# Hertfordshire Safeguarding Children Board

# Serious Case Review

# Sophie

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**11.05.2016**

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# 1 Introduction

## 1.1 The reason for this serious case review

1.1.1 This serious case review concerns the death of a four year old girl (known throughout this report as Sophie) who was killed by her father in March 2014. He was convicted of her murder in May 2015, sentenced to life imprisonment and ordered to remain in prison for 21 years before being considered for release.

1.1.2 Sophie had previously been removed from her mother's care by Bedford Borough Council and placed with foster carers. Four months before her death, Luton County Court had granted Sophie's father a Residence Order and she moved in with him at the end of December 2013. Sophie's father lived in Hertfordshire and a Supervision Order was made by the Court to Hertfordshire County Council.

1.1.3 Statutory guidance[1] requires that when a child has died and abuse or neglect is known or suspected, the Local Safeguarding Children Board must carry out a serious case review. As Sophie was resident in Hertfordshire at the time of her death, the chair of the Hertfordshire Safeguarding Children Board commissioned this review. Although led by Hertfordshire Safeguarding Children Board the review has taken place with full cooperation from Bedford Borough Safeguarding Children Board.

## 1.2 Agencies and geographical areas involved with this review

| AGENCY | ROLE |
|---|---|
| **Agencies linked to Bedford Borough Council area** | |
| Bedford Borough Council Children's Services | Provision of social work services to Sophie and her siblings.<br>Independent Review of plans for Sophie whilst she was placed with foster carers. |
| Bedford Borough Council Legal Department | Legal advice and services to the Local Authority in relation to public law proceedings for Sophie and her siblings. |
| Independent social work service | Provision of expert assessment for the Court in relation to Father's parenting capacity. |
| Independent fostering agency | Provision of foster carers for Sophie and her siblings. |
| Community pre-school | Pre-school in area where foster carers lived (unnamed unitary authority). |
| Cafcass | Provision of children's guardian for the Court proceedings in respect of Sophie |
| Community Health Trust | Provision of community health services in the area where the foster carers lived |
| Bedfordshire Police | In relation to an incident in November 2013 |

[1] Working Together to Safeguard Children 2013 (updated in 2015)

| Agencies linked to Hertfordshire County Council area | |
|---|---|
| Hertfordshire County Council Children's Services | Provision of social work service to Sophie and her siblings, prior to her mother's move to Bedford Borough.<br>Provision of social work service to Sophie's half-brother Joe.<br>Provision of social work service to Sophie after a Residence Order was awarded to her father.<br>Provision of children's centres.<br>Provision of nursery school for Sophie. |
| Hertfordshire County Council Legal Department | Legal advice and services to the Local Authority in relation to proceedings for Sophie and for Joe |
| Hertfordshire Community NHS Trust | Health visiting services. |
| Hertfordshire Partnership University Foundation Trust | Mental Health services for Father. |
| NHS England | GP and primary care services |
| Hertfordshire Police | Involvement in domestic violence allegations against Father in relation to Sophie's and Joe's mothers |

## 1.3 Review methodology

1.3.1 Once the decision to carry out a serious case review had been made careful consideration was given to the best method of conducting the review taking account of the principles set out in statutory guidance at the time. A further consideration was the ongoing criminal investigation.

1.3.2 A review panel consisting of senior managers from Bedford Borough Council and Hertfordshire County Council was appointed and chaired by Keith Ibbetson, Independent Consultant and standing chair of the Hertfordshire serious case review subcommittee. Two experienced independent lead reviewers, Edi Carmi and Jane Wonnacott were commissioned to work with the panel to carry out the review and produce the final report.

1.3.3 The panel received reports from most of the agencies identified in section 1.2 above. Information was gathered directly through conversations between the lead reviewers and the foster carers, the foster care agency, the pre-school Sophie attended when she was living with her foster carers and the children's centres in Hertfordshire.

## 1.4 Scope and terms of reference

1.4.1 The full terms of reference are set out in the appendix of this report.

## 1.5 Family involvement

1.5.1 Family members contributed to this review through meeting with the lead reviewers:

- Sophie's mother, maternal grandmother and aunt,
- Sophie's father,
- the mother of Sophie's half-brother Joe.

## 1.6 Practitioner involvement

1.6.1 Practitioners participated in the process through:

- interviews with the authors of the individual agency reports,
- lead reviewers meetings with staff groups:
  - children's centre
  - pre-school in the unnamed unitary authority
  - nursery school in Hertfordshire
  - social workers in Bedford Borough, Hertfordshire and the independent social work agency
  - all practitioners involved with the family
- lead reviewers' individual meeting with:
  - foster carers
  - supervising social worker
  - ex member of staff from Bedford Borough Council

# 2 Summary of what happened

## 2.1 Introduction

2.1.1 This serious case review concerns the death of a four year old girl killed by her father in March 2014. This was less than three months after she moved to live with him following the decision at Luton County Court to grant him a Residence Order. The child's father was convicted of her murder in May 2015.

2.1.2 The child, called Sophie for the purposes of this review, was one of a sibling group of three children. Sophie was born in Hertfordshire, where there were concerns for the children in the family because of domestic violence incidents relating to the mother's partners. This included a violent incident with Sophie's father, which was reported to police and children's social care. Mother was advised by children's social care to separate from Father.

2.1.3 Mother and siblings moved to Bedford Borough and from this point there was only one further contact with Sophie's father whilst Sophie lived with her mother.

2.1.4 Bedford Borough Council removed all three siblings from their mother in March 2012, due to mother's continuing chaotic lifestyle, substance misuse and domestic violence in the home. An interim care order was obtained and Sophie and siblings placed together with foster carers in another unitary authority.

2.1.5 When care proceedings are initiated, other family members must be considered as potential alternative carers; consequently Sophie's father was located, expressed a wish to be her carer and became subject to an assessment. By this point he had been involved in another relationship and had another child, called Joe for the purposes of this serious case review. The father and Joe's mother lived in Hertfordshire, but did not live together. Joe lived with his mother, but had regular contact with his father.

2.1.6 This review relates to a complex set of circumstances involving two family groups, two local authorities and foster carers residing in a third area. One of the local authorities is a large shire county and the other two are unitary authorities covering much smaller geographical areas.

2.1.7 In order to assist the reader, the table below sets out the relationships and names used in the report. These are not the real names of the individuals concerned.

| Term used in report | Relationship with Sophie | Age at March 2014 | Home address in March 2014 |
|---|---|---|---|
| Sophie | Subject of review | 4 years | Hertfordshire |
| Sophie's mother or Mother | Mother of Sophie | | Bedford Borough Council |
| Sophie's father or Father | Father of Sophie | | Hertfordshire |
| Siblings | Maternal half siblings | | |
| Joe | Younger paternal half sibling | 21 months | Hertfordshire |
| Joe’s mother | Mother of paternal half sibling | | Hertfordshire |
| Joe's siblings | Joe's maternal half siblings | | |
| Foster carer/s | The people Sophie and her 2 maternal half siblings lived with prior to Sophie's move to her father | | Unnamed 'Unitary authority' |

## 2.2 Summary of key events

2.2.1 The following table provides the key events within Bedford Borough and Hertfordshire County Council.

| | Bedford Borough | Hertfordshire |
|---|---|---|
| 2009-2010 | | Mother pregnant with Sophie. Living in Hertfordshire. Domestic violence incidents relating to partners included a violent incident with Father reported to police and children's social care. Mother was advised by children's social care to separate from Father and his contact with Sophie ceased in Hertfordshire. |
| 2010 | Sophie born and lived initially in Hertfordshire with Mother and elder half sibling before the family moved to Bedford Borough. Mother was advised by children's social care to separate from Father and mother and children subsequently moved to Bedford Borough. Father's contact with Sophie ceased in Hertfordshire. | |
| 2011 | | Father began a relationship with a new partner, another woman with children. |
| March 2012 | Sophie and siblings placed with foster carers and care proceedings initiated by Bedford Borough Council. | |
| June 2012 | | Joe, Father's child with his new partner was born in Hertfordshire. Parents separated in August. Joe remained with his mother but had regular contact with Father. |
| November 2012 | Father became party to the care proceedings in respect of Sophie after DNA tests confirmed his paternity and the Court ordered there should be an assessment of his suitability to parent. | |
| January 2013 | | Domestic violence incident between Father and Joe's mother led Hertfordshire social work team 1 to undertake assessments of Joe's welfare: The case was "stepped down" to a CAF[2] when assessments ended in March 2013. |
| February 2013 | Expert assessment of Father commenced in early February, followed by the first contact session between Father and Sophie later that month. | The social worker for Joe in Hertfordshire social work team 1 became aware that Father was being assessed as prospective carer for Sophie. |
| March 2013 | Father's psychiatrist became aware that Father was trying to "get custody" of his | |

[2] Stepped down to a CAF is the process when children's social care cease to be involved working with a family as the lead professional and refer to other agencies to provide support

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| | daughter. The psychiatrist assessed Father as stable and functioning well. | |
| May 2013 | Sophie's foster carers expressed concerns at a Looked After Child review about Sophie's reaction to contact with Father.<br><br>An interim report on the parenting assessment was completed by the Court appointed expert. This recommended that Sophie should be offered the opportunity to be placed with Father but further work was required. | |
| June 2013 | Further concerns about Sophie's reactions to contact with Father were expressed by the foster carers at the Looked After Child review. | Joe's mother confirmed to her social worker that her relationship with Father had resumed, although immediately after this both she and Father raised concerns about each other's behaviour, which led to a child protection conference.<br><br>A private law application was made by Joe's mother for Residence and Prohibited Steps Orders in respect of Joe, to prevent Father from removing him from her care.<br><br>Eight days later Father also made an application for a Residence Order and Prohibited Steps Order for Joe.<br><br>The day after Father's application, Hertford County Court made a Contact Order specifying that Father should have contact with Joe from 7.30am on Saturdays to 7.30pm the following Tuesday (starting at the end of June) i.e. Joe would spend half the week with his father and half with his mother. The Contact Order was timetabled for review in September 2013. |
| Early July 2013 | Luton County Court made a number of directions designed to provide sufficient additional information from Father's medical records, Hertfordshire Police and Hertfordshire County Council (children's social care) in order to assess Father's capacity to parent Sophie. | |
| Late July 2013 | | A child protection conference in Hertfordshire made Joe and siblings subject of a child protection plan (category neglect). |
| August 2013 | Extended contact arrangements between Father and Sophie began: this decision was taken at 'professionals' meeting between the children's guardian and the independent social work service. | A legal planning meeting in Hertfordshire decided against legal proceedings in respect of Joe and half siblings but to work with the child protection plan. |

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| Early Sept 2013 | Final report by the Court appointed expert providing the parenting assessment which states 'I believe that we are at the point when Sophie should move to her father's care' and 'I am concerned that the toing and froing will start to have an impact on Sophie and that decisions need to be made to progress the matter forward'<br><br>One day later a psychiatric report commissioned by Father's solicitor was filed. The latter report (from a locum psychiatrist in the team treating Father) raised concerns about Father's behaviour in the interview with the psychiatrist. | |
| Late Sept 2013 | Bedford Borough social worker filed a statement agreeing with the independent social work assessment: Sophie should be placed with Father as soon as possible. | |
| 4th October 2013 | Luton County Court made a Residence Order to Father in respect of Sophie and an Interim Supervision Order to Bedford Borough Council. Hertfordshire County Council were directed to confirm whether they would accept a final Supervision Order in their favour by 18th October and file and if so file an addendum care plan. | |
| 1st Nov 2013 | Final Court hearing in respect of Sophie. Residence Order and Parental Responsibility Order made in favour of Father and Supervision Order to Hertfordshire County Council for 12 months. Sophie to be accommodated under s20 and remain with her foster carers until Father had suitable accommodation. | Sophie was allocated in Hertfordshire to a student social worker in social work team 2 (called allocated worker team 2). |
| 14th November 2013 | | A private law hearing in respect of Joe at North and East Hertfordshire family Proceedings Court resulted in a Contact Order specifying Father should have contact with Joe from 7pm Sunday to 7pm Tuesday. A section 7 report[3] to be prepared and a review hearing to take place in February 2014. |
| Middle November | S.47 enquiry by Bedford Borough social worker following report from foster carer that Sophie had told them that she had | |

[3] Under Section 7 of the Children Act 1989 a Court may ask the local authority for a welfare report when they are considering any private law application.

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| 2013 | been hit by Father during contact. The enquiries concluded that no further action was needed. | |
| Dec 2013 | The foster carers and fostering support worker informed Bedford Borough of their increased concerns about Sophie's move to Father. The Bedford social worker replied saying that Father and Sophie would need support as a "Child in Need". | |
| End Dec 2013 | | Sophie moved in with Father. |
| Early Jan 2014 | Sophie's case file closed to Bedford Borough. | |
| Jan 2014 | | Sophie started new nursery school in Hertfordshire. Father was visited by two workers from children's social care in Hertfordshire, one in respect of the section 7 report (team 1) and another in respect of the Supervision Order (team 2). The school also carried out a home visit in early January. |
| Early Feb 2014 | | The Hertfordshire social worker from social work team 1 filed the section 7 report in Court. This did not support Father's application for the Residence Order and Prohibited Steps order. Father disputed the reports contents. |
| 11.02.14 | | Sophie's allocated worker (team 2) e-mailed Bedford Borough Council alerting them that the 'placement' might break down, and requesting a professionals meeting: this was agreed for 19.03.14 |
| 12.02.14 | | The allocated worker (team 2) wrote to Father to make an appointment for a home visit to Sophie and Father for 24.02.14 |
| 14.02.14 | | Sophie's last day at school: school broke for half term<br><br>Father telephoned to speak to the allocated worker's manager (team 2) to cancel visit for 24.02.14. He also tried to speak with Joe's worker's manager (team 1) to express his anger at the s.7 report. |
| 21.02.14 and 25.02.14 | | Joe's mother advised by allocated worker (team 1) that she could stop contact between Joe and Father if she has concerns |
| 26.02.14 | | Sophie did not return to nursery on 24th February after half term, but Father emailed |

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|---|---|---|
| | | the school on 26th to say they were away and Sophie would return the next week on Monday / Tuesday.<br>Supervision decision that allocated worker (team 2) should not visit or speak to Father alone. Agreed case to be transferred to another worker in team 2 |
| 28.02.14 | | Supervision note (team 2) to hold professionals meeting with Joe's allocated team 1 worker and arrange a CIN meeting for Sophie. |
| 03.03.14 | | Father cancelled arranged home visit by the allocated worker (team 2) |
| 04.03.14 | | Supervision of allocated worker (team 2): agreed to undertake joint visit the next day. Re-iterated previous supervision decisions. |
| 05.03.14 | | Unannounced home visit by allocated worker and team manager (team 2) - no one answered door. The allocated worker visited Sophie's school and spoke of arranging a Child in Need meeting |
| 06.03.14<br>(school records) | | Father contacted school to say they were still in Leeds.<br>School 'record of concern' completed and children 's social care (team 2) informed that school had concerns for Sophie's safety |
| 07.03.14 (children's social care records) | | Call from the school to social work team 2 to 'discuss concerns' that Sophie not yet returned to school. No action recorded. |
| 10.03.14, 11.03.14 and 12.03.14 (school records) and 11.03.14 (social care records) | | Father emailed the school again to say he was still in Leeds. The school logged a record of concern on each of the 3 days, and the social work team was contacted daily with concern for Sophie's safety and chasing up arrangements for the Child in Need meeting (Source is school records).<br>Social care records show a call on 11.03.14 from school with concern for Sophie's safety |
| 12th March | | Father calls emergency services for assistance. Sophie died later that day |

# 3 Evaluation of what happened

## 3.1 Introduction

3.1.1 The period under review is from 13.06.12 (the date of Joe's birth) to Sophie's death on 12.03.14. Information about prior events has been considered insofar as they could or should have affected practice with Sophie during the review period.

## 3.2 Sophie subject to an interim care order: June 2012 to September 2013

3.2.1 During this period Sophie was living with foster carers in another unitary authority, along with her siblings and throughout this time she remained the subject of an Interim Care Order to Bedford Borough Council.

3.2.2 The focus of work was identifying a permanent placement for Sophie and as part of this process her birth father was appropriately identified and located. He expressed an interest in parenting her and a viability assessment[4] of Father as a potential carer was undertaken by a social worker at Bedford Borough Council. This assessment was comprehensive, identified the significant issues for further consideration and should have provided a good basis for subsequent assessments.

3.2.3 In November 2012 Luton County Court directed that an expert assessment should be carried out to evaluate Father's capacity to parent Sophie. An independent social worker service (agreed by all parties) was instructed to provide an expert assessment for the Court. All parties agreed to the particular expert concerned.

3.2.4 This expert assessment was of Father, but needed to run alongside a full understanding of Sophie and her needs. This did not happen. There was reliance by Bedford Borough Council on the independent social worker to address all aspects of social work with Sophie. This resulted in a significant gap in the overall assessment process from the start.

3.2.5 The letter of instruction agreed between all parties in the legal proceedings did not include all the relevant issues identified by the viability assessment and Bedford Borough Council Children's Services did not clearly establish the role and boundaries of the independent assessment vis a vis other aspects of the social work task. There was limited social work input from the local authority social worker and social work assessments that should have been undertaken for Sophie and her siblings as a foundation for care planning did not take place.

3.2.6 There were intermittent concerns by the foster carers. Following the introduction to her father, increased contact and overnight stays with him, Sophie exhibited disturbed behavioural patterns. The view taken by the independent social worker undertaking the expert assessment was that, in the context of her earlier childhood experiences, the recent changes had led to the return of such indications of inner trauma, rather than the disturbed behaviour being caused by the contact with Father itself. Whilst this was possible, it was an assumption and was not adequately investigated or challenged by any other professional.

[4] A viability assessment is a short but detailed assessment, which gives an overview of whether further assessment is warranted of a potential carer for a particular child, usually a parent, relative or family friend.

3.2.7 The assessment was completed in September 2013 and recommended that Sophie should move in with her father. The assessment was limited in its scope, relied largely on self-reported information and observation of the father/child relationship in supervised contact. It did not address all the questions in the letter of instruction, did not gather information regarding Father's history of domestic violence and involved limited triangulation of information provided, as could have been obtained through discussion with father's ex-partners and relatives (see 4.3 for further discussion).

3.2.8 Father's solicitor had requested a report of Father's mental health from the team responsible for his treatment. This was undertaken by a locum psychiatrist, who whilst not knowing Father previously, provided a highly relevant report to the proceedings (see 4.3 for further discussion).

3.2.9 The content of this report should have called into question Father's ability to manage stress, describing how he became so angry that a colleague overheard and knocked on the door to check on the 'safety' of the psychiatrist. Father's anger continued to such an extent that the psychiatrist felt 'intimidated' by him. When the psychiatrist tried to end the interview, Father would not leave. The psychiatrist's colleague joined the interview to calm Father down. This took 45 minutes. It is of note that the accounts that Father gave during this interview were inconsistent, and the anger was partly his response to challenge on such inconsistencies.

3.2.10 What is surprising is the apparent insufficient scrutiny of this report by all those involved in the legal proceedings. This was partly because it was filed late, after the assessment of the independent expert. However, the report ends with a judgement that the prognosis for Father was good on the basis of his stable employment and consistent use of medication in the previous year. It has been suggested that this positive prognosis may have contributed to the lack of full consideration of the implications of the content; however, that statement referred to the prognosis of Father's mental health (the purpose of the report) as opposed to his parenting. In fact the cautionary suggestion of possible psychological input to help him work on his difficulties 'in a deeper way', mentioned with this prognosis, should have alerted the reader to the need for further assessment.

3.2.11 Meanwhile, a social worker in Hertfordshire (team 1 allocated worker) was the social worker for father's son. Father had a relationship with his son's mother after his relationship with Sophie's mother ended. This boy (called Joe for the purposes of this review) was aged one year old in the autumn of 2013. After Father applied to the Court for a Residence Order and Prohibited Steps order in respect of Joe, a Contact Order was made by Hertford County Court in June 2013. This stated that Joe should spend from Saturday morning to Tuesday evening living with his father and the rest of the week with his mother. Joe was also subject to a child protection plan as a result of allegations made by Father of his ex-partner's parenting. No safeguarding checks were requested by the Court at this point as would have been expected practice. This appears to have been due to an administrative error.

3.2.12 The high level of contact that Father had with Joe should have been fully understood in relation to the assessment of him as a carer for Sophie, but during this period there was limited contact between social workers in Bedford Borough and in Hertfordshire. The independent social worker undertaking the expert assessment of Father did not obtain information on Father's background from Hertfordshire, nor any feedback from his attendance at Children's Centres in Hertfordshire (where he went to increase his parenting skills). It is not clear if either the independent social worker, or the Bedford Borough social worker appreciated that Joe was spending half his week with Father and that Father had applied for a Residence Order for him. Most critically, the advice provided to Father by practitioners in Bedford Borough to give priority to Sophie, did not take account of Father's strong desire to have his son live with him and perhaps his inability to do as advised.

## 3.3 Father granted a Residence Order and Sophie accommodated by Bedford Borough October

3.3.1 All parties to Sophie's Court proceedings (Bedford Borough Council, the child via the Cafcass Guardian, the legal representatives for Mother and Father) agreed to recommend to the Court that:

- Father should be awarded a Residence Order in respect of Sophie, giving him parental responsibility
- She should move in with him as soon as he was able to find suitable accommodation
- Hertfordshire County Council should have a supervision order for 12 months.

3.3.2 Father was awarded a Residence Order by Luton County Court in October 2013 and an Interim Supervision Order was made to Bedford Borough Council. This interim order was in place whilst agreement was sought from Hertfordshire County Council that it would accept the Supervision Order, as father lived in their area. The Court asked Hertfordshire to provide an addendum to the care plan. Sophie remained with her foster carers and Father agreed that she should be accommodated under s.20 Children Act 1989 by Bedford Borough Council.

3.3.3 Arrangements for Sophie at this point required close work across local authority and health boundaries in order to keep her safe and develop a clear transition plan. This was because:

- Sophie resided with the foster carers in the unnamed unitary authority and father now held parental responsibility: this was a significant change in Sophie's legal status as it meant that if the local authority were sufficiently concerned about Father and felt that Sophie should not move to him, they would have to return to Court for a further order (unless Father agreed with the local authority).
- Sophie was a looked after child and as such Bedford Borough Council were responsible for planning for her care; Bedford Borough Council had also been awarded an interim Supervision Order.
- The ultimate plan was for Sophie to live with her father in Hertfordshire with a Supervision Order managed by Hertfordshire children's social care.

3.3.4 The close working across boundaries that was required at this stage did not happen. There was a lack of clarity as to who had overall responsibility for driving the transition plan forward, and this did not get rectified in the transitional period before Sophie moved at the end of December 2013.

## 3.4 Sophie accommodated by Bedford Borough Council and subject to a Supervision Order to Hertfordshire County Council: November - end of December 2013

3.4.1 The final hearing which made the Supervision Order to Hertfordshire County Council was on 01.11.13. Sophie remained with her foster carers in another unitary authority, until the end of December, still accommodated under s.20 Children Act 1989 to Bedford Borough Council. There remained at this point services from three different local authorities. A student social worker from Hertfordshire social work team 2 was allocated the case (allocated worker team 2).

3.4.2 During this period the foster carers continued to raise concerns about the move to Father and the impact contact with him was having on Sophie and on one occasion this involved an allegation from Sophie that her father had hit her. This was investigated by Bedford Borough Council and it was concluded that there was no need for further action . The conduct of this enquiry had shortcomings (see 4.6), with a lack of multi-agency strategy discussion, lack of involvement of the Hertfordshire team 2 allocated worker and seven days delay before Sophie was asked about the incident.

3.4.3 Meetings were held in both Hertfordshire and Bedford to plan the transition; however the meeting in Hertfordshire (13.11.13 )took place without representation from Bedford Borough Council (the Bedford Borough social worker was unavailable as she was investigating Sophie's allegation) and the one in Bedford ( 9.12.13) had no Hertfordshire County Council representation. At this last meeting, following Father's cancellation of two contacts with Sophie, according to the supervising social worker, Father expressed his view he was not yet ready to have Sophie to live with him.

3.4.4 The foster carers and their supervising social worker[5] raised concerns again about the planned move for Sophie in an email to the Bedford Borough social worker on 20.12.13. This referred to Sophie's ongoing references to Father having smacked her (on the one occasion), her reluctance to go to contact with him, her subsequent disturbed behaviour and Father missing or being late for contact since the granting of the Residence Order. Also mentioned was how Father would cope given that he also had his son for three nights a week and that Sophie would be likely to have an increased need for attention, after the move.

3.4.5 The Bedford Borough Council's social worker's response to this communication referred to Sophie continuing to be supported as a Child in Need and to the fact that the independent social work service (which had provided the expert assessment at Court) had given positive feedback in relation to a recent supervised overnight contact. There was more value being put here on what was regarded as independent observations of the father-child relationship, as opposed to the foster carer accounts, perhaps because it was consistent with the perceptions already held of Father and a view of what was best for Sophie that had been formed early in the assessment .

3.4.6 There is no evidence that the foster carers concerns were communicated to the Hertfordshire team 2 allocated worker, despite the fact of the Supervision Order.

[5] Supervising social worker is the social worker who has the role to support the foster carers: in this case the foster carers were provided by a private fostering agency and the supervising worker was employed by that agency

3.4.7 Meanwhile, the Court hearing in respect of Joe in June 2013 had not asked for any safeguarding checks by Cafcass (as would usually be the case) and it was only at the further hearing in November 2013 that the Cafcass officer in Court that day informed the Court of the child protection plan for Joe. At this point the Court requested that Joe's social worker (team 1 allocated worker) prepare a section 7[6] welfare report.

## 3.5 Sophie living with her father and a Supervision Order to Hertfordshire: End of December 2013 - mid March 2014

3.5.1 Sophie moved into Hertfordshire to live with her father between Christmas and New Year 2013 and the Hertfordshire allocated team 2 worker visited her shortly after this in early January, along with the Bedford social worker. Bedford Borough Council then closed Sophie's case and there was no further contact between Sophie and her former foster carers and siblings. Contact was intended to resume once Sophie was considered to be settled. Although this plan was made in good faith and believed to be in Sophie's best interest the evidence base for this decision is not clear (see 4. 7).

3.5.2 Although Hertfordshire allocated worker team 1 filed the section 7 report with the Court in early February 2014 the significance for Sophie of its conclusion (that Father should not be awarded a Residence Order in respect of Joe) was not considered by either the team responsible for her, team 2, or the team responsible for Joe (team 1).

3.5.3 Father responded angrily to the section 7 report, disputing some of the content. This content included an allegation that Father kicked an elder sibling of Joe under the table in a restaurant and that he had hit Joe's mother's head against the wall. The father expressed his anger on the phone to Sophie's allocated team 2 worker, who heard him being verbally abusive to Joe (aged 18 months) during the call. She reported this to Joe's allocated team 1 worker.

3.5.4 The Hertfordshire allocated team 1 worker supported Joe's mother in stopping contact between Joe and his father on the basis of his reported behaviour and anger. Meanwhile, due to increasing concerns that Sophie may not be able to remain with Father, Sophie's allocated team 2 worker tried to arrange a meeting with Sophie's previous social worker at Bedford Borough Council to discuss the possibility of Sophie being included in plans for her half siblings on the basis of a likely 'placement' breakdown. A meeting to discuss the concerns was arranged for mid March: the delay was due to finding a time when the Hertfordshire allocated worker (team 2), the Bedford Borough social worker and the Bedford Borough consultant social worker were all available.

3.5.5 At this stage, Father's behaviour was perceived (by allocated worker team 1) to be a concern for Joe, such that ceasing contact was warranted. In team 2, whilst it was considered that discussions were required about Sophie's future with Bedford Borough Council, there was no perceived urgency to intervene. See 4.6 for further discussion of this response.

[6] Section 7 report: A Court may ask the local authority for a welfare report when they are considering any private law application under the Children Act 1989;

3.5.6 Meanwhile Sophie's school were unaware of father's history of domestic violence and mental health difficulties or of the subsequent developments regarding the Residence Order for Joe. Sophie continued to attend school until half term, but did not return following this holiday and her father contacted the school providing explanations involving visiting relatives 'up North' and car problems (see chronology of key events p.11 and p.12).

3.5.7 The first the school knew about Father's history was by chance through another Children's Centre on 03.03.14. Mention was made of Father's domestic violence history and possible changes in his access to his son. The other Centre's staff member advised to avoid seeing Father on his own because he 'may twist what is said'.

3.5.8 Father cancelled home visits with the allocated team 2 worker on 24.02.14 and 03.03.14. By this point there had been a decision within team 2 that the worker should not visit on her own due to 'escalating verbal aggression and serial telephone calls/texts/VMs'[VM presumably refers to voice mails] and for a Child in Need meeting to be held along with a professionals meeting with Joe's allocated worker (team 1). A joint visit by the allocated worker and her team 2 manager was undertaken on 05.03.14, but there was no answer and the father's car was not there. The allocated worker (team 2) called at the school to check if Sophie was attending, learnt she was expected back that day and left a message about arranging a Child in Need meeting.

3.5.9 The next day Father contacted the school to say he was still in Leeds. The school completed a 'record of concern' and according to their records stated the school had concerns for Sophie's safety. However the call is logged in children's social care on 07.03.14, without mention of concerns for Sophie's safety, just the information she had not yet returned to school.

3.5.10 When Father emailed the school again on 10.03.14 to say he was still in Leeds, the school logged a record of concern and left messages on the allocated team 2 worker's phones (landline and mobile). The school's chronology indicates that they communicated concern for Sophie's safety as well as chasing up the prospect of a Child in Need meeting.

3.5.11 The next day (11.03.14) the school again called the allocated team 2 worker, who returned the call and was told about the concerns for Sophie's safety. The school referred to the advice they had recently been given about not seeing Father on his own, as well as the issues around contact with his son stopping. The allocated worker (team 2) was planning to follow up with Joe's allocated worker (team 1), to check if she had had any recent contact with Father. At this point school staff understood Sophie to still be in Leeds, in accordance with the information Father had provided.

3.5.12 The father telephoned emergency services for help the next day, 12th March 2014. Sophie died later that day.

3.5.13 Through the criminal investigation it was subsequently discovered that Sophie and her father, although they had travelled during half term, returned to their home and Sophie's father deliberately misled professionals and avoided contact with social workers.

# 4 Findings and recommendations

## Introduction

With hindsight one of the puzzling aspects of professional practice in this case was consensus within the professional network in Bedford Borough and in the care proceedings that Sophie should move to live with her father permanently, despite the fact that she had not known him previously, and that there had been allegations against him of domestic violence in Hertfordshire with both Sophie's and Joe's mothers. Moreover, in the face of Sophie's disturbed behaviour following contact, the lack of consideration of alternative options appears as difficult to comprehend. Findings 1, 2 and 3 explain why practitioners and their managers made such decisions at the time and why the course of action was at the time perceived to be in Sophie's interests.

The rest of the findings focus on explaining why, following the making of the Residence Order to Sophie's father, the risk to Sophie was not sufficiently recognised and acted upon before her death.

## 4.1 FINDING 1: The 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. (Bedford)

4.1.1 This finding concerns the pressure described by practitioners to place a child with a birth parent unless there is overwhelming evidence to indicate that this is not in the child's best interests. They believed that in this case there was insufficient information to indicate that it was not in Sophie's interests to live with her father. This appears to have contributed to a fixed view that Father would be able to care for Sophie, with insufficient analysis of his history of domestic violence or consideration that he may not be sufficiently skilled to be able to look after a child with Sophie's particular needs.

4.1.2 If a child is placed with foster or adoptive carers, the carers will have undergone a rigorous assessment process, which will include taking references, speaking to relevant family members, ex-partners and being approved by a panel of experts. By contrast assessment of family members can be less thorough, with the process to some extent varying between different local authorities and dependent on the circumstances of the case. However, there is generally a belief that the benefits of retaining a child within the family, will lead to a view of what is 'good enough parenting' as opposed to the particular skills required by foster parents to be able to parent a child who may have experienced trauma. In this case, the legal representatives present at Court when the Residence Order to Father was made, noted that everyone present was delighted that Sophie would be getting the opportunity to live with her father and within her birth family.

4.1.3 In some cases this approach may be acceptable when a child is moving to someone they know, who has previously been successfully involved in her/his care and about whom there are no known concerns. In this instance though Sophie's father had no prior relationship with her before he was assessed. Moreover there were known concerns about him in Hertfordshire, with new ones arising during the assessment process.

4.1.4 The pressure perceived by practitioners to place a child with a birth parent unless there is overwhelming evidence to indicate this is not in the child's best interests, partly led to less rigour in the assessment. Notable in this, was the acceptance of Father's self-reported explanations relating to the circumstances of domestic violence, without triangulation of evidence from Hertfordshire files and without speaking face to face with family members (Father's parents and siblings) and ex-partners. Given that Father suggested he would, as a single parent, receive help and support from his siblings, the lack of such corroboration is a major omission of the assessment process.

4.1.5 The early view that Sophie should be placed with her birth father, contributed to an assessment approach which started from the father's capacity to parent based mainly on observations of the two together. This is in contrast to an assessment of Sophie's needs and the qualities this would require in a parent. This meant that there was inadequate consideration given to:

- Sophie's particular needs and the skills required to help her overcome her traumatic earlier life experiences, as evidenced by a report from an educational psychologist in April 2013, which advised that Sophie's previous abuse and neglect led to her difficulties socialising and her destructive behaviour; this report recommended she be provided with a consistent environment
- Father's ability to cope with the stress of being a single parent managing such difficult behaviour and in particular his response to challenge: the report from a psychiatrist in September 2013 which expressed concern about his agitated, angry and distressed behaviour in a meeting.
- Father's conflicting intentions with regard to his application for a Residence Order for his son Joe was not sufficiently explored, especially the implications of how father's different emotional commitments to the children and Joe living half the week with him would be compatible with Sophie's needs

4.1.6 The view that the Court would expect Sophie to be placed with her father led to insufficient understanding of Father's motivations to look after both her and Joe, and the extent to which both of these desires needed to be understood together. The advice apparently provided as part of the assessment process to put Sophie before Joe was naïve, ignoring the existing bonds between father and son which had yet to develop between father and daughter.

4.1.7 The foster carers told the authors that as time went on they thought it became clear that Father's priority was with his son: this was particularly evident when his contact with his son ceased in November 2013 during the child protection enquiry following Sophie's allegation that he had hit her. He expressed this anger to the carers. However, by this time the Residence Order was already made. Sophie's foster carers and their supervising social worker become increasingly convinced that a move to Father was not in Sophie's best interests and this was communicated to the Bedford social worker However, whilst they anticipated that Father would be unlikely to be capable of parenting Sophie in the long term, and therefore let it be known that they would be happy to have her returned to their care, neither foster carers nor anyone else considered Sophie to be at risk of significant physical harm.

**Recommendation 1**

Bedford Children's Services to review whether the

- assessments of friends and family as carers for children are conducted with equivalent rigour to the assessments of foster carers and adopters
- current policies, guidance and procedures for assessment of friends and families adequately supports this requirement

Hertfordshire LSCB to consider if this recommendation is also relevant to the County Council.

## 4.2 FINDING 2: The confusion within the professional network about the role of an expert within care proceedings, led to insufficient challenge of the quality and conclusions of the independent social workers report (Bedford)

4.2.1 A central problem with the assessment process was the lack of challenge to the expert assessment undertaken by the independent social worker. One of the contributory factors to this was a misunderstanding and confusion about the expert's role in relation to Sophie, the Court and to the Bedford Borough Council's social work service.

4.2.2 The nominated expert was an independent social worker from a private provider, an independent social work service. The provider (and the particular independent social worker) had other contracts with Bedford Borough, being used for a variety of functions including assessments and contact supervision.

4.2.3 In this case the expert was instructed by all the parties involved in the legal proceedings. The agreed letter of instruction itself had shortcomings in terms of specifying what needed to be assessed, but was clear that this was an assessment as part of the legal process.

4.2.4 The assessment itself was predominantly based on self-reported information by father as well as observation of him and Sophie together. As mentioned in finding 1 the assessment did not involve triangulation, and involvement of family and ex-partners, nor full information from other involved agencies with Sophie or with Father. Given these weaknesses, it is puzzling on the face of it why others involved in the legal proceedings all accepted its recommendations without challenge.

4.2.5 A major factor behind this was the role confusion around the status and function of the assessment and of the independent social worker.

4.2.6 Firstly it was the only assessment undertaken as part of these proceedings, and as such seems in the eyes of the practitioners to be seen as being ***the*** assessment to determine Sophie's future, as opposed to one limited to the father's parenting capacity. The local authority did not undertake its own assessment of Sophie's needs and hence there was insufficient weight in the decision making given to Sophie's particular additional needs as identified by the educational psychologist (see 4.1.6), foster carers or nursery she attended.

4.2.7 Secondly the independent social worker's role and authority grew as she appears to have become involved in case decision making beyond the brief of the assessment. There were many examples of other practitioners referring to the independent expert as 'the' social worker and referring to her views as opposed to those of the local authority case holding social worker. A clear example of the blurred boundaries was a professionals meeting in August 2013, when two members of the independent social work service along with the children's guardian effectively made the decisions about the care plan[7], without the case holding local authority social worker, who was unable to be present at the meeting. The independent social worker told this review that s/he understood that such decisions were recommendations to the local authority social worker, but others perceived this as the forum at which the decisions were made. For considerable periods records show there to have been limited social work contact by the local authority as opposed to the independent expert.

4.2.8 A third factor in the lack of challenge was a perception communicated by practitioners to the author of the Bedford Borough Children's Services management review, that because the expert was independent the practitioners should not influence the content. However, there is a difference between influencing the views of an independent expert and that of challenging the quality of a report or of taking a different viewpoint. The Bedford Borough Independent Reviewing Officer (who chaired Sophie's statutory reviews as a Looked After Child) did in fact challenge the quality of the independent report in early summer 2013, which helpfully did (along with new concerns about Father's relationship with Joe's mother and Sophie's response after contact) help to further areas being defined for the final assessment report.

4.2.9 The children's guardian is appointed to safeguard the interests of the child in care proceedings; the role is to ensure that the child's situation is well assessed and to challenge on behalf of the child if decisions and assessments are not in the child's best interests. In this case Cafcass failed to do this. Cafcass has identified that this was due to the performance of the individual guardian, but when set within the multi-agency context, it can be seen that the guardian shared the common mind-set in this case, in which all those involved appear to have accepted the view of the independent expert without sufficient scrutiny. This should have been challenged and explored within Cafcass's supervisory and management arrangements.

**Recommendation 2**

Bedford Borough Council Children's Services and legal services should establish a clear framework for the consideration of independent assessments conducted as part of legal proceedings. Where appropriate agencies have a responsibility to challenge the conclusions of the assessment.

**Recommendation 3**

Hertfordshire LSCB to ask Cafcass to demonstrate how supervision and management processes have improved since this case and if this is effective in supporting guardians to retain their focus on the child, challenge expert assessments and maintain their independence from the local authority.

[7] The Children's Guardian is appointed by the Court to represent the rights and interests of children.

## 4.3 FINDING 3: All parties in the Court arena failed to appropriately consider the implications of the September 2013 psychiatric report, and consequently did not argue for a delay in the final hearing so as to develop a care plan better able to meet Sophie's needs.

4.3.1 Finding 1 refers to the assumptions by practitioners that the Court would expect a birth parent to be given care of a child unless there is substantial evidence that this would not be in the child's best interests. This finding refers to the lack of delay at the end of the legal proceedings to adequately take into account the evidence in Court papers and in particular to the psychiatric report submitted in September from the mental health service responsible for the father's treatment.

4.3.2 The care proceedings were protracted largely because of its complexity and because the father was identified some months after the start of proceedings. Practitioners and their managers told the authors that because of the earlier delays, any further postponement of the final hearing would not be tolerated by the Court. The case had by then been in progress for much longer than the 26 week time limit introduced in 2013 as part of the piloting of the revised PLO[8], which subsequently came into effect in the Children and Families Act 2014.

4.3.3 This perception that no delay was possible in the legal process was articulated to the foster carers and their supervising social worker at the time, in response to foster carers' concerns about Sophie's reactions to contact. They recognised how anxious Sophie was following the increased contact with her father and advocated taking things more slowly in planning Sophie's move.

4.3.4 Significant information was received near the end of the legal proceedings on 10.09.13.and should have, but did not, cause constructive delay. This new information was contained in a report from a psychiatrist (in the service providing Father with treatment) in response to a request by Father's lawyer for a report on Father's mental health. The report mentioned Father being agitated and anxious, changing his account frequently, becoming angry and it taking 45 minutes to calm him down. Most significantly, the psychiatrist referred to being intimidated himself by Father's behaviour.

4.3.5 Such information should have caused immediate alarm bells: if Father was able to intimidate an adult male professional by his behaviour, his risk to a child was of great concern. However, although the social worker and her managers did see the report, the contents were not seen as alarming at the time. This appears to the independent serious case review authors to be surprising. Social workers and managers in both Bedford Borough Council and Hertfordshire County Council told the authors that their understanding at that point was there should be no delay in making the Final Order and it is likely that this will have impacted on the lack of detailed consideration given to the report's contents.

4.3.6 A further reason for the report being insufficiently considered was its conclusion of a good prognosis of Father's mental health (see 3.28 - 3.2.10), which may have mistakenly been confused with his parenting prognosis. Whilst this was a report about his mental health, and not about his parenting, the content indicated further consideration was needed about his ability to parent a young, disturbed child, who may test a parent's abilities to the limit.

[8] PLO is the Public Law Outline introduced in 2008 to reduce unwarranted delays in family Court cases

4.3.7 This rush at the end of the legal proceedings was compounded by the case holding social worker being on holiday and then on another three week Court hearing for another case in August and September, along with the solicitor being on leave in September.

4.3.8 It would appear that the legal process had a daunting effect on those involved; this can be positive to the extent it discourages drift, but should not have meant that the plan and the actual move was rushed and ignored significant and worrying new information that was emerging at the end.

4.3.9 In theory target timescales may be achieved by the parties working harder, faster and smarter. In practice a trade off between efficiency and thoroughness will arise in many cases. In some it may lead to additional risks, particularly if the local authority and other parties are not aware that they are entitled to challenge what they perceive to be inappropriate timescales.

**Recommendation 4**

Bedford Borough Children and Legal Services to review the current training provided to social workers and lawyers to ensure that this provides the necessary skills and authority to be able to represent the child's best interests in Court. Such training to emphasise the need to retain a sense of challenge at all stages of the process, even if this involves lengthening the legal process in the child's best interests.

**Recommendation 5**

Hertfordshire LSCB and Bedford LSCB) to ask the Local Family Justice Boards in Hertfordshire and Bedfordshire to consider the findings of this review and consider how, in future, cases will be identified where decision making is being adversely affected by the pressure to avoid delay, or further delay. The groups should work with the local authority, Cafcass and others to reduce the risk of this having an adverse effect on welfare of children.

## 4.4 FINDING 4: Weaknesses in management within and between different local authorities and social work teams led to a lack of full understanding of potential risks (both Bedford Borough and Hertfordshire)

4.4.1 This case was challenging for professionals due in large part to the complex family compositions and the movement of Sophie between three different local authorities. There was a need for close working across team and local authority boundaries, consistent information sharing and joint planning at all stages. This did not happen and there was insufficient management oversight to support practitioners in working with this level of complexity. This was particularly critical given the allocation to a student social worker.

4.4.2 This meant that none of the social workers had an understanding of the whole case:

- Bedford Borough focused on Father as a carer for Sophie with insufficient understanding of his history in Hertfordshire and his involvement with his son.
- Social work team 1 in Hertfordshire had the best understanding of Father and the risks he posed to children as evidenced by the section 7 report and the support provided to Joe's mother's in stopping contact with Father in February 2014.

- Social work team 1 in Hertfordshire, whilst recognising the challenges for father in parenting two children instead of one, did not consider what the content of their assessment meant with:
    - Regard to his parenting only one child [Sophie] and
    - Continuing to parent two children if Joe continued to spend half his week with Father
- Hertfordshire social work team 2 had initial reservations about Father as a potential full time carer for Sophie prior to her move to him in December 2013 and in February 2014 they appropriately initiated discussions with Joe's social worker and raised concerns with her following Father's display of anger during a telephone conversation - however, team 2 were unaware of the decision to cease Joe's contact with his father, so could not consider what impact this may have had on his emotions and any consequent increase in the risk for Sophie.

4.4.3 Good management and supervision would have helped practitioners to stand back and reflect on the case as a whole and It would have also helped practitioners to manage competing demands on their time. There is little evidence that this happened in either authority.

4.4.4 Within Bedford Borough Children's Services, supervision was task focused and did not promote the level of critical analysis required in a case such as this. The supervisor carried his own caseload and this meant that he struggled to provide cover when the social worker could not attend meetings as he had meetings for children on his caseload to attend. This was significant as one of the issues in this case is the difficulty of setting up meetings between Bedford and Hertfordshire staff, at a time when there could be representatives from both organisations.

4.4.5 Across the two authorities, planning at the point of transition to Father's care was limited and the meetings (one in Hertfordshire and one in Bedford) were only attended by practitioners from the 'home' authority. Managers in both authorities should have ensured representation and attended themselves if the workers were unavailable due to other professional commitments. The result of the lack of transition planning was a limited understanding in Hertfordshire of the concerns being expressed by the foster carers and their supervising social worker during this period. Whilst no-one perceived Father to be a physical risk to Sophie, the foster carer and supervising social worker did not consider him to have the parenting skills Sophie needed, and the supervising social worker thought that he would not be able to cope and Sophie would return to the foster carers.

4.4.6 As well as problems with the quality of the direct supervision of the social worker in Bedford Borough, there was a lack of management oversight within Bedford Borough of the totality of the planning process for Sophie. There is no evidence that any manager at any level grasped the significance of the complexity of the case and this was one reason why important aspects of the planning for the future of Sophie and her siblings were lost. Of particular significance was the lack of any follow through of plans for contact between Sophie, the foster carers with whom she had a close relationship and her siblings (see 4.7).

4.4.7 Within Hertfordshire, the involvement of two teams and the allocation of the case to a student social worker (allocated worker team 2) presented further management challenges. It is possible that the impact of the Court decision having been being made so recently suggested to managers in Hertfordshire that Father's capacity to parent had been looked at thoroughly and there needed to be time to see how he coped. However, this is not supported by the evidence. The social work team 2 manager and allocated worker expressed a level of concern about the Court decision at an early stage which was re-iterated in the section 7 report written by team 1's allocated worker. This expressed doubts about the conclusions of the section 47 enquiry undertaken in November 2013.

4.4.8 Whilst Father registered Sophie with a GP, sorted out a school placement and up to half term took her there every day, there was no multi-agency Child in Need planning process initiated to help support the family as well as monitor progress. Given the allocation to a student social worker, this should have been addressed by social care managers. There was a lack of management presence at a key professionals meeting in February 2014 when information was shared between Joe's allocated worker (team 1) and Sophie's worker (team 2). As a consequence there was no documented plan to integrate the findings of the section 7 process into the work with Sophie, despite it having identified significant concerns about Father's parenting. There is no evidence that the eventual report was shared and the depth of concern expressed about Father within this report considered by the team responsible for Sophie.

4.4.9 As well as management oversight from the team manager, because she was a student, the work of the allocated worker (team 2) was overseen by a practice educator, responsible for assessing her professional development. Handwritten notes of these meetings are kept separately from the 'child specific supervision forms' maintained by the team manager yet they contain important observations such as the worker had "already picked up a concern as to whether there is a right decision by Luton Court" (5.11.2013). This was a very important and insightful comment that was not followed through by the practice educator in formal discussion with the team manager.

**Recommendation 6**

Bedford Borough Children's Services to provide evidence to Bedford LSCB that steps have been taken to embed reflective supervision within social work teams.

**Recommendation 7**

Hertfordshire children's social care should review case management arrangements for student social workers in order to clarify roles and responsibilities of practice educators and team managers.

**Recommendation 8**

Hertfordshire children's social care to review case management arrangements so that the allocation of each child who is a full-time or part-time member of a household to the same caseworker is always considered. When household members are allocated to different caseworkers, the respective social workers must keep themselves aware of the care plans for each child so that these are consistent and the work is well coordinated.

## 4.5 FINDING 5: The Child in Need planning and service delivery in this case did not provide co-ordinated multi-agency involvement (Hertfordshire)

4.5.1 This finding addresses the practice in Hertfordshire subsequent to the making of a Residence Order to Sophie's father in October 2013 and the Supervision Oder to Hertfordshire in November 2013.

4.5.2 A care plan was put in place at the point that the Supervision Order was made outlining the responsibility of the Local Authority. Initially there was an attempt to initiate multi-agency involvement with a meeting held with Father, team 2 team allocated worker and the manager, a SENCO and a housing officer. It was also meant to include the Bedford Borough social worker, but she was unable to attend. This meeting focused on Sophie's move and Father's housing needs. At that point Father was waiting for housing and hence it was not known where the family would live; for that reason there was no involvement of health visiting or of the as yet unknown education provider.

4.5.3 Once it was known where the family would live and which nursery school Sophie would attend there was no evidence of further consideration of the need to take a multi-agency approach to the provision of support to Father and no indication that the Local Authority saw itself as taking a lead role in this respect.

4.5.4 Sophie at this point was a Child In Need and the plans within Hertfordshire should have involved working with professionals and with her father to develop an agreed Child in Need plan, with multi-agency meetings and a co-ordinated team around the child. It is not entirely clear why this did not happen, but there was no communication with education services and no liaison with health.

4.5.5 The result of a lack of multi-agency Child in Need planning meant that Sophie's school, where she attended the nursery class, were unaware of significant aspects of her history or how they could most effectively work with social workers and other professionals to meet her needs. They were therefore working with a child with additional needs, who had experienced a recent significant change in her living arrangements and was subject of a Court order, without the information needed in their day to day work with her. When Sophie missed days at school, just prior to her death the school did alert Hertfordshire children's social care after the absence became prolonged. Sophie was not yet of statutory school age and the head teacher has queried whether this can influence thinking when a child misses school. A Child in Need plan would have enabled all professionals to have been aware of the role that school played and the significance of her absence.

4.5.6 This situation was exacerbated within the heath visiting service where there was no formal notification to Hertfordshire health visitors of Sophie's move into their area as the health service had not been told by Bedford Borough social workers of the move. This meant that there was no advance planning, no handover, notification was delayed and detailed reports were not transferred about Sophie's additional needs.

4.5.7 Health visitors attending meetings relating to Joe heard informally that Sophie had moved but this did not prompt any further exploration of how a health visiting service would be provided. A factor which potentially contributed to Sophie becoming lost at this point was significant organisational change, including team mergers and redistribution of caseloads within Herts Community Trust.

4.5.8 A health visiting assistant did become aware from the GP that Sophie had moved into the area and at that point acted promptly to obtain the records and send Father a routine transfer-in letter. However, without the records, any handover from the previous health visitor or information from children's social care, the Hertfordshire health visiting team were not aware of Sophie's additional needs and there was no formal planning to address her health needs as part of an overarching Child in Need Plan.

**Recommendation 9**

Hertfordshire LSCB to initiate multi-agency audits to establish whether the practice in this case is unusual, or if there is a systemic problem around the quality of multi-agency child in need service planning and delivery. The audits to include interviews with staff, so that the reasons for any weaknesses in multi-agency practice are explored.

**Recommendation 10**

Hertfordshire children's social care to introduce systems so that all Supervision Orders are routinely subject to Child in Need planning and review processes .

## 4.6 FINDING 6: Shortcomings in the response to the suspicion of child protection risks may have left Sophie at risk of harm.

4.6.1 There were two occasions when there were concerns or incidents which in the view of the authors of this report were sufficient to lead social work managers to initiate child protection procedures in the form of a multi-agency strategy discussion and if required a section 47 enquiry [9]. These were when:

- Sophie alleged in November 2013 that her father had slapped her and
- Concerns accumulated in February 2014 following Father learning he was not going to get a Residence Order for Joe.

4.6.2 On both these occasions there were shortcomings in the responses to the concerns, albeit for different reasons.

**November 2013**

4.6.3 In November 2013, Bedford Borough did initiate a section 47 enquiry in response to Sophie's allegation, but this was done without a multi-agency strategy discussion and the involvement of other agencies in planning or undertaking enquiries (even though Sophie was by this point subject to a Supervision Order to Hertfordshire).

[9] Section 47 Children Act 1989, requires local authorities to undertake enquires where a child in their area is suffering or is likely to suffer significant harm

4.6.4 Critically the social worker did not see Sophie until over a week after the allegation, which was a long time for a four year old child, especially one with a range of additional behavioural and emotional needs. Sophie gave an account of being hit but this was not believed, largely because the community pre-school's account that she sometimes lied about being hit was uncritically accepted as the explanation for this particular allegation. The reason for the conclusion of no further action was not provided to the allocated team 2 worker in Hertfordshire; if it had it might have alerted Hertfordshire to potential risks relating to physical abuse.

**February - March 2014**

4.6.5 During the latter half of February and March 2014 Hertfordshire County Council did not initiate a strategy discussion, nor any other type of multi-agency forum to consider the emerging concerns about father's emotional responses, and possible implications for Sophie.

4.6.6 In February 2014, following Father learning he would not obtain a Residence Order for his son Joe, he expressed his anger in telephone conversations and voice mail messages to both Sophie's allocated team 2 worker and Joe's allocated team 1 worker. The allocated team 2 worker reported to Joe's allocated team 1 worker of hearing Father swear at Joe: this led to advice to Joe's mother that she could stop Joe's contact with his father if she had any concerns. Unfortunately, there is no evidence that Joe's allocated worker (team 1) told social work team 2 of this decision, so that consideration could be given to any potential impact on Sophie's welfare.

4.6.7 Father's 'escalating verbal aggression and serial telephone calls/texts/VMs' towards allocated team 2 worker and his allegation that she had lied about him led to the decision that she should not visit the home on her own. Her manager also decided to transfer the case to a full time social worker, hold a professionals meeting (with Joe's allocated worker) and a Child in Need meeting. Moreover Hertfordshire County Council alerted Bedford Borough Council that the placement with Father might break down and the need to consider alternatives was agreed and a meeting arranged.

4.6.8 At this point, in the opinion of the authors, these concerns should have led to consideration of what this might mean immediately for Sophie and recognition of a 'reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm'. This should have triggered a strategy discussion with multi-agency partners to consider whether to initiate a section 47 enquiry to assess the risk and the urgency of the situation. This did not occur because of differing interpretations as to the meaning of 'reasonable cause to suspect' and a tendency to use strategy discussions primarily where there is an obvious risk of physical or sexual abuse rather than an accumulation of concerns. In this case, whilst there were long term concerns about the sustainability of the placement, the managers at the time did not perceive an immediate risk of harm to Sophie.

4.6.9 If the view at that point was that this threshold had not been reached, at the ***very least*** there needed to be an expedited professionals meeting or child in need meeting, or failing that communication with Joe's allocated team 1 worker, the school, GP and health (albeit the latter were not involved).

4.6.10 If such multi-agency discussions had occurred it is by no means certain that a section 47 enquiry would have been initiated, but it would have shared the concerns across the professional network, enabled the school to know of the accumulating concerns, team 2 to learn about Joe's contact with Father being stopped and enabled more informed decision making of the level of risks to Sophie. Although the health visiting service had not yet made contact with the family, it had by this point received Sophie's health records which set out fuller details of her developmental, emotional and behavioural difficulties. This information would have strongly underlined her vulnerability.

4.6.11 There was no professional contact with Sophie during the last four weeks of her life. The cancellation of visits by Father and Father's explanations for the reason that Sophie had not returned from school after half term, with hindsight, reflect the extent to which Father went to keep Sophie away from professionals.

4.6.12 School records and social work records for this period differ around the communication of concerns for Sophie's safety by the school to social work team 2, but it is clear that from the 7th March onwards social work team 2 were regularly informed of Sophie's continuing absence, and both agencies concur that on the 11th March this was expressed in terms of concerns for her safety. However, the combination of Father's avoidance of social work contact coupled with Sophie's lack of school attendance should have raised the level of concern.

4.6.13 The fact that Father was maintaining contact with the school about his plans to be away, gave false re-assurance to the social work team as he had not previously been identified as devious and he was thought to have kept the school informed of his movements. Action was therefore not taken to expedite multi-agency consideration of any need for more assertive intervention through the child protection process prior to Sophie's death.

**Recommendation 11**

Hertfordshire and Bedford Borough LSCBs should review with all partner organisations whether there is a routine use of multi-agency strategy discussions to decide whether to initiate a section 47 enquiry whenever 'there is reasonable cause to suspect that a child .... is suffering, or is likely to suffer, significant harm'[10], and not only when an incident has occurred which appears to provide evidence of harm.

Such discussions should be used not just for incidents of suspected abuse, but also for accumulation of concerns, as more typically found in cases of emotional abuse or neglect.

[10] Section 47, Children Act 1989

## 4.7 FINDING 7: Following a change of carers, contact with previous non abusing carers and siblings will usually be in the interests of the child's emotional well-being: this did not happen in this case

4.7.1 A major indication of the lack of child focus in this case was the absence of professional attention to Sophie's needs for contact with her siblings and foster carers. Given that Sophie's relationship with her elder sibling was the most enduring relationship in her life and that this sibling remained with the foster carers, such ongoing contact should have been a very important part of Sophie's future.

4.7.2 However, Sophie had no contact with either her foster carers or her siblings after she moved, despite an understanding by the carers and the supervising social worker that they would see her for the first half term holiday and subsequent school holidays. The carers' understanding is consistent with the Care Plan provided by Bedford Borough to the Court (dated 23.09.13) which included for Sophie to have contact with her elder half sibling six times a year in school holidays. As her sibling lived with the carers, this was equivalent to the carers' understanding.

4.7.3 The reasons for this lack of contact arise from:

- A confused view in Bedford Borough around the advisability of contact in the early stages of a new placement
- The fact that a Supervision Order does not provide the legal basis for the supervising authority to arrange contact - this legally was the father's responsibility and as a result Hertfordshire's amended care plan offered 'support and advice during regular Child in Need meetings which will assist in reviewing the contact needs'

**Confusion around contact arrangements in Bedford**

4.7.4 The Care Plan by Bedford Borough Council provided for contact with Mother three or four times a year; with elder sibling and carers six times a year in school holidays and letterbox contact with the younger sibling as he would be adopted. Before this plan there had been various other plans put forward:

- the Bedford Borough independent reviewing officer at Sophie's last Look After Child statutory review at the end of October recommended that Sophie spend one week-end a month at the carers' home to provide respite for Father, maintain the relationship between siblings and monitor Sophie's welfare: the Bedford Borough Council team manager agreed this, but it was not included in the care plan
- Sophie's foster carers and supervising social worker both understood the plan was for contact to occur with Sophie's sibling and the carers during the first half term and in subsequent school holidays: this is not in the records of either Bedford Borough or Hertfordshire County Council,

4.7.5 Father himself has no recollection over the contact plans, other than he and Mother would arrange this between them. He did tell the authors he would have welcomed the plan for Sophie's regular staying contact with the foster carers, although this is hindsight and we are not sure in reality that he would have facilitated this at the time.

4.7.6 The first contact, understood to be arranged for February 2014 half term by the foster carers and the supervising social worker, was (they recalled) cancelled. The carer and her supervising social worker both said that they were informed of this by the Bedford Borough social worker (during her contacts with them about Sophie's half siblings). The reason given was that Sophie was not settled. The Bedford Borough social worker concerned has no recollection of this.

**Was there a mistaken belief that contact should only occur when a child has settled ?**

4.7.7 The Hertfordshire team 2 allocated worker has explained she understood from the Bedford Borough social worker that there would not be contact until Sophie was settled, not before Easter. Discussion with the Bedford Borough team manager has confirmed that this used to be the culture in Bedford Borough Council Children's Services (and from the lead reviewers experience in many other places). This stems to a long standing (and flawed) belief within some social work teams and departments, now largely discontinued, that children would settle better with new carers if they had no contact with their previous carers until they are attached to their new carers.

4.7.8 Whilst there may well have been an argument to delay contact with Mother, as seeing her did upset Sophie, the lack of ongoing contact with her sibling and foster carers must have been very difficult for her to comprehend. Being 'unsettled' should not mean a cancellation of contact following a move - in fact it may mean a greater need for it! It certainly should have acted as an indication that a social worker should check on Sophie's welfare .

**Hertfordshire County Council responsibility as part of the Supervision Order**

4.7.9 Given that the Supervision Order was to Hertfordshire and not Bedford, the team 2 allocated worker and her manager did have a responsibility to challenge such fixed thinking about contact and to have considered Sophie's needs as part of a Child in Need plan. However, without any Child in Need meetings (see finding 5) this did not happen.

**Recommendation 12**

Bedford Borough Children's Services to review current guidance and practice norms around children's contact arrangements following a move to a new permanent placement: contact with people of psychological importance to a child should **not** be delayed until the child is judged to be 'settled.

# Appendix: Terms of Reference

The terms of reference were fully addressed by the individual management review authors. The serious case review report authors then analysed the information supplied and in their report addressed the issues most relevant to professional safeguarding practice within Hertfordshire and Bedford Borough Council.

**TERMS OF REFERENCE FOR THE SCR ON SOPHIE v3 - KI 12/5/2014**

**Factual matters to be established**

1. What contribution did agencies make to the decision that Sophie should live with her father?
2. What background and historical information about Father was scrutinised by agencies (individually and collectively) in order to inform recommendations and decision making about Sophie?
3. What information from the contemporary private law proceedings in relation to Joe (another child of Father) was scrutinised by agencies in order to inform their work in relation to Sophie?
4. What assessments informed the recommendations made to the court in relation to Sophie? Did the recommendations make fully reflect the information available?
5. What risk assessment was carried out and what plan of support was in place in order to assist Father to assume the care of Sophie?
6. How was the plan of support implemented? Were new risks identified during the period when Sophie was in the care of her father and if so what action was taken?

**Evaluation of professional practice and services provided for Sophie**

7. What was the quality of the assessments provided in order to inform decision making?
8. Were additional assessments considered and could they have contributed positively to decision making?
9. Were the recommendations made to the court concerning Sophie appropriate in the light of the information held by professionals?
10. Was the work of professionals in relation to the court concerning Sophie effective?

**Evaluation of factors that shaped professional practice**

11. What contributory factors (at individual, team and organisational level) shaped professional practice and decision making by individual agencies and in the multi-agency network?
12. How did the case law and current public policy in relation to family court proceedings concerning Sophie impact on the work of the professionals?
13. How effectively did agencies and professionals work together across geographical boundaries? (i.e. between Bedford Borough, Hertfordshire and unnamed unitary authority)

Findings for the LSCBs

14. What do the findings in relation to the care provided for Sophie tell the LSCBs and member agencies about the strengths and vulnerabilities of wider arrangements to safeguard and promote the wellbeing of children?
15. What steps should the LSCBs or member agencies consider taking in order to improve services for vulnerable children?