written for publication in 'plain English' (HM Government, 2015:79). The content of this report aims to meet national directives to provide a succinct summary of learning, to consider wider systemic issues (as well as individual practice issues) and to demonstrate the way in which a family's history helps to understand their present vulnerabilities (Sidebotham *et al*., 2016).

1.7 This overview report opens with a short narrative chronology that summarises the key events in Adam's life that have informed the SCR. The chronology begins at the time that his mother was referred to maternity care by her GP and ends with his emergency admission to a specialist hospital.

1.8 Adam's story is followed by a brief description of the terms of reference and methodology for the review. The findings of the review are then summarised and discussed. This provides the opportunity to share good practice, as well as emergent issues for learning and improvement. The section also highlights the continuing improvement in safeguarding and child protection practice in Bedford. The final section outlines the key learning points for consideration by Bedford Borough Safeguarding Children Board.

2. Adam's story

2.1 The review was informed by an integrated chronology of agency involvement and service delivery to Adam and his family. Whilst the review timeline began with mother's pregnancy, and ended with Adam's admission to hospital, some agencies also provided details of prior contacts with his parents. Where relevant, this background was considered by the panel.

2.2 Adam's mother, who was in her early 20's at the time of his birth, appropriately attended the GP early on in her pregnancy, and this led to a timely referral to maternity services. Her lifestyle has been described by professionals as being 'chaotic'; but this description belies the multiple adversities that she has experienced.

2.3 Notably, there had been a very short interval between the birth of a previous child (who was not in her care) and the pregnancy with Adam. This is important because this meant that mother was already known to a number of services, including children's social care and health services.

2.4 At the time of her pregnancy, Adam's mother was living in temporary housing and, following contact with the multi-agency safeguarding hub (MASH), a housing officer made a referral to the social worker. This referral was accepted, and a social worker and independent reviewing officer (IRO) already involved with the family (due to the placement of mother's previous child) were allocated to manage the proceedings relating to the pregnancy and birth of Adam.

2.5 Although there was, briefly, a question-mark regarding putative father, Adam's biological father was named by mother as being the likely father of her unborn baby from the outset. Health professionals were aware of information suggesting that he was known to services following an allegation of 'inappropriate behaviour/sexual offences with a minor'. The fact that father had a significant police record that included 'numerous call outs' for domestic violence, a conviction for battery, being a suspect in a rape case and three child

protection incidents relating to the daughter of a partner, was not shared with universal services at this time.

2.6 During the pregnancy, children's social care (CSC) convened the first of two strategy discussions. The agreed actions from the meeting were for there to be a 'pre-birth assessment, an initial child protection conference' and 'parallel planning' once 'other proceedings had ended'.

2.7 A second strategy discussion took place between police and children's social care services via the telephone. Detailed information was shared regarding father's police record (as above). Crucially, police (and other agencies) had been involved in a child protection incident that occurred in 2007, when the seven-month-old infant of another partner was presented to hospital with facial injuries that were noted to be highly indicative of non-accidental injury. This injury had occurred when the baby was in the care of Adam's father.

2.8 At the strategy discussion, the social worker reported that a 'single assessment' (also referred to as a pre-birth assessment) had been completed. This appears to have been very focused on the mother, whose history was reported to 'preclude her from parenting a new baby'. There is no evidence that maternity services were invited to contribute to this strategy discussion; although there is a record that a call was made to the clinic staff by the social worker to ascertain whether mother was attending her antenatal appointments.

2.9 An Initial Child Protection Conference (ICPC) took place when mother was 32 weeks pregnant. A decision was made that unborn Adam should be made subject to a child protection plan (CPP) under the category of neglect. At the core group that followed, father reiterated that he wished to be assessed to care for the baby. However, the parenting assessment was put on hold until paternity was confirmed. A post-birth discharge plan was for Adam to initially be placed in foster-care with supervised contact with parents.

2.10 When Adam was three weeks old, a Review Child Protection Conference (RCPC) was held. The conference recorded that the supervision of father's parenting at contact would form part of the assessment. As Adam was in foster care, and had become a looked-after child, the CPP was discontinued. The health visitor recorded dissent with the decision to discontinue the child protection plan. She noted that there was a risk (born out in the placement of an older sibling) that mother could withdraw her voluntary support for the s.20 agreement in place at this time.

2.11 At a looked-after child review father reported that he had previously raised a child 'as his own' and continues to have contact with them. It was also noted at this meeting that although he had talked of a supportive role of his extended family, they were absent from a list of family members and genogram (family tree) he provided to the local authority legal services. Steps were put in place to undertake a parenting assessment of father. This was undertaken by an independent social worker (ISW).

2.12 The Court granted an Interim Supervision Order on the basis that father would continue to agree to the s.20 arrangements. The Court also directed that Adam be subject to a Child Arrangement Order to enable the father to exercise his parental responsibility.

2.13 The Judge had ordered that: 'upon all parties agreeing that if confidence increases in father's capacity to meet [Adam's] needs and keep him safe, agreement could be reached

between the parties for [him] to be moved into his father's care without bringing the matter back to Court.'

2.14 A week after the hearing, the ISW contacted children's social care to raise concerns that father 'may be saying what he thinks professionals may want to hear at any stage and there may be a disparity about how he truly feels.' Her report noted that '[father] could not parent Adam safely and that he is not able to protect [him] from other risks, such as those posed by mother.'

2.15 As a result of these concerns, the guardian and child's solicitor asked parties at a Court Management Hearing for their agreement for a psychological assessment of father to address the concerns raised. He was subsequently reported to have told his contact worker that 'it's not looking good, but I will fight for him all the way.'

2.16 The clinical psychologist who undertook the assessment found 'no reason why' father would not be able to parent Adam. The report noted that [her] contact observations had been 'very positive'. The children's guardian reviewed the two reports and the position statement of the local authority, which supported the rehabilitation of Adam to his father's care under a Child Arrangement Order and Supervision Order for 12 months.

2.17 However, at a subsequent looked after child review, the IRO recorded her disagreement with the plan for Adam to be cared for by his father. The children's guardian supported the local authority's request for a further period of assessment, although this was opposed by the parents. The Court refused to agree to an Interim Care Order and gave directions for a limited extension of the period of assessment (four weeks).

2.18 Adam moved from foster care to placement with his father towards the end of 2015 and they began attending the local children's centre for a parenting programme. Professionals initially visited daily. Father made an appointment with GP to discuss his low mood and depression and shared he was now a single parent. Although he had stated that he would receive help from his extended family, this does not appear to have been forthcoming.

2.19 When the IRO visited the home she found that father was struggling with basic tasks (shopping, preparing meals and setting up a home). Adam did not have a proper cot to sleep in (father had been loaned a travel cot by the foster parents).

2.20 During his short period in the care of his father Adam was seen by a GP with a history of a cough and wheeze. He 'seemed well' but was noted to have a 'red curved mark on his face in keeping with lying on zip of jacket.' No further concerns were raised about this.

2.21 The health visitor also carried out a home visit. Whilst Adam was meeting his developmental milestones, he was noted to be 'watchful and wary in contrast to his presentation in foster care.' His behaviour was considered to be related to his recent move and change of primary carer. The findings of the visit were shared with the social worker as part of her preparation for the Court hearing.

2.22 The ISW, who had been asked to provide an addendum to her initial report, contacted the social worker to share her safeguarding concerns. These were that father's

'ex' partner had informed her that they were in a relationship, but that he had told her not to tell social workers of this. She added that he takes Adam to her house and stays over (but not on the days he is expecting a social worker to visit).

2.23 Whilst both the ISW and the psychologist expressed concerns about father's ability to be open and work with professionals, the local authority's position was that Adam should remain in his placement with his father, as the concerns at that time did not merit his removal for adoption.

2.24 Adam and his father subsequently attended the social worker's offices to obtain a travel warrant for father to attend a planned Court hearing. The social worker observed Adam as seeming 'somewhat distant'. She also observed 'a slight bruise and puffiness beneath his left eye.' This was reported by father to have occurred when he 'banged his head on the cot'. The social worker also noted that his eyes 'did not look quite right'. A business administrator also noted that something was 'wrong with Adam's left eye' akin to a 'lazy eye'.

2.25 The Children's Centre had also been concerned about Adam's wellbeing and had signposted father to the pharmacy and to register with a local GP, in case a home visit was required.

2.26 Father told the social worker that he had taken Adam to Bedford Hospital. The social worker followed this information up with a call to the hospital and discovered that there was no record of this attendance. She also had a discussion with the children's guardian, who asked about arrangements being made for a child protection medical.

2.27 The social worker e-mailed the sessional worker who had been working with Adam and his father at home. The worker reported that 'there is nothing particularly worrying during visits ... he has always been calm and relaxed and seemingly on top of things'. She added that the day before father had turned off the buzzer for the flat to 'avoid being disturbed by random people at night' and that she had not been able to gain access.

2.28 The concerns about Adam's presentation were discussed by the social worker with the team manager, who recorded:

'A joint home visit to be undertaken by the social worker and team manager, this evening, to see Adam and for a second opinion of what was observed by the social worker and business support today; and discuss with father that we have no evidence of his attendance [at A&E] yet he has insisted that he has attended (persistent theme of him being untruthful/not open and honest).'

2.29 When the visit took place Adam was in bed, asleep, in the dark, with a light coming through the door. The manager reportedly used 'the light from her mobile phone' to examine his face. They could not see the puffiness, or turn in his eye, that had been evident earlier in the day, and they left.

2.30 The next morning Adam was taken to a childminder, so that father could attend Court. When father and Adam arrived at her home Adam was asleep in his buggy, and there was only time for a quick handover. When Adam woke, the childminder observed the 'turn' in his eye and the bruise on his cheek. He was described as being grizzly and that he

vomited. Having not met Adam previously, and not having been made aware of the concerns, the childminder assumes 'all is normal for him.'

2.31 The children's guardian, having read the transcript of the conference call with the ISW and psychologist, was of the view that a further eight-week period of assessment of father was required to assess his commitment to engage in counselling, to be open about his relationship with his partner, and to take a more immediate risk assessment of how Adam sustained the injury.

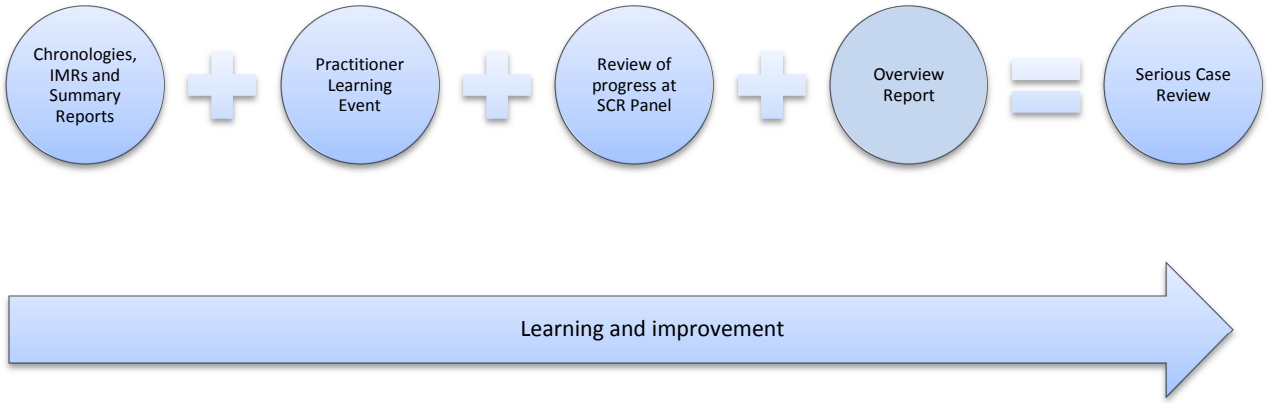
2.32 At Court, the social worker confronted Adam's father about his alleged visit to Bedford Hospital. He insisted that he had attended and described the characteristics of the doctor and nurse he had seen. The social worker asked him to take Adam to the 'doctors' to be checked. This did not happen, seemingly because father was delayed on public transport in returning to collect him. This meant that he would have missed the appointment. He told the childminder that he would ring the GP the next day.

2.33 The following morning Adam's condition was critical, and he was taken by ambulance to Bedford Hospital, prior to transfer to a regional paediatric intensive care unit. The following morning Adam's condition was critical, and he was taken by ambulance to Bedford Hospital, prior to transfer to a regional paediatric intensive care unit. The police were called and commenced an investigation.

2.34 It was quickly established that in 2007, Adam's father had been investigated for an alleged assault on an 8 month old baby, whereby facial bruising and lacerations were present. The case was ultimately filed on CPS advice due to inconclusive medical advice and lack of evidence. Adam's father had also previously pleaded guilty to domestic abuse common assault in 2007, and to a domestic abuse related offence of criminal damage in 2008. In March 2012, Adam's father had committed a further domestic abuse criminal damage offence in respect of a new partner; this led to a police caution being issued.

3. Terms of reference and methodology

3.1 A serious case review (SCR) is an independently-led, collaborative learning and improvement process and a statutory requirement in cases of serious and fatal child abuse and neglect (HM Government, 2015). The overview report is best considered to be a published summary of the key findings and learning points from the review that hold Local Safeguarding Children Boards and their partners to account. Importantly, the overview report is not an 'endpoint' in itself, the SCR is an iterative process (with a number of components) with learning and improvement continuing to be embedded after the report is published. The stages of this SCR are illustrated in the diagram below;



3.2 The Serious Incident Review Group (SIRG) had expressed their preference that this review was informed by Individual Management Reviews (IMRs) from key agencies and summary reports from others. These reports were commissioned early on in the review and, together with the integrated chronology, have made an important contribution to the findings reported here. The IMR reports were structured by the use of a pre-populated template that has been designed for local use.

3.3 Whilst a number of practitioners were interviewed by the IMR authors, the lead reviewer also met with the independent social worker and a children's centre worker and their manager. A telecom was held with the clinical psychologist. Regrettably neither parent felt able to make a contribution to the review. Foster parents met with the author of the children's social care IMR.

3.4 In addition to the reports, a Practitioner Learning Event was held. This was facilitated by the Lead Reviewer and attended by 26 practitioners (from all key agencies) and five of the IMR authors. The purpose of this event was to help to triangulate the findings from the written reports and to map out an optimum pathway (or journey) for children who cannot be placed with their birth mothers. Whilst the holding of such an event sits outside of the otherwise 'traditional' SCR, it does meet the BBSCB objective to try out new methods of learning, as recommended by statutory guidance (HM Government, 2015).

3.5 The terms of reference for this review centre on the question of whether there is a pattern in Bedford Borough of over-emphasis on the rights to a family life that may be leaving children and young people at risk. There was a need to understand why professionals felt it was appropriate for Adam to be placed with his father at the time that the decisions to do so were made. The context and learning from other local SCRs (e.g. Sophie) and national reviews that concern similar themes have formed an important focus for the analysis of the findings.

3.6 BBSCB has developed a set of generic terms of reference for serious case reviews to help to ensure comprehensive and analytical reporting and they have informed the content of this report.

3.7 The conduct of the review has been supported by a Serious Case Review Panel (SCRP) of senior representatives from the core agencies. The Lead Reviewer has chaired this panel, and has been supported by the BBSCB Manager and Secretary. The SCRP met

face to face on two occasions and members have commented on two early drafts of this overview report via secure e-mail.

4. Discussion of key findings

4.1 There is a tension in meeting the brief for a concise report, but also doing justice to the detailed IMR reports, case summaries and practitioners' insights that have informed the findings. The approach taken here has been to structure a discussion of the findings around a framework of over-arching (and cross-cutting) practice themes that will inform learning and improvement across the system.

4.2 The practice themes identified in this review relate to:

- The importance of maintaining child-centred practice
- The safe placement of infants who cannot be with their birth mother
- Professional relationships and the impact of hierarchy
- Compliance with local policies and procedures
- Workforce/organisational issues that impacted on the case

4.3 Whilst the themes are treated as 'stand-alone' for the purpose of analytical structuring, they are inter-related. Where there is good practice, over and above what would be expected, this is acknowledged. Conversely, apportioning blame to any individual is not helpful; and rarely realistic. The reality of child protection practice is that it involves the assessment of complex and dynamic risk and protective factors that need to be managed within the wider system. Where there are weaknesses in the system, these may conspire to inhibit good practice and the achievement of positive outcomes for the child and their family.

The importance of maintaining child-centred practice

4.4 We begin by considering the child in this case. The first principle of the Children Act 1989 is that the welfare of the child is paramount. Whilst it was clear from the outset that Adam's mother would not be able to parent her son (and the evidence that threshold was met for legal proceedings was established) there was considerable evidence of drift and delay in the assessment of father and permanence planning for this child. This is a significant finding of the SCR. The need to ensure a child-centred approach is the fundamental principle of child protection practice (Munro, 2011; HM Government, 2015).

4.5 In their evidence-informed framework for return to home practice, Wilkins and Farmer (2015) note the special considerations that need to be made for babies. This is that decisions need to be made 'as swiftly as possible' (p.106) to allow the child to develop a secure attachment with a caregiver.

4.6 The delay in Adam's case seems to be partly associated with workforce issues (highlighted later in the findings) but also in the time it took to begin an assessment of father, for whom, at least at the outset, very little was known. Whilst we can accept that there was, briefly, a question of paternity, this was all but resolved prior to the pre-birth strategy discussions and child protection proceedings, and confirmed when Adam was two weeks old.

4.7 At a recent[2] hearing concerning a new-born baby, Nottingham City Council v. LW and Others [2016] EWHC 11 (Fam), the presiding Judge summarised and shared his concerns about delays in proceedings, which he described as 'egregious [outstandingly bad] failures of the local authority'. He argued that (unless there was a case of 'clandestine' [hidden] pregnancy) the social work team should have all the relevant documentation for the legal department to issue care proceedings at birth.

4.8 By the time he was placed full time with his father (with whom he had had only short periods of contact i.e. 1.5 hours three times a week: with two of these sessions for 'contact' and the other for 'assessment'), Adam was just over seven months old. The author of the children's social care IMR concluded that this level of contact was not 'what would be expected for a parent who is to assume full time care of their child.'

4.9 This is important, because the extended period of time in foster care, and brief contact time with his parents meant that Adam's primary attachment would have almost certainly have been to his foster-parents. At interview with the author of the children's social care IMR, the foster father suggested 'Adam seemed to have been of secondary consideration.'

4.10 In looking at the reports and chronologies, I am curious to know why, without exception, references to Adam's paternal grandmother and aunt were to 'father's mother' and 'father's sister'. This may be seen as my being picky over semantics, but it adds weight to the foster father's suggestion noted above. It may also have reflected the superficial engagement that these individuals appeared to have had in being part of Adam's family.

4.11 One hypothesis put forward in the course of the review, is that there was an expectation at the outset that Adam would be placed for adoption. This assumption was seemingly based on the extensive knowledge and experience of agencies in permanency planning for Adam's elder half-siblings. Thus early proceedings were largely informed by information on *mother* with a lack of meaningful progress made on assessing father (and his wider family), variously reported as being due to 'the need to establish paternity' (post-birth) and father's 'initial ambivalence'. However, as a member of the serious case review panel suggested, it is possible that professionals' mindset and actions reflected their earlier involvement with the family, and that the expectation of adoption prevailed.

4.12 Once a process of assessment of was commenced, the focus appears to have been on what father did, with little reference to the needs of Adam. Those observing father's parenting of Adam (at contact, as well as once placed at home) generally reported on *father's* behaviours and actions, rather on how Adam behaved when in his father's care (and at times noted there was 'nothing to report' an astonishing finding in the observation of a rapidly developing infant and his novice father). This matters because, as Wilkins and Farmer (2015) note, behavioural observation is a vital mechanism for assessing pre-verbal children. This is an area that requires a high degree of skills, knowledge and training that includes being able to report on infant reciprocity, parental responses to an infants' cues and needs and attachment.

4.13 One notable exception to a father-centric approach (and a reflection of good practice) was the skilled assessment of the ISW. When we met she told me that she was very clear

[2] i.e. since Adam's case was initially heard in the Family Court

that father would struggle to meet Adam's physical and emotional needs. Not only had she taken a comprehensive history (including speaking to paternal grandmother and father's partner) she had observed that Adam demonstrated concerning behaviours in his father's presence, including excessive crying and evading contact. Her findings were presented to the Local Authority at the beginning of August 2015.

4.14 The ISW, who is highly experienced, told me that she does not recommend unification/reunification with parent(s) in approximately 10-20% of the cases that she assesses. She also disclosed that she had never been in a situation where her judgement was not acted on (save that it did lead to the Court commissioning a psychological assessment). This is an important finding of the review.

4.15 The legal IMR author summarised the judicial view of what was needed in a Court report as being a 'global, holistic and multi-faceted evaluation of a child's welfare, taking into account the positives and negatives and pros and cons of the options.' In this case, the options could be seen to be straightforward i.e. placement with father or adoption.

4.16 However, in reality, the decision to place Adam with his father was complicated by emergent concerns from the parenting assessments, as well as the historical information regarding his involvement in previous child protection and domestic violence incidents. How this information was *balanced* with the positives, is more difficult to determine, particularly given an apparent reliance on the self-reporting of father on matters that required a more forensic analysis.

4.17 When a decision was reached that Adam be placed with his father, this was on the basis that there would be a further period of assessment, a package of support to enable him to parent Adam, and for father to engage with counselling to address his ability to manage his relationships and depression. Nevertheless, concerns remained about father's ability to be open and honest with professionals; a factor recognised by the ISW and psychologist as a being a risk in itself.

4.18 With the spotlight on return to father, and what father required, it appears that there was a loss of focus on preparations for Adam. Whilst it was acknowledged that further delay was not in his best interests, there were some basic provisions for his homecoming that did not appear to have been in place, and should have been. These included material needs, such as bedding and flooring suitable for a baby, financial (welfare) benefits and the need to ensure that universal health services (health visitor and GP) were in place and aware of the plans in advance of Adam's move.

4.19 Whilst maintaining a child-centred approach is important in individual practice, the child at the centre is also reflected in multi-agency working, for example through a 'team around the child'(TAC). Although the TAC is more commonly associated with early-help provision, the concept is equally applicable to safeguarding and child protection practice. In Adam's case, better engagement of the professional network with the plans for his care, including the move from being 'looked-after' to a child in need plan, may have provided a more robust approach to the management of risk in the critical period that followed.

The safe placement of infants who cannot be with their birth mother

4.20 As reflected in the IMR reports, initially very little was known about Adam's father, although what was known was not necessarily shared in a timely manner (see below). It has transpired that, like Adam's mother, he too suffered a range of adversities in his own childhood, including maltreatment and rejection by his biological mother (and subsequent adoption) and a significant bereavement at a young age. The impact of this is borne out in his adult life; in his relationships with women, his depression and mood changes, his poor employment history, criminal activity and homelessness.

4.21 As a biological parent of Adam, who had parental responsibility, the fact that his father had to be considered to care for him, is not contentious, and quite appropriately, his solicitor questioned the depth of assessment being undertaken. Mother had also supported father caring for Adam; albeit her motives for doing so may include the fact that, although not in a relationship, they had known each other over a period of time and move in the 'same circles'.

4.22 The initial lack of information on father may have impacted on the time that the assessment took; but his vacillation (at least initially) over whether or not he wished to be considered as the primary caregiver for his baby son, may also have contributed to the drift and delay outlined above. However, a number of agreed actions (at child protection and legal proceedings) were not undertaken in a timely manner, leading to somewhat rushed and, at times, superficial assessment (the ISW assessment being an exception to this).

4. 23 Adam is understood to be father's first biological child, but he has reported being a 'father figure' to his partner's child. There is evidence that he has been drawn to relationships with other women with small children, some of whom are also known to children's social care. What emerged during the proceedings was that these relationships have not only featured domestic violence and abuse, but also harm to children.

4.24 As the author of the legal IMR notes, there a number of static risk factors in this case, which, whilst not being definitive for the perpetration of child maltreatment in the future, did place an additional risk that needed to be forensically examined and proactively managed through the assessment and placement of Adam.

4.25 The history that emerged during the period of assessment was, even with the benefit of hindsight, highly concerning. There was evidence that at crucial junctures (e.g. the initial child protection conference) past events were minimised or denied by father and/or not judged to be as significant as they should have been by professionals. Given the evidence base that reflects the particular vulnerability of babies to significant harm (Sidebotham *et al*., 2016) these past events should have more clearly informed the professional discourse, assessment and decision-making.

4.26 A balanced assessment of potential risk and protective factors is essential in returning [placing] children with their parent(s). It is significant that in this case there was no other parent, or family member, able to offer the additional protection to this child that is considered to be a major component of balancing risk and protection (NSPCC, 2015).

4.27 In their seminal text, Reder and Duncan (1999) discuss theoretical frameworks for assessment of individuals. In doing so, they promote the principles of an interactional framework that 'portrays individuals as existing in relation to other people and functioning in

a social and relational context' crucially adding that 'their history helps to describe who they are' (p.101).

4.28 The impression gained, on reviewing this case, is of father as an individual with a known history of abusive and dysfunctional relationships, marginalised by, and alienated from, his wider biological and adoptive families. Added to this, was the broader social context of exclusion related to poverty, worklessness and housing issues.

4.29 In addition to this highly concerning history and background, father's ability to make a nice home for Adam was brought into sharp focus by the report from the IRO who undertook a visit shortly after the placement commenced. These findings were echoed in my discussion with the children's centre worker who undertook a joint home visit with the social worker on 11th November 2015 to offer advice on home safety. She described the flat as being 'stark' and looking 'more like somewhere that someone dossed in', rather than a warm and welcoming home for a baby.

4.30 Whilst the psychologist's report was more favourable than that of the ISW, she did report that she too had concerns about father's ability to be open and honest and the impact that this would have on his parenting. Furthermore, because of drift and delay, she reported a tight timescale for the report's completion, an absence of background information, no sight of father's requested medical records and thus a reliance on father's self-reporting of his history and psychological well-being.

4.31 Children's social care does not have data on the numbers/percentages of children who are placed with their father as sole carer; but it is likely to be a relatively rare occurrence. In the United Kingdom, 25% of families with dependent children are headed by a lone parent. Fathers are said to comprise just 10% of these families (Office National Statistics, 2015). Their minority status may provide a hurdle to those who are seeking to assess and monitor parenting when their children are subject to care proceedings. Such challenges may reflect a lack of professionals' experience in working with lone fathers, both in general, and in cases that are subject to statutory proceedings.

4.32 A study of violent men involved in child protection cases in one English local authority is of relevance here. It was found that, in many cases, information about men was not systematically gathered or recorded by social workers, and that there was a lack of contact with them. The study also found that little attention was paid to men's practical caring skills (Baynes and Holland, 2012). It seems, therefore, that parental gender may continue to challenge professionals, and thus the more recent work of the NSPCC in promoting fathers' roles is worthy of a mention here, for further reference (Hogg, 2014).

4.33 An SCR in a neighbouring authority strongly resonates with the current review (Peterborough Safeguarding Children Board, 2015). After a period in foster care, 'Child J' (also a young baby) was placed at home with his father, with a package of intensive support arranged. Similarly to Adam's father, this father's history and background reflects significant adverse childhood experiences, criminality, domestic violence and mental health issues. A month after placement, Child J presented with facial bruising and other injuries that led to his removal.

4.34 The Child J overview report highlights concerns about the assessment and analysis of the potential risks posed by Child J's father, as well as missed opportunities resulting from

poor engagement across professional networks. As in Adam's case, the pre-birth assessment was reported to have focused on J's birth mother, with father described as a 'peripheral figure' at this time. Crucially, the overview author concluded that there had been 'over-optimism' by professionals on the likelihood of a successful placement of a 'fragile and totally dependent baby'. It appears that, whilst acknowledging that there was some professional dissent in placing Adam with his father, the 'rule of optimism' (Dingwall *et al*., 1983) may also have been evident in his case.

4.35 Of additional interest, is that in Child J's case, there was a proposal for the father's parenting assessment to be undertaken in a supervised residential placement. However, in practice, Child J was assessed in the community. The question of the potential benefit of a residential placement for fathers was raised in the current review. However, it is apparent that such placements are generally provided for mother and baby assessments. This may be an issue that is of wider interest nationally.

Professional relationships and the impact of hierarchy

4.36 One of the striking features of this case is that there were many professionals and support staff involved in providing care to Adam and his family. However, there is evidence of significant gaps in information-sharing, information seeking and communication between agencies, as well as questions about the degree to which the skills and expertise of different disciplines was utilised to best effect.

4.37 Examples include:

- The partial sharing/seeking of information on father's history and the absence of shared and robust multi-agency analyses of the known risks
- The weaknesses/gaps in the threshold document concerning father placed before the Court
- The health visitor being unaware that Adam had been discharged from hospital to foster-care (finding this out from his mother when calling to arrange a new birth visit)
- The police reporting not having Adam's paternity confirmed on their records until 'several months' after his birth
- The father's GP's being unaware that a clinical psychologist's report on father was being undertaken and not having notice of Adam's planned placement with his father (until informed by father at a consultation that he was now a single parent)
- The health visitor not being updated about plans for Adam's placement with his father, despite providing ongoing universal health services (well-baby and developmental checks and looked after child health reviews)
- The IRO not being given advance notice of the plan to place Adam with his father on 20th November 2015
- The apparent lack of challenge on the context for various enquiries that may have led to a shared analysis of presenting factors (e.g. the social worker seeking information about whether or not Adam had attended Bedford hospital)

4.38 The gaps highlighted above are also illustrative of the question of how professional expertise and practice experience was captured and utilised. As borne out at the practitioner event, one example here is the untapped potential of the expertise of health visitors in supporting parenting assessments (also a finding of the Child J SCR discussed above).

4.39 The apparently superficial engagement between the social worker and health professionals may have been due to her reported inexperience in undertaking community-based assessments. However, it is also important to recognise that 'health' comprises a confusing array of discrete organisations that may be difficult to navigate by an 'outsider'.

4.40 The impact of professional hierarchy (both real and apparent) is also notable in this case. There is a perceptible inverse relationship between those who had the most contact with Adam and his parents, and the esteem placed on their contribution to decision-making. An example here is the potential for the observations of contact and sessional workers to be more robustly and proactively sought, albeit this needs to be supported by high-quality supervision (and potentially more training) to ensure that this contribution is child-centred and meaningful.

4.41 It was interesting to hear at the Practitioner Learning Event of some professionals feeling 'unable to challenge social care'. This is at odds with recognised good practice in safeguarding children, which rests on an ability to demonstrate professional curiosity, respectful uncertainty, and the ability to challenge both parents and other professionals (Tuck, 2013).

4.42 Professional disagreement is not uncommon in the complexity and emotion of child protection practice; escalation and management of concerns is a sign of a well-functioning system, not a failure in professional practice (Sidebotham *et al*., 2016). The effective use of challenge, and of escalation of concerns, in the context of Adam's case, is worthy of some discussion.

4.43 Notably, the IRO sought to find ways to express her disagreement with the plan to place Adam in the care of his father. Escalation of her concerns led to an urgent legal gateway meeting and clarification of what the concerns regarding father were, as well as a further submission that stated that the local authority did not believe that Adam could be safely placed with his father on a permanent basis without there being a robustly monitored plan, further assessment, and an Interim Care Order (ICO) to safeguard Adam.

4.44 The changed position of the local authority was challenged by the Court, and although the judge agreed to a short period of supervision for further assessment, there was no agreement to an ICO. The ruling created a rush to place Adam in his father's sole care, without preparations for his return being completed. This included ensuring the timely notification and involvement of the wider professional network.

4.45 Once Adam was placed with his father, he ceased to be a 'looked-after child'. However, the IRO (who, as noted above, was not informed in advance of Adam's placement) decided to go ahead with the final looked-after child review meeting on 27th November 2015 (the original plan for placement being the end of the month). By this time the IRO had undertaken a home visit. She recorded her disagreement with the plan at this meeting (as documented in 2.17 above).

4.46 The children's social care IMR author notes that, whilst the IRO expressed disagreement with the plans, she did not use the escalation policy at this time, as she had already done this, leading to the local authority changing its position. However, his view is

that the policy may also have been used to raise concerns about the fact that she was not informed of the decision to bring his placement forward.

4.47 Equally, others in the professional network (e.g. GP, health visitor, housing provider) were not made aware of the timing of the placement, nor were they proactively engaged in the assessment and support of Adam and his father. They too could have escalated their concerns to their manager/safeguarding lead in line with established inter-agency procedures. This brings into sharp focus the concerns raised above about some professionals feeling unable to challenge children's social care.

4.48 A view held by a number of contributors to this review is that it might have been better if Adam had moved from being a 'looked-after child' to being made subject to a child protection plan. The rationale for doing so rested on the continuing concerns about his safety, but also the fact that this would have led to multi-agency involvement. Furthermore, the dual role of the IRO in Bedford (IRO/Child Protection Conference Chair) would have enabled some continuity and oversight of his welfare.

4.49 This view is understandable. However, multi-agency engagement should not be predicated on statutory intervention alone, but rather on a collegiate approach to the care of families with additional needs. This approach would engender an appreciation of the roles and responsibilities of all parties and the opportunities to ensure broader safeguarding practice (for example 'early help').

4.50 This section concludes by considering the importance of case supervision as an integral component of authoritative child protection practice. There was evidence from contributing agencies that the arrangements for supervision were not as robust as they should have been. Supervision is important because it enables a critical reflection on what is happening in a case and provides a safe space for practitioners to (in the words of the children's social care author) 'play their own devil's advocate'. Importantly, this allows for changes of plans as new evidence becomes available over time.

Compliance with local policies and procedures

4.51 At the time of mother's pregnancy with Adam, the BBSCB Pre-birth procedures and assessment tools were being developed, and these were implemented in July 2015. Their application may have helped to ensure a more robust response to unborn Adam's needs and the planning of his care (albeit the *timing* of referrals to MASH/children's social care, strategy discussions and ICPC were commendable). However, there were fundamental gaps in compliance with existent local and national policies and procedures that are examined in this section.

4.52 The first concerns the conduct of strategy discussions. These can take place face to face (which is clearly preferable) but also by telephone 'in an emergency'. A record should be made which clearly set out actions and timescales and responsibility for completion. The statutory guidance requires that:

'A local authority social worker and their manager, health professionals and a police representative should, as a minimum, be involved in the strategy discussion. Other professionals will depend on the nature of the individual case.' (HM Government, 2015:37)

4.53 In this case there were two formal strategy discussions in the pre-birth period. The first was tripartite, as it involved children's social care, police and a midwife. However, given that the initial focus was on the risks posed by mother, her mental health worker should have also been in attendance to provide advice (even if this was to discuss the impact of her disengagement with the service).

4.54 The subsequent strategy discussion (which included a conversation regarding putative father) was between children's social care and the police, although there appears to have been an attempt by the social worker to gather information about mother's engagement with health care (by calling the antenatal clinic to check she had been attending). This was a missed opportunity to more meaningfully gain the professional input of a midwife and a health visitor.

4.55 Also of concern is the conduct of the Initial Child Protection Conference that was held in February 2015. This was attended by parents, a friend of the parents, a social worker, health visitor and midwife. It was chaired by an IRO/Conference Chair. Police, GP, housing and mental health services sent apologies, although the health professionals did send reports. No report was received from the police, although one was subsequently found on file by the police IMR author. Parents had not had time to review the reports prior to the conference, as would be expected practice.

4.56 According to BBSCB procedures, this ICPC was not quorate; it should, therefore, have been postponed. This is because it did not meet the requirements for the presence of 'children's social care and at least two other agencies with direct contact with the child.' This meant that father (and apart from the certain proof of the paternity test, he was there as 'father') was not able to be adequately challenged in his (untruthful) defence of his criminal history in this crucial forum.

4.57 Attendance at child protection conferences is an issue that concerns busy practitioners and their managers, especially if there has been no direct contact with the child and/or family. However, the sharing of multi-disciplinary knowledge and professional expertise at conference is 'bigger than the sum of its parts' (Aristotle). This is recognised by the BBSCB procedures in terms of expected attendance reflecting 'expertise relevant to the case and/or knowledge of the child and family'. Conference attendance and compliance with the procedures will be taken further as a learning point for the Board.

4.58 One of the most concerning aspects of this review, however, are the events of the 16th to 18th December 2015. It is difficult to express my thoughts on these events dispassionately. It is important that lessons are learned, and shared, and that all practitioners and managers who work with children and families respond appropriately to the presence of bruising in an infant and concerns that a child is suffering, or at risk of suffering significant harm.

4.59 Adam's presentation with clear indicators of a potential non-accidental head injury (National Collaborating Centre for Women's and Children's Health, 2009) was seemingly recognised by a 'lay' person (the administrator) as well as by the social worker. The response, however, was inadequate at a number of levels, and failed to follow the very clear tri-borough procedures on the management of bruises, bites and suspicious marks in children (Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards, undated).

4.60 This concerning presentation in the context of father's history, and false claims of seeking treatment, required urgent assessment by means of a child protection medical, police involvement and the commencement of s.47 enquiries, as detailed in the Children Act 1989 and statutory guidance (HM Government, 2015). It was not appropriate to ask father to make an appointment for Adam to be seen by a GP. As the tri-borough procedures clearly emphasise:

'In light of research, guidance and learning from serious case review an unexplained bruise/mark/bite must be assessed by a paediatrician. ***Do not refer to a GP***.'

4.61 An already grave situation was exacerbated by an inadequate and misguided response to the signs of non-accidental head injury. Children's social care has addressed the poor practice of the practitioner and her manager through formal processes. However, it is also notable that a number of other individuals involved in Adam's care and/or present at the Court hearing on the 17th December 2015 did not take the opportunity to ensure a proportionate and timely response to a highly concerning presentation.

Workforce/organisational issues that impacted on the case

4.62 Systemic issues inform the context for practice. During the timeline for this review there was evidence to suggest that practitioners were feeling the impact of workforce shortages, restructuring and new information-systems. Some staff faced the possibility of redundancy, with resultant low morale. There is a strong likelihood that these issues had a bearing on this case.

4.63 Workforce shortages due to sickness, maternity leave and/or restructuring were reported by children's social care, legal services, police and community health services. Where possible the resulting gaps were variously covered through the use of locum staff and, in the case of legal services, by outsourcing work to a neighbouring borough. This is good practice. However, it is apparent that there were, at this time, significant pressures on practitioners and their managers, resulting in high caseloads, sub-optimal supervision and reduced management oversight of case progress that contributed to drift and delay.

4.64 More fundamentally, during the timeline, both children's social care, and legal services, were undergoing significant organisational change and restructuring. For children's social care this meant that there was a short term loss of experience and organisational knowledge. A number of interim senior managers were appointed. It is notable that, in Adam's case, both the allocated social worker and her manager were locums.

4.65 There is a national shortage of social workers. The use of locum social workers is therefore not uncommon. Although there is reportedly a negative perception of their contribution, in many cases this is unfounded (Brody, 2014). Similarly to any other post, good practice in recruitment, induction, and the provision of continuing professional development, support and supervision for locum social workers is critical to their success.

4.66 Familiarisation with records systems is an important aspect of induction. Health, children's social care and legal services all reported challenges in the introduction of new electronic case records systems. For health (which we have already noted as being a confusing array of discrete organisations) these challenges relate to the differing levels of access to *SystmOne*, which ironically aims to provide a unified view of patients' health records for all clinicians. In children's social care, the introduction of a new system *Azeus* was beset with teething problems and questions on functionality. These issues are being addressed.

4.67 The situation concerning case records kept by legal services appears to be more complex. Records were variously kept on an electronic system called IKEN, or as paper records, or on Outlook. The view of the legal services IMR author was that the use of paper and/or electronic recording rested on the personal preference of the solicitors, but possible gaps in recording were also highlighted. Staff spoken to identified a training need in using the electronic system. The legal IMR identified the need for all records to be accessible and complete in one place.

4.68 In addition to commentary on issues for individual organisations, it is important to consider the child protection system in Bedford Borough as a whole. Evidence was shared and gathered during the course of the review of an improving picture. Most notable are the changes that are being brought about through the work of the Bedford Borough Children's Services Improvement Board, which was established in December 2014. These are reported to include improvements in leadership and the stability of the children's services workforce, in performance management and in better outcomes for children. A peer review undertaken in September 2015 reported improvements in inter-agency working (BBSCB, 2016a).

4.69 Consideration of current and recent local serious case reviews provides a critical 'window on the system'. The case of 'Sama' (BBSCB, 2016b) reflected a similar timeframe to that of Adam's review. As in his case, there were reports of excessive workloads within children's social care, as well as evidence of the improving picture. Similarly, to Adam, there were findings of poor engagement of the professional network, inquorate child protection conferences and gaps in professional supervision. The information regarding father's criminality and history of domestic abuse was not seen to have been adequately risk assessed. Escalation of concerns from health to children's social care, whilst persistent, did not achieve a satisfactory resolution.

4.70 The learning points from the Sama review included (amongst others): the need to embed the pre-birth assessment procedures and practice guidance; to use knowledge of the dynamics of domestic abuse to inform practice; and to understand, record and use criminal history and background information. The concurrency of the Sama case with this review meant that BBSCB and partners were already engaged in relevant improvement activities.

However, recommendations for further developments in practice in line with the findings of Adam's review are made at the end of this report.

4.71 Although commissioned by a neighbouring authority, a high-profile serious case review concerning 'Sophie' (who was killed by her father) involved BBSCB because this child spent time living with her family in Bedford, and the local authority was involved in decisions about her care (Hertfordshire Safeguarding Children Board, 2016).

4.72 There are similarities with Adam's case, and Sophie's, in that this was a child who was placed in the permanent care of her father by the courts. There were also findings in common in the review. These include a limited assessment of father, whose self-reporting of his history and background (which included perpetration of domestic abuse) were apparently accepted without a forensic approach and triangulation of evidence. There were also limitations in face to face discussions with family members and ex-partners. There was a report of inadequate attention given to the likely stress of being a single parent and of considering the significance of his mental health issues. There were said to be gaps in the provision of high-quality supervision for staff and in management oversight of the case.

4.73 There was an apparent blurring of the roles and remit of the ISW, which was noted to contribute to gaps in the input of the local authority social worker, and in the assessment of the child's needs. Contact between father and daughter was said to be focused on father, with limited reference to Sophie's needs. Not enough attention was given to her disturbed behaviour following contact.

4.74 The principle finding of the Sophie case was that 'assumptions about the rights of the birth family within family Court proceedings contributed to acceptance of a limited assessment and a lack of focus on the needs of the child' (Hertfordshire Safeguarding Children Board, 2016:16). In undertaking Adam's review, we were asked to specifically consider whether over-emphasis on the rights to a family life may be leaving children and young people at risk.

4.75 Compared with Sophie's case, where there was an apparent consensus within the professional network that she be placed with her father, placement of Adam with his father did not go unchallenged. I would consider that the risks to Adam arose not because there was an emphasis on a 'right to a family life', but because of the quality of assessment of father (including his support network), and in the timely and comprehensive provision of information regarding threshold [for proceedings] to the Court.

4.76 As seems to have been apparent in Adam's case, the SCR for Sophie recognised that practitioners find the legal processes 'daunting'. Court skills training is currently being rolled out to social workers and team managers in Bedford to help to address this. There is a need to try to resolve cases in 26 weeks. However, the assistant director of children's social care services is supporting his staff to ask for an adjournment to be granted if they feel unable to make a decision, or if their decisions are over-turned, so that they can liaise with their head of service, or himself. This is a positive way forward in supporting practitioners in making the complex decisions that inform the safe placement and care of children.

Summary

4.77 This section has presented the key findings from the review. A thematic framework has been used to structure the discussion, reflecting cross-cutting issues concerning the importance of maintaining child-centred practice; the safe placement of infants who cannot be with their birth mother; professional relationships and the impact of hierarchy; compliance with local policies and procedures and workforce/organisational issues that impacted on this case.

4.78 Suggested learning points for consideration by BBSCB follow. These take account of the developments that are already in progress. They also draw on the suggestions from the Practitioner Learning Event held in September 2016, which both reflected the positive direction of travel and a renewed commitment to work together to improve safeguarding and child protection practice in Bedford Borough.

5. Learning Points for consideration by Bedford Borough Safeguarding Children Board

5.1 This review has highlighted the importance of maintaining child-centred practice, with a focus on the child and their daily lived experiences. Behavioural observation is a vital mechanism for the assessment of pre-verbal children. Good practice was evident in this case, but this was not consistent throughout the proceedings, which need to reflect the best interests of the child at all times.

a. How can the Board gain assurance that all those involved in the assessment, contact and supervision of parenting have the skills, knowledge and training that enables them to report on infant reciprocity, parental responses to an infants' cues and needs and attachment? How are the views of these practitioners utilised and valued? What quality assurance mechanisms are in place?

b. To help to guard against drift and delay, and the impact that this has on the child, could the practitioner generated 'optimum pathway for any child who cannot be with their birth mother' be further refined and adopted as an annex to the Pre-birth procedures?

5.2 The safe placement of an infant who could not be with their birth mother is central to this review. The decision to place Adam with his biological father was complicated by emergent concerns from the parenting assessments, as well as historical information regarding his involvement in previous child protection and domestic violence incidents.

a. In conjunction with recommendation five of the recently published Sophie SCR (Hertfordshire Safeguarding Children Board, 2016), the Local Family Justice Board should be asked to question whether the pressure to avoid delay/further delay in proceedings is preventing the critical analysis of concerns about parents/carers that emerge during the assessment process.

b. How has learning from good practice in the care of birth mothers whose children are removed (e.g. Pause project, Broadhurst *et al*., 2015) impacted on the services provided in the Bedford locality?

c. Should the pre-birth procedures and assessment tool be revised to more clearly articulate the early assessment of fathers (or other family members), when there are indicators that removal of an infant from their birth mother is a likely outcome?

d. Given the marginal difference in the cost of non-invasive pre-birth, rather than post-birth DNA testing, can the Board recommend that this is funded in cases where it is necessary to determine the paternity of an unborn infant?

e. How can the lay/faith member of the Board seek to engage communities (e.g. the Church) in supporting vulnerable parents and children in the absence of help from family and friends? How can this support be monitored and assured?

f. What is the national picture regarding 'father and baby' residential placements? Is this something that should be escalated to policy makers?

5.3 This review found some evidence of a culture of silo-working and tensions in professional relationships, due in part to a perceived hierarchy. The reported improvements in multi-agency working are welcome, but need to be sustained and built on. Sharing the message that escalation and management of concerns is a sign of a well-functioning system, not a failure in professional practice, is critical.

a. Do the local providers of professional education programmes (e.g. nursing, social work) offer inter-professional learning as part of the curriculum? How do services in Bedford induct new staff into their roles and responsibilities, including promoting an understanding of the wider children's workforce?

b. Should the Board and its partners initiate a programme of job-shadowing opportunities with the aim of building capacity, improving relationships, and developing a clearer appreciation of each other's contribution? Is this a role for the BBSCB Frontline Practitioners' Group?

5.4 As part of the programme of improvement, the factors that have affected compliance with local policies and procedures are being addressed. The quality assurance of child protection and legal proceedings now includes expectations of attendance, purpose of meeting and the timeliness of reports and distribution of minutes. ICPCs are held on the same day each week and this aids the planning of attendance (e.g. by the police). The *Management of bruise, bite and suspicious/unexplained mark in children* is now a 'stand-alone' chapter of the procedures.

a. What strategies (beyond their training function) do the Board and its' partners use to promote awareness and accessibility of their child protection procedures across the wider children's workforce?

b. How is this monitored and evidenced?

5.5 The workforce and organisational issues that impacted on this case have been/are being addressed. However, it is important that the BBSCB maintain an oversight and are in a position to recognise and respond to the impact of pressure points in one organisation on others in the system.

a. How does the Board monitor vacancies within the children's workforce and seek assurance of good practice in recruitment, induction, and the provision of continuing professional development, support and supervision for all staff, including those in locum/temporary positions?

References

Baynes, P., Holland, S. (2012) Social Work with Violent Men: A Child Protection File Study in an English Local Authority *Child Abuse Review* 21: 53- 65

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards *Procedures Manual* http://bedfordscb.proceduresonline.com/chapters/contents.html [accessed during the review period]

Bedford Borough, Central Bedfordshire and Luton Safeguarding Children Boards (undated) *Management of bruise, bite and suspicious/unexplained mark in children* BBSCB.

Bedford Borough Safeguarding Children Board (2016a) *Annual Report 2015-2016* BBSCB.

Bedford Borough Safeguarding Children Board (2016b) *Serious Case Review Overview Report relating to Baby Sama* BBSCB (published on 4th April 2017).

Broadhurst, K., Alrouh, B., Yeend, E., Harwin, J., Shaw, M., Pilling, M.,Mason, C., Kershaw, S. (2015) Connecting Events in Time to Identify a Hidden Population: Birth Mothers and Their Children in Recurrent Care Proceedings in England *British Journal of Social Work* 45: 2241-2260.

Brody, S (2014) *Social workers twice as likely as the general population to work as locums, study reveals* http://www.communitycare.co.uk/2014/10/27/social-workers-twice-likely-general-population-work-locums-study-reveals/ (accessed 7/11/16)

Dingwall, R., Eekalaar, J. and Murray, T. (1983) *The Protection of Children: State, Intervention and Family Life*. Oxford: Blackwell.

HM Government (2015) *Working Together to Safeguard Children: a guide to inter-agency working to safeguard and promote the welfare of children* London: DfE.

Hertfordshire Safeguarding Children Board (2016) *Serious Case Review Sophie* HSCB

Hogg, S. (2014) *All Babies Count: The Dad's Project* London: NSPCC.

Munro, E. (2011) The Munro Review of Child Protection Final Report: a child-centred system. London: The Stationery Office.

National Collaborating Centre for Women's and Children's Health (2009) *When to Suspect Child Maltreatment*. London: RCOG Press.

NSPCC (2015) *Returning children home from care: learning from case reviews Summary of risk factors and learning for improved practice for reunification* https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/returning-children-home-from-care/ (accessed 6/10/16)

Nottingham City Council v. LW and Others [2016] EWHC 11 (Fam)

Office for National Statistics (2015) *Families and Households 2015* http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/families/bulletins/familiesandhouseholds/2015-11-05 (accessed 2/11/16)

Peterborough Safeguarding Children Board (2015) *Child J Overview Report* PSCB.

Reder, P., Duncan, S. (1999) *Lost Innocents: A follow-up study of fatal child abuse*. London: Routledge.

Sidebotham, P., Brandon, M., Bailey, S., Belderson, P., Dodsworth, J., Garstang, J., Harrison, E., Retzer, A., Sorensen, P. (2016) *Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014* London: Department for Education.

Tuck, V. (2013) Resistant parents and child protection: knowledge base, pointers for practice and implications for policy. *Child Abuse Review* 22:5-19.

Wilkins W, Farmer, E. (2015) *Reunification: an evidence informed framework for return home practice* London: NSPCC.

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Adam's parents were also invited to contribute to the review, but regrettably, neither parent was able to do so. Their thoughts on the services and support available to them would have been valuable in learning from the events that have led to the removal of their son from their care. I have asked BBSCB to ensure that the learning from the review is shared with them at the earliest opportunity.

Catherine Powell
29th March 2019