Serious Case Review

BSCB 2017-18/02

Lead Reviewer:
Hilary Corrick Ranger

Published 5th October 2021

CONTENTS

Number	Description
1	Introduction and Summary
2	Decision to hold a Serious Case Review
3	Process
4	Scope of the Serious Case Review
5	Key issues to be addressed within the Serious Case Review
6	Methodology
7	LILLY'S STORY
8	Key Issues
8.1	Quality and robustness of practice and of assessment and challenge during Special Guardianship Order
9	Quality of post court decision making, support and oversight
10	Quality of monitoring by universal services
11	Indicators of concern identified or missed
12	Nursery
13	GPs
14	Birmingham Children's Hospital
15	Operational, organisational and strategic context of safeguarding provision
15.1	Birmingham Children's Trust: Children's Social Care
16	Cafcass
17	Court service
18	Birmingham Community Healthcare NHS Foundation Trust
19	Birmingham South and Central Clinical Commissioning Group: GPs
20	Birmingham Children's Hospital
21	Probation
22	National, regional or local policy issues
23	Close family relationship, family support and contact
24	SGO and adoption
25	Court timescales
26	Views of professionals
27	Views of family members
28	Analysis and Conclusions
29	Finally
30	Learning Points
31	Postscript
Appendix 1	Abbreviations and acronyms
Appendix 2	Relevant other Serious Case Review's and research

1. INTRODUCTION and SUMMARY

1.1 Lilly was born on 21st February 2016. She was White British and the third child of her mother. Her two older siblings were cared for by her maternal grandmother.

1.2 Lilly was very ill after her birth and remained in hospital until the 15th March 2016 when she was placed by the Courts into the care of her maternal grandmother under a Child Arrangement Order (CAO) and Interim Supervision Order (ISO). By the 7th July 2016 Lilly had moved to live with her special guardian (a relative of the family) as her maternal grandmother was finding it difficult to manage her care in addition to her other caring responsibilities. A Special Guardianship Order (SGO) was made in favour of the special guardian on the 5th September 2016.

1.3 An ambulance and police were called to the home address of Lilly on the 19th November 2017. A person visiting the address, the partner of the special guardian, had found Lilly unresponsive. On arrival at hospital her condition was critical, and she was taken to the Paediatric Intensive Care Unit (PICU) where her prognosis was described as life threatening. A CT head scan was undertaken which showed the presence of subdural bleeding and there were clear signs of raised intracranial pressure. Lilly underwent two emergency brain surgery operations to save her life and reduce the swelling to her brain. She remained on life support until her death on the evening of the 22nd November 2017. These injuries were described as non-accidental. West Midlands Police conducted an investigation into the circumstances surrounding the death of this child, as a result of which the special guardian's partner was charged with her murder. He was convicted and sentenced on 26th March 2021 to a minimum term of 20 years in prison.

2. Decision to hold a Serious Case Review (SCR)

2.1 When a child dies and abuse or neglect is either known or suspected the Local Safeguarding Children Board is required to undertake a Serious Case Review (SCR). At the SCR Sub-Group on the 8th December 2017, it was established that the case met the criteria for an SCR. The Independent Chair of the Birmingham Safeguarding Children Board (BSCB) ratified the decision to commission an SCR on the 21st December 2017.

3. Process

3.1 BSCB commissioned Hilary Corrick Ranger as the author of the review. She has over forty years' experience of social care services, the majority with services for children and families as a practitioner and senior manager in local and national government. She has a professional social work qualification and is registered with Social Work England (SWE). She works as an independent consultant within Local Authority children and adult services, as well as the health economy and the voluntary sector. The main focus of her work is

safeguarding. She has undertaken case reviews and provided overview reports to several LSCBs. She has not worked for any of the services contributing to this SCR.

3.2 A Review Team was established to provide oversight, guidance, advice and support to the independent author. The Review Team consisted of safeguarding experts with no direct responsibility or management links to the case, from:

- Children's Social Care;
- West Midlands Police;
- Children and Families Court Advisory Service (Cafcass);
- Birmingham South and Central Clinical Commissioning Group (CCG).

4. Scope of the SCR

4.1 The Review Team agreed that the SCR should focus on the period from Lilly's birth on the 22nd February 2016 until her death on the 21st November 2017.

4.2 The SCR would not consider in detail Lilly's birth family nor the extended family network and agency contact with them unless there were issues which were directly pertinent to the key issues to be addressed by the SCR.

4.3 Each of the agencies that had contact with the family was requested to complete a Key Events Chronology and an Information Report based on their records and files relating to the case, identifying emerging learning and action that would be taken to implement any improvements to practice. Agencies were expected to analyse their agency's involvement with the case professionally and critically.

4.4 Key Event Chronologies and Information Reports were requested from the following agencies:

- Children's Social Care;
- Cafcass;
- Early Years;
- Mental Health;
- Birmingham Children's Hospital
- Heart of England NHS Foundation Trust Hospital;
- Probation;
- Birmingham Community Healthcare NHS Foundation Trust;
- West Midlands Police;
- Birmingham South and Central CCG.

4.5 Other agencies, Change, Grow, Live (Reach Out Recovery Drug Service) and West Midlands Ambulance Service, submitted Information Reports but these were not directly relevant to the review.

5. Key issues to be addressed within the SCR.

5.1 It was agreed the review would focus on the following key issues:

5.2 The quality of practice, supervision and management oversight and support of those multi-agency professionals involved with the case during that period and in particular:

a. The quality and robustness of assessments, reports to court, care planning and court decision-making processes;

b. The degree to which information about the individual making an application for an SGO was evaluated, assessed, challenged and analysed during the proceedings.

5.3 The quality of post court decision-making, support and oversight processes put in place to support and monitor the SGO placement.

5.4 The degree to which universal services were engaged in providing ongoing monitoring of the placement and whether they demonstrated appropriate rigour and professional curiosity about the nature of the household.

5.5 Whether any concerns, or indicators of concern were raised, identified or, with hindsight, missed in relation to the special guardian's care of Lilly following the placement, up to and including her death, by any agency, universal or specialist, in contact with the family in which she was living.

5.6 The operational, organisational and strategic context within which multi-agency children's safeguarding activity (including the court service) was taking place at the time of the court case and the degree to which this context affected front-line practice and decision-making.

5.7 Whether there are any key national, regional or local policy issues arising from the use of an SGO in the circumstances that need to be addressed.

6. Methodology

6.1 The Review Team analysed the Information Reports and the integrated Key Events chronology. They considered the professional systems and individual agency pressures.

6.2 A Professionals' Learning Event shared knowledge between agencies and individual professionals who knew Lilly and the special guardian and her family, and discussed the key issues and what could have been done differently.

6.3 The Independent Author had hoped to meet with members of Lilly's family, with a member of the Review Team at an early stage of the Review, and listen to their thoughts about what happened to Lilly. Unfortunately, the police investigations and legal processes delayed this for a significant period, but

meetings have now taken place with Lilly's mother, her maternal grandmother and her special guardian.

7. LILLY'S STORY

7.1 Lilly was 21 months old when she died. The nursery she attended described her as a happy and healthy little girl who was meeting all her milestones. In court a family member, on behalf of the family, said she was loving, cheeky and a perfect little girl. She was mostly shy and cautious around new people, but it would never take long before she was dancing around with her arms in the air. When we met her mother and maternal grandmother, they described her dancing when they saw her shortly before her death.

7.2 She was born on 21st February 2016 at Good Hope Hospital, then part of the Heart of England Foundation Trust, now part of University Hospitals Birmingham NHS Foundation Trust. Her mother had received no antenatal care, and came to the hospital with vaginal bleeding. She admitted to chronic substance misuse before and during her pregnancy (crack cocaine and heroin).

7.3 Lilly was ill following her birth with complications associated with prematurity and substance misuse. On the day she was born she was transferred to the Neonatal Unit at Birmingham Heartlands Hospital and the Special Care Baby Unit.

7.4 Lilly's mother informed the hospital midwives that she had two older children who were in the care of her mother (maternal grandmother). She discharged herself from hospital against medical advice on the day of Lilly's birth.

7.5 A referral to Children's Social Care was made by the midwives on the same day, in line with Safeguarding Children's Policy. A Strategy meeting was held by the Multi-Agency Safeguarding Hub (MASH) the day after Lilly's birth. It was decided that Section 47 enquiries were not required and responsibility was transferred to the area safeguarding team to undertake an assessment.

7.6 The assessment was opened the same day with a view to:

- Ensure that support was available to the mother;
- Ascertain the mother's wishes for Lilly;
- Consider her capacity to change;
- Liaise with health services and ensure a discharge planning meeting is held for Lilly;
- Liaise with maternal grandmother, who had offered to care for Lilly;
- Establish if the mother wished to have Lilly returned to her, in which case immediate legal advice to be sought.

7.7 On the 25th February the mother told the social worker that she wished to care for Lilly herself; a Legal Planning Meeting was held on 1st March as a result, where it was agreed that:

- The legal threshold for removal was met;
- Family members and other connected persons were to be assessed as carers for Lilly;
- Lilly to be placed in specialist foster care on discharge from hospital;
- A detailed and robust parenting assessment of the mother to be completed.

7.8. On 2nd March the social worker spoke to the special guardian about the mother's wish for her to become the carer for Lilly. On the 10th and 11th March the social worker explained to the mother, maternal grandmother and the special guardian that the Local Authority planned to place Lilly in foster care when she was discharged from hospital.

7.9 14th March: the Court hearing. Both the mother and maternal grandmother opposed the Local Authority plan for an Interim Care Order (ICO) and for Lilly to be placed with foster carers. A Cafcass Children's Guardian was appointed for Lilly. The Local Authority was asked to consider further the Special Guardianship Order assessment which had been undertaken of maternal grandmother to be the carer for Lilly's siblings, and the support plan, for the Court to consider the following day.

7.10 At the Court hearing on the 15th March a Child Arrangement Order (CAO) was made, placing Lilly in the care of maternal grandmother, with an Interim Supervision Order to the Local Authority. The Local Authority did not object, and the Cafcass Children's Guardian supported the plan. Lilly was discharged from hospital on 17th March, to the care of maternal grandmother. Both maternal grandmother and the special guardian, put themselves forward as long-term carers for Lilly.

7.11 The assessment of maternal grandmother, filed at Court on 29th March, did not support the long-term placement of Lilly with her maternal grandmother, as it was felt she would be unable to meet the long-term care needs of three children, and the placement of Lilly would undermine the care of her siblings.

7.12 The viability assessment of the special guardian was positive and a full assessment was to be undertaken by the Special Guardianship Team. She had visited Lilly in hospital and in the home of maternal grandmother. Lilly stayed with her in early April when maternal grandmother went on a short holiday. There was frequent contact during the assessment period, including overnight stays.

7.13 A "new birth assessment" was made by the health visitor at the local Primary Care Centre on 1st April. Maternal grandmother was invited to take Lilly to the Well Baby Clinic for her 6 week assessment on 12th April.

7.14 The Children's Social Care assessment of Lilly was completed on 5th April, with a recommendation that Lilly be placed with maternal grandmother on an interim basis while the Court concluded her long-term care and permanency. The possibility of reunification with her mother was kept open, although doubt was expressed about the mother's ability to make the changes necessary

within Lilly's timescales. The long-term future for Lilly was an SGO with the special guardian with a parallel plan for adoption if the assessment should not be positive.

7.15 A Child in Need (CIN) meeting was held in late April, confirming the above plan. Both the mother and special guardian were present, as well as the social worker and the health visitor. Following the CIN meeting the case was transferred to a different social work team.

7.16 Records suggest that Lilly was staying with the special guardian on 1st June, but an unannounced visit to maternal grandmother on 22nd June suggested she was still there. The likelihood is that she was being cared for by both the special guardian and maternal grandmother.

7.17 The special guardian presented very well and demonstrated structure in her life. She had had difficulties as a teenager but had addressed these and returned to education. The care of her children was to a high standard and reports from their school were positive. She had considerable support from her mother, who lived nearby.

7.18 The SG assessment, recommending that the special guardian be made the special guardian for Lilly, was completed on 29th June, and the assessor closed the case. A CIN meeting on 30th June recommended that Lilly move to live with the special guardian. She did so on 7th July.

7.19 On 14th July a CAO was made for Lilly to live with the special guardian.

7.20 The final court hearing took place on 5th September, when an SGO was made to the special guardian. Discussion took place considering the possibility of a Supervision Order alongside the plan, but the special guardian argued, as did the Cafcass Children's Guardian, that support would be provided by the Local Authority through the SGO support plan and the CIN plan.[1]

7.21 Lilly attended the Well Baby Clinic for the special guardian's area.

7.22 On the 18th November a support worker from the SG team was allocated to the special guardian. The support worker made contact with the special guardian on 30th November, but there seems to have been no response and the case was closed by the team on 7th December.

7.23 Supervision notes from 25th January 2017 in the children's social work team suggest that visits were taking place to see Lilly and the special guardian, but no records exist, and the case was closed to the service on 22nd March 2017.

[1] A Supervision Order gives the Local Authority the legal power to monitor the child's needs and progress. The Local Authority has the responsibility to "advise, assist and befriend" the child. In practice this means the Local Authority gives help and support to the family as a whole. The person with authority for the child, such as the Special Guardian, is required to give details of the child's address and allow the Local Authority social worker reasonable contact with the child. In this case, it would have given the Local Authority more formal authority to pursue the Child in Need plan for a specified period.

7.24 There was little post-placement support, either from universal services (health visiting) or specialist services either through a CIN plan or an SG support plan, but Lilly appears to have settled well and happily into the special guardian's family. The nursery she attended from April 2017 described her as a happy, well cared for child who was meeting all her milestones.

7.25 The convicted perpetrator was the father of the special guardian's first child, but at the time of the SG assessment she told the assessor that she had not had contact with him since she became pregnant, and he had had no contact with this child, at the time of the SG assessment.

7.26 He had a long history of mental health problems and struggled to find a consistent service. At one point he was referred for ADHD services but there was a year's waiting list and in the event he never accessed the service.

7.27 He also had a history of violence: he first became known to West Midlands Police in 1999 as a result of committing offences as a juvenile. Some of these involved assaults committed at school. From 2005 to 2016 he committed a number of domestic abuse offences, including assaults against two previous partners, and family members. He also committed violent offences against members of the public.

7.28 On 24th March 2017 a previous partner dialled 999 and reported to police that he was 'smashing up' her house, and that she was outside whilst he was inside with their child. She stated that they had had an argument in relation to contact with their child. This was identified as a domestic abuse incident and graded medium risk by means of the Domestic Abuse Safeguarding Risk Assessment (DASH).

7.29 He was arrested for assault and criminal damage. He was bailed with conditions not to contact this partner or attend her property, and to appear at Birmingham Magistrates Court.

7.30 The report was reviewed by a Public Protection Unit (PPU) officer within Birmingham MASH. It was forwarded for joint screening by the Children's Advice and Support Service (CASS), with the recommendation that a family assessment was required.

7.31 He appeared before Birmingham Magistrates Court on 3rd July 2017. He was found guilty of battery and criminal damage and sentenced to a 12 month Community Order with two requirements: a Rehabilitation Activity Requirement and Building Better Relationships (BBR), a domestic abuse perpetrators' group work programme. A restraining order was also issued.

7.32 The Probation Service began to supervise him on the 12th July 2017. He was known to present a "medium" risk to his former partner but the risk to their child was assessed as low.

7.33 He attended as required for the most part. Where he did not, enforcement action was taken in the form of warning letters, in line with Probation's procedures.

7.34 The BBR programme pre-work was completed as required by the Probation Officer (PO) on 28th July. On 14th August he attended a one day session facilitated by an officer and a peer mentor entitled Transition and Hope where he participated well. On 20th September he was seen by the Programmes Tutor for pre-group session 1 of the BBR. At this meeting he disclosed that he was in a new relationship with a woman who he used to see when he was younger. The record is comprehensive and details that this new partner, who is unnamed, has three young children. At an earlier stage in his order, he signed a statement of understanding which informs participants of BBR that victims will be contacted, that new relationships should be disclosed so that new partners can also be contacted by the Women's Support Worker (WSW).

7.35 Although this information was recorded, the information was not individually communicated to the Probation Officer, as required by procedures, nor copied in to the WSW, so that information about the risks posed by him was not shared with the special guardian or Children's Social Care. Had this information been shared with Children's Social Care it is likely that a Strategy meeting would have been held and a Section 47 investigation undertaken.

7.36 In October 2017 the special guardian expressed concern to the nursery about the number of bruises sustained by Lilly. On 2nd October Lilly was referred by the GP to Birmingham Children's Hospital (BCH) with unexplained bruising. She was said to have been vomiting the previous day. She was seen by a triage nurse, a junior doctor and a consultant paediatrician. A diagnosis was made of a rash, possibly as a consequence of a virus. The special guardian was requested to return on the following day for a thorough examination of the child and blood tests. Following that visit the consultant paediatrician concluded that there were no safeguarding concerns.

7.37 On 30th October the special guardian told the nursery she had seen new bruises on Lilly on the Saturday. She had not seen the bruises on Friday but had put Lilly to bed as soon as they got home from nursery. The nursery said there had been no incidents on the Friday but agreed to keep a record of marks or bruises on body maps.

7.38 On 14th November the special guardian took Lilly to the GP as she was concerned that she appeared to bruise easily, was bruised in odd places, and did not appear to react to pain. The GP later telephoned the PAIRS advice line (Paediatric Advice and Integrated Referral Service). This service is staffed by consultants. The GP talked to a consultant paediatrician, who noted that no safeguarding concerns had been identified when she was seen at BCH on the 2nd and 3rd October. An "urgent" appointment for 21st November was made.

7.39 On 19th November Lilly was found unresponsive by the special guardian's partner, the convicted perpetrator, who called an ambulance. On arrival at hospital her condition was found to be critical and despite two emergency

brain operations and life support, Lilly died on the evening of 22nd November 2017.

7.40 The Sentencing Remarks of the judge in the trial of the perpetrator makes it clear that the perpetrator was an accomplished liar and manipulator and was persistently able to convince the special guardian that he was not responsible for Lilly's injuries, despite her concern and possible suspicions.

8 KEY ISSUES

8.1 The quality and robustness of assessments, reports to court, care planning and court decision making processes and the degree to which information about the individual making application for an SGO was evaluated, assessed, challenged and analysed during the proceedings.

8.2 A referral was appropriately made to Children's Social Care as soon as Lilly was born and a strategy meeting held the following day. A decision was made at that meeting that the case would be dealt with under Section 17 of the Children Act 1989 by Children's Social Care as single agency. The case was allocated to a social worker in the area safeguarding team and an assessment of Lilly commenced with detailed instructions, including the need to ascertain the mother's wishes for her child and her capacity to care for Lilly, and a viability assessment of maternal grandmother's ability to care for Lilly.

8.3 It was appropriate to deal with the case under Section 17 as Lilly was in a place of safety and at the time her mother was not proposing to remove her; however the decision not to undertake a Section 47 investigation meant there was no independent perspective on the care planning that followed.

8.4 When the mother expressed her desire to care for Lilly herself, on 25th February, a Legal Planning Meeting was appropriately held on 1st March, and the Court process was put in train. The assessment of Lilly was completed on 5th April and signed off by the team manager on 10th April, within the required timescales. The assessment summarised Lilly's family situation well and detailed her health and progress while in hospital though there is no information about her health after discharge.

8.5 There is no reference in the assessment to a possible impact on Lilly's emotional development of her having been in hospital for the first three weeks of her life.

8.6 The assessment of Lilly was completed to a good standard. The team manager showed a good knowledge of Lilly's circumstances and the issues, and demonstrated oversight of the work. The plan for Lilly was not finally settled at this time. It was rightly concluded that she needed long term care arrangements settled as soon as possible and the actions required of Lilly's parents for them to assume care of her were detailed.

8.7 The plan at the conclusion of the assessment, when Lilly was seven weeks old, was that her parents should take steps to demonstrate their capacity to provide her with a safe and secure home.

8.8 This does not seem to have been realistic: Lilly's mother had said that she wanted Lilly to live with her and visited her in hospital, but she had only attended one planned contact since Lilly's discharge. Further she had not engaged with drug treatment services or sought help for depression which she said she had experienced for ten years. Lilly's father was also dependent on drugs. Lilly's parents continued to live with each other and there was no indication that her mother planned to secure her own home to further her aspiration to care for her daughter.

8.9 While it was right to encourage and support Lilly's parents to resolve their difficulties and find stability in their lives there was no basis for believing that this could be achieved in timescales compatible with Lilly's needs. Clear plans for permanent care by others should have been in train at this point. It is probable that had Lilly been in Local Authority care with no prospect of a placement within her family, planning for adoption would have been pursued by this time.

8.10 Enquiries were made with maternal grandmother who was caring for Lilly's siblings; she offered to care for Lilly also. The team manager instructed that the suitability of this arrangement be assessed.

8.11 On 2nd March, in preparation for Court, the social worker contacted maternal grandmother and told her that the Local Authority intended to initiate care proceedings and asked her if she would be willing to care for Lilly while assessments in relation to her permanent care were completed. Maternal grandmother said she did not want Lilly to be placed in the care of the Local Authority and agreed that she would care for Lilly on an interim basis. This discussion was contrary to the view of the Legal Planning Meeting held the previous day, when the advice was that Lilly be placed in foster care on an Interim Care Order, while assessments of parents and family members were carried out.

8.12 On 7th March the social worker completed the social work evidence template (SWET) for the Court proceedings, including the assessment of Lilly and her needs. The first option was for Lilly to be placed with her parents, the second was for her to be placed with family members and the third was adoption. Factors in favour and against each option were set out.

8.13 The Local Authority's preferred plan at this stage was for Lilly to be placed in foster care while an updated assessment of her parents and proposed family members took place. Placement with members of the extended family was not recommended in advance of assessments being completed.

8.14 At the first court hearing on 14th March both the mother and maternal grandmother opposed the plan to place Lilly in Local Authority care. The Court directed the Local Authority to consider further the SGO assessment of maternal grandmother which had been completed the previous year when she was awarded care of Lilly's siblings.

8.15 The Cafcass Children's Guardian was appointed at this hearing. She had read the key papers and was aware that Children's Services were seeking an Interim Care Order (ICO) and planned to place Lilly in Local Authority foster care. She met the mother, maternal grandmother and special guardian at the first hearing. Maternal grandmother and special guardian told the Court that the family had met and believed that Lilly should remain in the family and that the special guardian would be best placed to care for her. However, she had not been assessed. The Cafcass Children's Guardian's view was that Lilly should be placed on an ICO with maternal grandmother as a Connected Person's foster carer.

8.16 The Local Authority's policy was that a Connected Person required a full assessment before a child was placed with them as it was difficult to remove a child from the care of a relative even if the assessment was negative.

8.17 The social worker visited maternal grandmother in the evening of the first Court hearing and made a good range of enquiries and observations, talking to Lilly's two siblings and seeing school attendance certificates. Maternal grandmother said she routinely provided day care for two other children. There were no immediate safeguarding concerns for Lilly in the care of her maternal grandmother but there remained questions about the contact she had with Lilly's mother and what support she needed and would have from other family members while caring for three children.

8.18 A CAO with an Interim Supervision Order (ISO) was made to maternal grandmother. The Local Authority did not oppose the CAO although it was not their preferred plan for Lilly. An ICO would have given Parental Responsibility to the Local Authority whereas the CAO and ISO allowed the family to decide between themselves the arrangements for Lilly's care.

8.19 The social worker completed viability assessments of maternal grandmother and of the special guardian and filed these in Court as directed on 29th March 2016. A full assessment of maternal grandmother as a Special Guardian to Lilly was not recommended. The assessment was good and balanced with strong analysis of the strengths and vulnerabilities of this care arrangement in the long term. Had this been available for the first Court hearing it would have given strength to the Local Authority view that an ICO and placement with Local Authority foster carers while assessments were completed was the best plan for Lilly's long-term care.

8.20 The viability assessment of the special guardian was positive and led to a full SG assessment by an SG assessor.

8.21 The Cafcass Children's Guardian also assessed the needs of Lilly, her mother's ability to care for her and met with and observed maternal grandmother's and special guardian's care of Lilly. By the end of April she was aware that the special guardian was already probably Lilly's primary carer. As Lilly was placed with maternal grandmother on a CAO this was a decision that maternal grandmother was able to make, though it is not clear that the Local

Authority was aware that the balance of care had moved to the special guardian.

8.22 A positive assessment of the special guardian for Lilly was received and placed before the Court on 14th July 2016. The assessment did identify some vulnerabilities, and the Cafcass Children's Guardian explored these further with the special guardian on two further visits.

8.23 The assessment was as thorough as it could be, within the time constraints set by the Court timescale (see Paragraph 9.7). The assessment was completed using the Connected Persons Form C assessment framework which requires checks and references in line with fostering regulations. There were six interviews at the special guardian's home, three interviews with personal referees, a health assessment, seen and signed off by the agency medical adviser, and other agency checks. The assessor spoke to each of the applicant's children and observed them with Lilly. The assessor felt that the applicant was quite open, and that she had got to know her well in the course of the assessment.

8.24 There were significant positives in the assessment:

- The applicant had received counselling following a difficult childhood which she said had involved abuse, and a period of alienation from her mother. Counselling had enabled her to rebuild her relationship with her mother;
- Although she left school early she had studied as an adult and was waiting to take up a university place;
- The care of her children was observed to be of a high standard and the schools the children attended spoke highly of her as a parent.
- She had protected herself and her children when a partner became violent.

8.25 However, there were areas of the assessment which could have been explored in more detail:

- A decision was made not to interview any of her former partners. It was only thought to have been feasible to interview the second partner, who had been violent, and permission was given by a senior manager that this was not necessary. In fact, there seems to have been no reason why this former partner, who was the father of the eldest child and the subsequently convicted perpetrator, should not have been seen, although the relationship was thought to have finished some ten years before.
- There was no real exploration of the applicant's relationship history, and a lack of professional curiosity about the links between her childhood and adolescent difficulties and her apparent difficulty in sustaining a long term relationship.
- There was a failure to explore the extended family dynamics in which Lilly's mother, maternal grandmother, the applicant and Lilly lived and which would impact on Lilly's life as she grew up. There was little discussion on how contact by Lilly's mother might be managed.

- It was known that the applicant's mother, who lived nearby and was the special guardian's main source of support, had a child with difficulties for whom she was caring, and there was no discussion about the limits on the support she could provide, nor the amount of support which the applicant provided to her mother.

8.26 A fuller assessment would probably have precluded her approval as a foster carer or adopter (see paragraph 29.1). Nevertheless, she was a close relation of Lilly, was the choice of Lilly's mother and maternal grandmother and would ensure that Lilly grew up within her own extended family and culture.

8.27 The initial assessment of maternal grandmother and special guardian, followed by the SG assessment, met the court timescales for completion within 26 weeks, but gave no time for reflection or monitoring of the placement prior to a final decision.

9 The quality of post court decision making, support and oversight processes put in place to support and monitor the SGO placement.

9.1 The post court support and oversight processes were based on the care planning processes described in detail in the previous section. The CIN planning process and the SGO Support Plan were the two mechanisms in place at the time the SGO was made and these were intended to continue for at least three months after the making of the Order.

9.2 The first CIN meeting was held in late April, when Lilly's mother, special guardian, the health visitor and social worker were present and the plan clarified the detail of where Lilly would live and who would care for her in the long term. An ISO was in place alongside the CAO from the point of Lilly's placement with maternal grandmother until the SGO was made. Social workers were unclear about their separate responsibilities within this role and the ISO plan used the framework for an Interim Care Plan. However the role was carried out within the CIN plan, which itself was part of the care planning process, and seen by Children's Social Care as driven by the Court processes.

9.3 The original team and social worker changed after the first CIN meeting and some of the care planning impetus was lost, as is often the case. The next CIN meeting is recorded as having taken place on 30th June, although there is no detail available about this meeting, and it would seem the health visitor was not invited. The meeting was, therefore, just the social worker and the family. The social worker and her manager have said that the care planning was driven by the Court processes.

9.4 The SG Support Plan, about which the Cafcass Children's Guardian had some concerns, was made more robust prior to the final hearing. The CIN plan was intended to be in place for three months post order and would focus on the needs of the child. The SG Support Plan would be in place for six

months post order. It relied upon the special guardian taking up the offer of support, which she did not do.

9.5 There is no provision for formal oversight of children placed through SGOs, although many Local Authorities provide training and regular support to SGs, subject to their accessing it.

9.6 However, on 19 May 2016 Mr Justice Keenan, Family Division Lead Judge for the Midland Circuit circulated a letter by e-mail to Directors of Children's Services. Following this on 19 July 2016 he held a meeting with the Chairs of the Local Family Justice Boards and in August circulated a further, clarifying letter to Directors of Children's Services. The letters are both wide ranging but SGOs feature prominently in both and he stated:
"It is imperative that these are considered to be at the adoption end of the spectrum and not, as I fear they are now, at the CAO end of the spectrum…

A SGO should not be made, absent compelling and cogent reasons, until the child has lived for an appreciable period with the prospective special guardians."

9.7 Compliance with this would have required time to embed and it does not appear to have been considered at the conclusion of proceedings for Lilly. The Local Authority was required to commit to a plan within a month of placement (because of the legal requirement to conclude care proceedings within twenty-six weeks) and in the SGO support plan the Local Authority was offering three months' support of Lilly through a CIN plan, to be extended if required or requested.

9.8 Following Mr Justice Keenan's letter, in Birmingham it has been the expectation that, following a positive assessment of a prospective SG for a child who is the subject of an ICO, the Local Authority will approve the carer as a Connected Person foster carer and the child will be made the subject of a Care Order for a trial placement of around twelve months. If this is successful, the matter will be returned to Court for revocation of the Care Order and the making of a SGO. By the time the meeting with the local Family Justice Board Chair's and clarifying advice was circulated (August 2016) Lilly was already placed with the special guardian.

9.9 However there remains no agreed route to a trial period with a prospective SG when the child has been the subject of a CAO during care proceedings.

9.10 Lilly was placed with the special guardian in July, shortly before the school holidays. At the time she was the subject of a CAO to the special guardian and an ISO. The SG assessment was complete, and although Lilly would have been seen at Court hearings on 14th July and 5th September (final hearing) there is no evidence of visits by the social worker until 7th September.

9.11 It would seem that the Cafcass Children's Guardian visited and saw Lilly with the special guardian on 6th July, 12th July and 26th August, although no record of these visits are available, the information gathered having been used for the Guardian's final report to the Court.

9.12 The support plan for Lilly was that the social worker would continue to visit monthly after the Order was made, and hold regular CIN meetings. A CIN plan is intended to offer support to enable a parent or carer to best meet the child's needs. Its success depends on the engagement of the carer. At the same time a SG Support Team worker would be allocated, who would offer support to the special guardian and her needs.

9.13 Although supervision of the social worker in January 2017 noted that "visits taking place; Lilly doing well; special guardian engaged" there is no actual record of any visits or of any CIN meetings after the SGO was made. No health visitor was involved in any meetings after April. The case was closed on 22nd March 2017. In other words there is no firm evidence of any visits after the 20th October from Children's Social Care. There was contact recorded from the social worker by email and telephone about the larger car which the special guardian wished to purchase to transport her now larger family, and the financial support she sought from Children's Services.

9.14 A SG Team support worker was allocated on 18th November 2016. The worker contacted the social worker on the 30th November for advice about specific support for the special guardian. The case was closed by this team on 7th December as there was no response by the special guardian to telephone calls and offers of help.

9.15 Both the case holding team and the SG Support Team should have been monitoring whether support was taken up. The lack of recorded visits and meetings should have been picked up by data monitoring and highlighted to managers. Had CIN meetings, home visits, support visits taken place practitioners might have had a proper sense of what life was like for Lilly within this family.

10 The degree to which universal services were engaged in providing ongoing monitoring of the placement and whether they demonstrated appropriate rigour and professional curiosity about the nature of the household.

10.1 In terms of health visiting services, as a child subject to an SGO, Lilly should have received additional monitoring and support. In fact, the health visitor from maternal grandmother's local clinic, who had been part of the original CIN, contacted the social worker on 26th July to be told that Lilly had moved to the special guardian and had a new social worker. On 13th September Lilly was taken to the special guardian's local Well Baby clinic for the first time. At this time Lilly was not identified as a child new to the caseload and no assessment of her needs took place during her

placement with the special guardian. This was the last recorded contact with Lilly by the health visiting service.

10.2 The Community Child Health Services (health visiting) was aware that Lilly was subject to an SGO, and that her neonatal health was seriously compromised: this information was held within the system. There was poor communication to this service by Children's Social Care but in fact the information was already with the service. Not only did the service not offer any monitoring or oversight of the placement, there was no enhanced service to a child with potential additional health and social needs, information that was available from the safeguarding nurse in the original MASH meeting. It is not clear whether there was any routine referral from Heartlands Hospital to Community Child Health Services when Lilly was discharged from hospital, although there appears to be a system for this.

11 Whether any concerns or indicators of concern were raised, identified or, with hindsight, missed in relation to the SG's care of Lilly following the placement, up to and including her death, by any agency, universal or specialist in contact with the family in which she was living.

11.1 As can be seen above there was little contact by Children's Social Care or health visiting services with the special guardian or Lilly after the SGO was made, and none during 2017. However, Lilly attended a nursery on a daily basis during term time from March 2017. She was also seen seven times at the GP surgery, and three times at the Emergency Department of Birmingham Children's Hospital.

11.2 Bruises and other injuries were brought by the special guardian to the attention of professionals on several occasions, including at the ED: she presented as a worried parent. It is possible that she was suspicious of her partner and hoping for confirmation or reassurance. It is also possible that she was concerned that there was a medical cause for the bruising.

11.3 Disguised compliance is the term used to describe a carer giving the appearance of cooperating with services, while in fact failing to do so. Disguised reporting, where a carer reports injuries as of unknown origin when in fact they are aware of how they happened, could have been a feature in this case.

12 Nursery

12.1 On 28th April the nursery recorded an injury to Lilly at the nursery; up to 23rd October there were 13 reports of minor injuries sustained at the nursery.

12.2 On 2nd October 2017 there was a conversation with the special guardian about bruises observed by her on Lilly: bruising on her back possibly caused by lying on her jumper; bruises in her ears from a hard building block. She told the nursery she was taking Lilly to the GP.

12.3 On 30th October, a Monday, there was a telephone conversation with the special guardian about new bruises she had noticed on Saturday, having put Lilly straight to bed on the Friday after nursery: bruises on the ears and under her chin. The nursery officer said there had been no incidents on the Friday but agreed to keep a record of marks or bruises on body maps. They reassured the special guardian and accepted her explanations. Later that day a bruise was noticed on Lilly's bottom when her nappy was changed.

12.4 A bruise was noted on the back of her head on 31st October.

12.5 On 1st November there was a meeting with the special guardian at the nursery. She described Lilly's early history and stated that she had been seen at the BCH. The nursery was told that blood tests were normal. The special guardian queried whether Lilly felt pain. The nursery agreed to complete the first of 10 body maps on Lilly. This one showed 16 marks including the bruising on her back and the bruise on the back of her head.

12.6 There is no evidence of challenge to the special guardian's narrative or explanations. For example, the nursery was aware that Lilly did in fact feel pain when she hurt herself at nursery. The nursery held no discussion with the Children's Advisory and Support Service (CASS) for advice, as they took the special guardian's words at face value. The Information Report identifies a lack of professional curiosity in the nursery.

13 GPs

13.1 Lilly had been in receipt of a Birmingham Primary Care Medical Service from August 2016, following her placement with the special guardian until her death. Staff at the medical centre were aware that Lilly was cared for firstly by her maternal grandmother and then by her relative, the special guardian. They received the Court documents and this was indicated within the medical record.

13.2 Lilly was seen in person at the surgery 7 times in the course of her life. This was for gastro-enteritis (August 2016); an upper respiratory tract infection (November 2016, twice); vaccinations (April 2017); chickenpox (May 2017); bruising and blanching spots (2nd October 2017); and further "easy bruising" (14th November 2017).

13.3 There were two key episodes in which Lilly was in contact with the GP service. The first of these was on the 2nd October 2017 when Lilly was brought to the surgery by the special guardian with non-specific blanching[2] spots on either side of her back and bruising on the inner ear. The GP noted a recent viral infection and made an urgent referral, with a letter, to A&E at BCH for further investigations, including blood tests. The letter included a query about child protection, and the GP told the special guardian that safeguarding issues might be raised. He telephoned BCH to inform them that the child was

[2] Blanching means that when a spot or mark is pressed it disappears. Eg, The "glass test" used to check for the rash seen in meningitis. It is usually reassuring if the rash disappears.

coming, and he later telephoned the special guardian to ensure that she had attended. When he learned that no blood tests had been undertaken he arranged for these to be done as an outpatient.

13.4 Nevertheless the GP did not seek advice from the safeguarding lead within the practice and nor did he make a referral to Children's Social Care. He thought that safeguarding issues would be addressed at BCH, and in any case he was aware that the symptoms could have a medical cause.

13.5 Later on the 2nd October the special guardian telephoned the GP and told him she had been recalled to the hospital the following day. On 3rd October there was a further telephone contact between a locum consultant paediatrician at BCH and the surgery, stating that the paediatrician had done the blood test and that he had no safeguarding concerns. This was confirmed in a letter dictated by the consultant the following day.

13.6 The second key episode is 14th November. The special guardian telephoned the surgery on 1st November with continuing concern about Lilly's "easy bruising". The (different) GP reviewed the notes and asked for Lilly to be seen by the health visitor (this did not happen) and herself on the 14th November.

13.7 The GP took a very thorough history and sought advice by calling the advice line at BCH PAIRS (see paragraph 7.38) and discussed concerns regarding unexplained bruising and apparent presentation of Lilly being unable to feel pain. The consultant arranged an appointment for the following week.

13.8 In both cases there were sufficient clinical grounds for the GP to take prompt action to arrange urgent paediatric medical opinion, and both GPs did this. However the simultaneous need for effective safeguarding was not fully recognised or acted upon. This was partly because the first GP was working under out-dated safeguarding procedures and assumed the hospital would explore safeguarding issues, and the second GP was reassured by the opinion of the BCH Consultant that there were no safeguarding concerns.

14 Birmingham Children's Hospital

14.1 Following the referral by the GP Lilly was seen at the Clinical Decision Unit on the 2nd October. She presented as unwell and vomiting and the referral was for unexplained bruising to her left ear and back. She was seen by the triage nurse, who noted the bruising and classified her as low priority. She was then seen by a junior doctor who assessed the marks as "non-blanching rash". She was then seen by a consultant paediatrician who made a diagnosis of "multiple petechial[3] rash/viral illness", and discharged her. His notes document that he did consider non-accidental injury in respect of the marks but made a final diagnosis of rash. He later contacted the special guardian and asked her to return with Lilly the following day.

[3] Petechiae are pin prick sized bruises.

14.2 The consultant paediatrician did not contact the safeguarding team at the hospital, but on the 3rd October undertook a very thorough examination of Lilly, with a chaperone present. He said this was as thorough as a safeguarding examination would have been, and was undertaken to ensure that there were no safeguarding concerns. He also arranged for blood tests to be taken.

14.3 It is unusual to call a child back in this way and suggests that the consultant paediatrician may have been uneasy about the case. At the professionals' meeting he was unclear why he had recalled her. He agreed it was a missed opportunity to have a discussion with the BCH Child Protection Team but felt that his own examination on 3rd October was the "equivalent of a child protection medical". He recorded "no safeguarding concerns" both in the medical notes and in the letter sent to the GP. These notes were used when the GP contacted the on-call paediatrician through PAIRS.

14.4 The safeguarding lead at BCH has clarified that there would have been an expectation to discuss the child with the safeguarding team if she were being recalled for an examination. They emphasised the need to be clear, when bringing a child back, whether this is a child protection medical or not. In this instance the consultant paediatrician had not undertaken lateral checks and had deviated from the established process.

15 The operational, organisational and strategic context within which multi-agency children's safeguarding activity (including the court service) was taking place at the time of the court case and the degree to which this context affected front-line practice and decision-making.

15.1 Children's Social Care

15.2 The two teams who had responsibility for Lilly were both fully staffed and stable (and continue to be). All workers with responsibility for Lilly had been in post for at least nine months at the time.

15.3 There had been some changes in the remit of the children's teams responsible for Lilly and workloads were high: all staff members were working to capacity. In terms of Lilly's second social worker she reported a workload which was not unmanageable but which required prioritisation decisions – and given that she had not been involved in the original decision making for Lilly, and that case planning was seen to be driven by the Court, inevitably Lilly's case was perhaps seen as lower priority. All staff interviewed said that workloads have now reduced and are more manageable.

15.4 Processes within Children's Social Care meant that Lilly had a change of social worker following the original CIN meeting in April 2016. The original social worker knew all the key players in the case and there was a lack of impetus following that case transfer, especially given the high case load of the second social worker and the view that the plan was in place and driven by the court.

15.5 All social workers said that their managers were available, supportive and gave effective supervision, though for Lilly's second social worker this frequently had to be cancelled due to other work demands. In fact, it is hard to agree that supervision was effective if it was frequently cancelled, and there is no recorded evidence that supervision was checking that the plan was being followed, nor of reflective and analytical discussion. Pressures have apparently abated and monthly supervision is now in place.

15.6 The Ofsted report on Birmingham (October 2016, i.e. immediately following Lilly's SGO) followed soon after the SCR on a Birmingham child subject to an SGO. The report stated *"The Local Authority has taken robust action to ensure, following a recent child death, that the circumstances of children subject to a special guardianship order (SGO) have been reviewed to ensure their welfare. Current assessments to place young people under SGOs with carers are now of satisfactory quality."*

15.7 *"The Local Authority took practical and decisive action to review and improve the welfare of children living with special guardians and connected persons following the death of a child in 2015. Detailed reviews of children who were subject to proceedings for special guardianship orders, and those who had been placed with special guardians over the preceding two years, were undertaken. Appropriate follow-up action was taken when relevant to promote individual children's welfare. The Local Authority has added substantial resources to develop the assessment and support service for SGOs and connected persons to ensure that these placements are timely, safe and supported for children. SGO and connected persons assessments are now of a good quality. Furthermore, the Local Authority is in the process of identifying and contacting all special guardians to explain its offer of support."* In relation to this case, this assessment by Ofsted may well have been accurate, but any review did not throw up concerns.

15.8 These changes were underway at the time of Lilly's placement and the assessment of the special guardian. Further changes were taking place in line with the letters from Mr Justice Keenan referred to in paragraph 9.6 but were not embedded at the time decisions for Lilly were taking place. Post SGO support (referred to in the Ofsted report) was only implemented in April 2016 so was at an early stage when this SGO was made. And indeed, planning for Lilly was made more difficult for the Local Authority given her legal status which effectively gave control to the family.

15.9 Birmingham Children's Services was assessed as inadequate by Ofsted in October 2016 and it is therefore likely to have been the case that advice and guidance were slow to be picked up and acted upon. Nevertheless, in a well-functioning Local Authority there would be an expectation that a director receiving such a strongly worded communication from Mr Justice Keenan, would immediately ask staff to identify what SGOs were ongoing and seek reassurance that each child had been placed with their carers for long enough to assess.

15.10 In fact, following the death of a young child subject to an SGO in 2015, Children's Services had reviewed all children subject to SGOs and those in proceedings, and had developed assessment processes and post-order services which were significantly better than many other authorities.

15.11 Within Children's Services it is clear that there was a lack of clarity between the roles of the child's social worker and the SG Support Team.

16. Cafcass

16.1 Both the Cafcass Children's Guardian and her manager had been in their posts for over ten years: this suggests a stable team and service, although at the time the team manager had no practice supervisors to support her, unlike other areas in the organisation, which meant that her time was stretched for supervision.

16.2 There was a failure by the Cafcass worker to record her visits to Lilly and the special guardian, merely including them in her assessment. This does not seem to have been picked up in supervision, nor by any practice-monitoring system.

16.3 There was an issue around Birmingham failing to give prior warning to Cafcass of pending applications, which made work difficult to plan.

16.4 There is some evidence in the Information Report of a lack of dialogue and understanding between Birmingham Children's Services and Cafcass about Birmingham's policies and procedures. For example, Birmingham did not approve family carers as Connected Persons foster carers prior to a detailed assessment, in line with the Fostering Regulations 2015; in some Local Authorities children could be placed with relatives approved as Connected Persons foster carers while subject to an ICO. Cafcass felt this arrangement worked well for children; the view of Birmingham was that this often pre-empted a poor assessment.

17. Court service

17.1 The legal proceedings regarding the care of Lilly took place before magistrates: a Family Court Judge might have had a more robust approach to the SGO, in line with the advice of Mr Justice Keenan.

17.2 Court timescales meant that the viability assessments of maternal grandmother and the special guardian, as well as the full assessment of the special guardian had to be completed within 26 weeks, giving no time to monitor and assess the special guardian's care of Lilly in the longer term. The DfE Special Guardianship Review (Dec 2015) identified a national issue about assessments being carried out "very quickly to meet court timelines".

18. Community Health Care: Health Visiting Service

18.1 Because the electronic birth notification records recorded Lilly's address as that of her mother at the time of her birth, the notification was forwarded to the Health Visiting Team based on her postcode. Subsequently there was a failure to notify the local health visiting service for maternal grandmother when Lilly was discharged to her care under a new health visiting team.

18.2 The Rio electronic patient system was new in January 2016, and staff took time to receive training on its use, and to become familiar with it.

18.3 The health visiting service was engaged with Lilly when she was placed with maternal grandmother as she attended the Well Baby clinic for Lilly to be weighed, and a health visitor attended the first CIN meeting. However, she was not told of the following CIN meeting, and when she pursued this, she found that the case had been transferred to a different social worker and team and that Lilly was now placed with the special guardian within a different health visiting area.

18.4 Lilly was taken by the special guardian to her local Well Baby clinic on 13th September 2016 soon after the making of the SGO. However, she was not identified as a child new to the area and therefore the Rio system did not generate triggers for normal checks.

18.5 The health visiting service for the special guardian moved their office base in September 2016, around the time that the SGO was made. This required the transfer of all paper records to the new base. It also detached the health visiting team from the GPs at the Medical Centre, meaning there was little face to face contact and informal exchange of information. It was also probably the reason why Lilly was not seen as requested by the GP prior to her appointment on the 14th November. Regular meetings are now taking place between the GPs and health visitors and these are audited.

18.6 A change in bordering arrangements at this time resulted in the relevant health visiting service receiving over 1000 records from a bordering team, with a requirement to contact all the families being transferred. There was significant sickness within the team and the senior nurse had left. No additional staff resources were available to support the team. There is no doubt that this affected the service provided to Lilly and the special guardian.

19. Birmingham South and Central CCG: GPs

19.1 GPs who have been in practice for many years may still be practicing according to the way they had previously been trained. Level 2 training includes the need for children with suspicious bruising to be referred to social care. All GPs have to be trained to level 3 in safeguarding. The report from the CCG states that level 3 safeguarding training covers a huge amount of material and it is hard to remain up to date with each area. In addition, training has not previously covered some of these areas in detail such as how to risk assess and manage a child with bruising in the surgery. There is no local brief

guidance for GPs to help them make decisions regarding a bruised child within the time pressure that they face.

19.2 All GPs who saw Lilly were up to date with CP training. However, the reality is that bruising can be presented in a complex context that is not dealt with in the training. It can be tricky to know whether to refer a child for medical investigations first in order to rule out medical causes of bruises or other symptoms, before referring to social care; or to do things in reverse order, or simultaneously. The previous practice was to refer to the hospital where a paediatrician would be better placed to make the differential diagnosis.

19.3 This GP was weighing up upsetting a family already anxious about their child's symptoms by referring them to social care, versus getting a medical opinion but missing an opportunity to safeguard a child. A telephone call to CASS for discussion is possible within working hours and could have been made when Lilly was seen on 2nd October. It was not done because the GP did not perceive CASS to be a source of advice or help due to unhelpful historic interactions with social care and its reputation for being slow to respond. There is an expectation that GPs are able to have difficult conversations with patients and parents in an appropriate way. GPs are encouraged to develop positive relationships with CASS and Children's Services through their safeguarding leads.

19.4 Health visitors are no longer present on site with GPs and have to be contacted by telephone, making it harder for GPs to discuss informal concerns with them rapidly. There is now, since 2018, a duty and advice line available.

19.5 There is another child on the practice list with congenital insensitivity to pain. The existence of this syndrome was in the GP's mind when assessing Lilly on 14th November and the GP felt it provided a possible explanation for the set of symptoms presented.

20. Birmingham Children's Hospital

20.1 It is evident from the Information Report that all the doctors working in the Emergency Department at BCH, apart from the on-call consultant, had received Level 3 Child Protection training. This includes the original Consultant Paediatrician and the Junior doctor, both of whom were locums who have since left the hospital. It is reassuring to note that all locum medical staff have the required child protection training. Nevertheless, it is possible that their locum situation meant a lack of familiarity with key processes which were possibly more embedded for permanent staff.

20.2 The expected procedure was that the consultant would consult with the lead safeguarding consultant, and the safeguarding team. This did not happen.

20.2 The Emergency Department at BCH is extremely busy during winter months including October and November 2017. The Emergency Department managers had raised the issue of workload and capacity with the Trust Board.

21. Probation

21.1 The Programmes Tutor in the Probation Service became aware that the convicted perpetrator had a new partner, the special guardian, who had children, in September 2017. Although the information was recorded on the case notes by her, procedures required that she inform the Probation Officer verbally (by telephone or in a face to face meeting) and confirm this information in an email. That email is duplicated by the system and copied to the Woman's Support Worker (WSW). In this case she did not inform the probation officer or the WSW.

21.2 The probation officer relies on the system working, so although in ideal circumstances, they would read the case notes and hence would have picked up the information and made the relevant referral to the WSW themselves, that did not happen in this instance. The probation officer was responsible for 60 cases at the time, so was unable to prioritise reading all the case notes.

21.3 Had the probation officer and WSW been made aware of the new information the response would have been a referral to the Multi-Agency Safeguarding Hub (MASH) with information on the new partner, the special guardian, and contact by the WSW with the special guardian to make her aware of the identified risks potentially posed to partners and children by the perpetrator.

21.4 The Probation Service guidance and process is clear. From this case, the Service has identified that the process is not sufficiently robust. A review is to be undertaken by the service to determine whether a change to the process is required.

21.5 Indeed, this omission may well have had very serious consequences for Lilly, and may be the single omission that could have made a difference.

22. Whether there are any key national, regional or local policy issues arising from the use of an SGO in the circumstances that need to be addressed.

22.1 The key issues for this case that arise from local and national research, and relevant SCRs (see Appendix 3 for a full analysis) are as follows:

- The importance of a close family relationship for the child with the special guardian;
- The importance of wider family support for the arrangement;
- The management of contact;
- The importance of understanding an SGO as at the adoption end of permanence;
- The pressure of court timescales.

23. Close family relationship, family support and contact

23.1 It is clear that, in the event of her not being able to care for Lilly herself, the mother favoured her placement with either maternal grandmother or the

special guardian. Lilly and the special guardian were related and in many ways the special guardian and Lilly's mother had grown up as sisters.

23.2 The Court was informed by both the special guardian and maternal grandmother that "the family" wished the special guardian to care for Lilly. There is no evidence of a family meeting or Family Group Conference being held.

23.3 There was no analysis in the assessment of the special guardian that the wider family dynamics were explored, nor that there was a detailed discussion of how contact might be managed, although this was part of the support plan.

24. SGO and adoption

24.1 The statement by Mr Justice Keenan (paragraph 9.6) is very relevant to the issue of the permanence spectrum, placing SGOs firmly at the adoption end. This is particularly relevant because SG applicants have often made their application in a rush faced with a difficult family situation, and subject to emotional pressure from family members. Adopters have generally reflected about their decision for a long period of time before making the decision to apply. They then are subject to an intense period of training and assessment. While SGs are assessed there simply is not sufficient time for the necessary depth of reflection, analysis or training to take place.

25. Court timescales

25.1 A Research in Practice deep dive study for the DfE (2015) identified a number of concerns around the use of SGOs within the context of care proceedings, including challenges in completing assessments within the court's timeframe and a disconnect between the views of the Local Authority and the court on the most appropriate order for the child.

25.2 As a result the DfE commissioned a qualitative case file study for children who have been the subject of SGOs with a particular emphasis on investigating the impact of the 26 week time limit and court judgments such as Re B-S, the 2013 judgment that adoption without consent was only permissible where "*nothing else will do"*. This has been interpreted by local authorities (and some courts), as placement within the wider family at all costs. This study looked in depth at 50 SGO cases from 5 Local Authorities and concluded that the timescales for completing assessments of potential SGs are squeezed following the revised PLO and the expectation that cases will be completed within 26 weeks. There was concern about the rigour of assessments and the support provided to SGs in comparison to the assessment processes and support services for adopters and foster carers, whose children may have similar needs.

25.3 There was a perception that, since Re B-S, Courts had lower thresholds for approving SGs, focusing on "good enough" here and now, while local authorities were looking further into the child's future. There was a level of tension identified between Courts and Local Authorities. Certainly there is

evidence in the case of Lilly that the Local Authority wished for Lilly to be placed with foster carers while in depth assessments of maternal grandmother and the special guardian took place but were aware of the Court's view and succumbed to it without testing it.

25.4 In December 2014 Justice Munby clarified the implications of his *Re: B-S* judgement:

"I wish to emphasise, with as much force as possible, that Re B-S was not intended to change and has not changed the law. Where adoption is in the child's best interests, Local Authorities must not shy away from seeking, nor Courts from making, care orders with a plan for adoption, placement orders and adoption orders. The fact is that there are occasions when nothing but adoption will do, and it is essential in such cases that a child's welfare should not be compromised by keeping them within their family at all costs."
Re R (A Child) [2014] EWCA Civ 1625
https://www.judiciary.uk/wp-content/uploads/2014/12/re-r-a-child.pdf

26. VIEWS OF PROFESSIONALS

26.1 A workshop was held for professionals and their managers who had been involved in the care of Lilly. There were 22 participants all of whom contributed in a thoughtful manner. The first part of the meeting members worked in small multi-agency groups, considering the key SCR issues. During the second half only those professionals involved in the last two months of Lilly's life took part and the events of those weeks were analysed together. This conversation is incorporated into the main body of the report. The small group notes can be found in Appendix 1.

26.2 Some significant thoughts from the workshop:

- Once the Court made the decision to place Lilly within the family it was difficult to propose an alternative plan, eg. foster care, unless there had been evidence of significant harm. The first order set the agenda;
- The Local Authority did not seek a change from magistrates to a designated judge: identified it as a "simple" case;
- Robustness of assessments: lack of analysis regarding former partners; lack of information about the mother's relationships within the family;
- The SG Team and support process were new at the time;
- Unfortunate that the SGO assessor left after the assessment because she could have provided post SGO support;
- Lack of professional curiosity about previous partners, mental health history and family relationships;
- Comparison of adoption and SGO assessment and post placement regulation and support.

26.3 Ultimately the consensus was that even if the assessment had been more in depth and explored previous partners, or the health visiting service had identified Lilly as a child with additional support needs, it is likely the court would have made the same order.

27. VIEWS OF FAMILY MEMBERS

27.1 There was a significant delay in meeting with family members because the police investigation was very complex requiring specialist advice which was in short supply and hard to access. The whole investigation and court process took nearly 4 years.

27.2 Once the police investigation and court case were complete the reviewer and a Review Team Member met with the mother and her mother, the maternal grandmother, and later, the special guardian.

27.3 There was no attempt to make contact with the father of Lilly, since there was no evidence from any of the reports that he had been involved in planning for Lilly's care, or in her life.

27.4 The meetings with family members took place nearly 4 years after Lilly's death. The body of this report was written early in 2018, soon after Lilly's death, and uses contemporaneous records.

The mother and maternal grandmother

27.5 The mother told us that she is now off drugs and no longer with Lilly's father. She stopped using drugs after the death of Lilly, and has been rebuilding her life and her relationship with her children. She told us that she believes that she could have cared for Lilly from when she was born, but even if she was not able to, her mother could have cared for Lilly. That was what she wanted at the time. She never wanted the special guardian to care for Lilly.

27.6 She believes that the assessment of the special guardian was inadequate because the family knew that although the special guardian was a good mother, she always got involved with violent men and when she had a boyfriend, she could only focus on him.

27.7 The mother told us that "Social Services" (CSC) lied when they said that she had failed to sustain contact with Lilly during the time of the Court hearing.

27.8 Her mother, maternal grandmother, agreed with her daughter that she should have been allowed to care for Lilly. They both blame CSC for the death of Lilly. The decision not to allow either the mother or maternal grandmother to have the long-term care of Lilly they believe came from CSC. Had she been placed with maternal grandmother she would still be alive today.

27.9 They also believe that CSC should have continued to monitor and supervise the care of Lilly while she was with the special guardian. In fact, they wish to make a national recommendation, to form part of the outcome of this review, that all children subject to an SGO should be monitored and supervised for at least 3 years post the Order.

27.10 Both the mother and maternal grandmother are grief stricken. Although a Family Liaison Officer (FLO) has supported them since Lilly's death, they do not feel that they have had adequate support. Mother's other children, who

are cared for by maternal grandmother under SGOs, have been very distressed by the death of their sister. The elder child suffers with anxiety as a result and this has been made worse by the pandemic. This child has not had adequate help.

27.11 As a result of our meeting, the FLO contacted the mother about financial support for the funeral and other issues.

27.12 The whole family has been torn apart by the death of Lilly, and the prolonged police investigation and court processes. The special guardian's children are in foster carer, subject to Care Orders and as yet, maternal grandmother has been unable to have direct contact with them. The mother and maternal grandmother have had no contact with the special guardian since Lilly's death.

27.13 Both the mother and grandmother requested that when the SCR is published that Lilly's name be retained within the report and a pseudonym not used.

The special guardian

27.14 The special guardian wept throughout our meeting. She told us that she blames herself completely for the death of Lilly: that she should have been more suspicious of her then partner, should not have taken his word, should not have allowed him to babysit for Lilly, should have seen the pattern in the bruises.

27.15 At the time she thought the bruises were the result of Lilly's early addiction to heroin, and had expected that someone would explain to her what the health implications were of that.

27.16 She blames "Social Services" (CSC) for Lilly's death because of her lack of support from them. She told us she had had no support from CSC, despite being told there would be courses – First Aid for example – available to her. She did not refuse help, was not out for visits or appointments, as claimed by the Special Guardianship Support Team.

27.17 She believes CSC should have kept in touch, should have monitored the care of Lilly. In fact, like the mother and maternal grandmother, she believes that supervision of SGOs should be made mandatory.

27.18 She also blames the police for not informing her about her then partners convictions. In fact, Probation (see Section 21) had a duty to inform her. She said, that had she known, she would have immediately taken steps to distance herself from him.

27.19 She blames all the other agencies – nursery, GPs, hospital – for failing to ask safeguarding questions. She had expected them, but none came.

27.20 The special guardian has been unable to return to University since Lilly's death. She has also been unable to access her house, which was viewed as a crime scene. Her children are in care and she has been staying with friends and family.

27.21 Because she was seen as “person of interest” she did not receive any support from the Police Family Liaison Team or Victim Support.

27.22 As a result of our meeting the special guardian’s house and property have been returned to her.

27.23 The above views of family members do not represent the findings of this SCR.

27.24 This recommendation was requested by the family: *In line with current Government Regulations, there was no on-going monitoring of the care of Lilly once she ceased to be a Child in Need. The Government should consider requiring local authorities to monitor the care of a child subject to an SGO for three years after the making of an Order, in line with Regulation 3 of the 2017 Special Guardianship Guidance, which requires local authorities to provide support services to special guardians.*

28. ANALYSIS AND CONCLUSIONS

28.1 Care planning and assessment

- The Local Authority could have sought a referral of the case to the oversight of a District Judge, rather than a Lay Bench, or the Gatekeeping Judge could have made this decision.
- The SGO assessment of the special guardian could have considered her mental health history in more detail and made enquiries of previous partners. It could also have explored the family dynamics more closely. There could have been more challenge, both by the assessor and the Cafcass Children’s Guardian. Nevertheless the assessment was thorough, and even if more time had been spent and these matters considered it is unlikely that the Court would not have made the order.
- The Court could have reflected on the letter from Mr Justice Keenan before it made the decision to direct the Local Authority to re-consider placement with the maternal grandmother.
- Family Court Advisers (Cafcass) need to ensure better understanding of the new Fostering Regulations 2015 as they relate to Connected Persons.
- Had a Supervision Order been in place there would have been a requirement for the special guardian to inform the Local Authority about her new partner.

Good practice

- The social work evidence template, with an assessment of Lilly’s needs, the options available for her care, and the factors in favour of and opposed to each option, was thorough and well evidenced, and necessarily completed expeditiously.
- The SG assessment of the special guardian had to be completed in a very short time because of court timescales. Nevertheless, within those constraints, it was extremely thorough and thoughtful.

28.2 Post placement support and universal services

- There was a systemic failure to ensure that Lilly was integrated into community health services, specifically health visiting, and to ensure that she was identified as a child with a challenging neo-natal history, cared for within an SGO, and therefore entitled to Universal Plus services.
- Support through the SGO Support Plan and the CIN plan was totally inadequate, despite a new SGO Support Team being in place and Cafcass insisting on a more rigorous support plan before the SGO was made.
- The nursery, which had most contact with Lilly on a day to day basis, failed to demonstrate professional detachment, curiosity and challenge, especially when injuries were brought to their attention.

28.3. Indicators of concern

- The special guardian herself was concerned about the bruises seen on Lilly and brought them to the notice of professionals on a number of occasions, and indeed the GPs and the hospital paediatrician investigated these concerns.
- There were no indicators of concern seen about the special guardian's lifestyle or behaviour during her care of Lilly. It is possible that the consultant paediatrician when he recalled her to the BCH, and the GPs when they followed up Lilly's visits to the surgery were perplexed by the injuries, or perhaps they were reacting to some unusual cues from the special guardian's behaviour but those who attended the professionals' meeting could not think what they might be. It might be that they were aware of disguised reporting (see paragraph 11.3). Nevertheless, it might be that the special guardian was concerned about her partner's care of Lilly and was hoping that other professionals would pursue investigations.
- None of the services in touch with the special guardian during the period of bruising: the nursery, GPs, the hospital – asked safeguarding questions. This was contrary to the guidance for all those agencies.
- The Probation Service was concerned about the perpetrator's involvement with a partner with children. There was a serious error of communication which resulted in the special guardian not being made aware of his history of violence towards partners, and Children's Social Care not being made aware of this relationship, which would certainly have resulted in a Strategy discussion had it been known.

28.4 However

- All the evidence suggested that the special guardian had used counselling appropriately to move on from a difficult past. She had returned to education and had begun a university degree. She was demonstrably a good and protective mother to her own children. Given Lilly's mother's wish that she should care for Lilly and the Court's view, post Re B-S, it is unlikely that any court would have made a different decision.

- It is evident that systems have been tightened in Community Health and that the SGO Team and advice from Mr Justice Keenan are now embedded in Children's Social Care procedures. Recommendations in the Information Reports from agencies are all relevant and address issues of omission and commission in the relevant services.

- There are national issues which need to be taken forward and these are reflected in the Learning Points from this report.

29. FINALLY

29.1 Had the special guardian applied to be an adopter or foster carer for Lilly, it is likely that her application would have been refused. Her vulnerabilities would have been explored in more depth and her position as a single mother of three young children, with no support from any of the fathers, would have precluded her at an early stage.

29.2 She did however, have a relationship with Lilly from soon after her birth and she was the choice of the mother and the wider family to care for Lilly. Her assessment was as thorough as it could have been given the demands of Court timescales, and there was no evidence to suggest that there would be a tragic outcome of the placement.

29.3 Support was not provided by the SGO Support Team within Children's Social Care because the special guardian failed to take up the offer: this could have raised alarm bells or led to more robust action. Support could have been offered at a later date, perhaps on a regular basis.

29.4 The GPs, hospital doctors and nursery staff were all aware that Lilly had sustained bruises on several occasions and none of them sought safeguarding advice from CASS or from their own safeguarding teams as directed in their own procedures.

29.5 The Probation Service failed to follow their own procedures when they became aware that convicted perpetrator had developed a relationship with a woman with children. Had they done so, Children's Social Care would have been alerted and safeguarding processes put in place.

30. LEARNING POINTS

30.1 Enough time should always be given to assess the integration of a child placed within a family, the care of that child and the impact on all members of the family, before a final SGO is made, including consideration of wider family dynamics and the impact of an additional child on children within the household. In this case, the making of an Interim Care Order, followed by a Connected Person fostering assessment prior to the making of an SGO, would have provided sufficient time to make a fully informed assessment.

30.2 In this case, the post placement support network was not clear, and a multi-agency pathway, with a named lead agency, and clear expectations of each agency, would have been helpful.

30.3 There appears to have been a negative impact on service provision during a period of organisational changes in the Health Visiting service, coupled with high levels of sickness. This resulted in referrals not being made and missed opportunities for the child to be seen by a Health Visitor.

30.4 A change of social worker and team in the middle of proceedings and planning was unhelpful in this case. Organisations need to reflect on how the impact of such transfers can be mitigated to keep the needs of the child at the centre.

30.5 The GP and the nursery were unsure of what action to take when the child presented with concerning bruising. The review identified that there was an absence of guidance for frontline professionals in this important area.

30.6 There was an absence of appropriate challenge and professional curiosity, particularly around apparently open reporting.

30.7 There was evidence that the Probation Officers within the Community Rehabilitation Company had unacceptably high caseloads, which contributed to a failure to share information in this case.

31. POSTSCRIPT

31.1 All agencies involved in this case have completed action plans in respect of the learning points identified, as well as the issues identified in their own analysis. These have been monitored by the BSCB.

31.2 The CCG has set up a duty advice line for health professionals which provides advice and supervision from Designated Nurses with access to Designated Doctors if needed.

31.3 There is now a simple guide for health professionals about bruising, and several training sessions have been run for GPs.

31.4 All carers who have an SGO granted in Birmingham are now offered support via the SGO Support Team for a minimum of six months post order with an allocated social worker. In addition, if they have current or previous Trust involvement they will also be subject to a CIN plan for a minimum of three months post order. CIN meetings will ensure that all professionals are informed of the SGO and that the support is in place. The SGO Support Plan can be updated if required at the end of the 6-month period. The SGO Support Plan will be reviewed on an annual basis. Special Guardians will have access to advice and guidance at any point. They will also have access to continued training, support groups and dedicated support to assist with the child's education.

31.5 Since the sad death of this child the local judiciary and the Local Authority have taken steps to ensure that children who achieve permanence through special guardianship receive the appropriate levels of support and supervision following the Order. In many instances a Care Order with a view to the making of a Special Guardianship Order is the judicial preferred way. Many children thrive into adulthood through Special Guardianship and it is important that the judiciary do not dismiss the idea of special guardianship in the first instance as a result of this sad event.

Appendix 1: Abbreviations and acronyms

Acronym	Description
A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
BBR	Building Better Relationships
BCC	Birmingham City Council
BCH	Birmingham Children's Hospital
BSCB	Birmingham Safeguarding Children Board
Cafcass	Children and Families Court Advisory Service
CAO	Child Arrangement Order
CASS	Children's Advice and Support Service
CCG	Birmingham South and Central Clinical Commissioning Group
CIN	Child in Need
CT scan	Computerised Tomography scan
DASH	Domestic Abuse Safeguarding Risk Assessment
DfE	Department for Education
FLO	Family Liaison Officer
GP	General Practitioner
HCPC	Health and Care Professions Council
HV	Health Visitor
ICO	Interim Care Order
IRO	Independent Reviewing Officer
ISO	Interim Supervision Order
LPM	Legal Planning Meeting
MASH	Multi-Agency Safeguarding Hub
PICU	Paediatric Intensive Care Unit
PO	Probation Officer
PPU	Public Protection Unit
PT	Programmes Tutor
SCR	Serious Case Review
SG	Special Guardian
SGO	Special Guardianship Order
SN	Statistical Neighbour
SW	Social Worker
SWET	Social Work Evidence Template
TM	Team Manager
WSW	Women's Support Worker

Appendix 2: RELEVANT OTHER SCRs and RESEARCH

1. Research into SGOs:

1.1 The Children's Services Information Report includes a review of research related to SGOs which notes:

- Possible higher rates of disruption of SGOs than of adoption orders, and SGO disruptions taking place more quickly and when children are younger;
- Recent increase in use of SGOs, especially for babies, indicating that SGOs are not solely being used as originally intended, for older children placed with family, friends or foster carers.

1.2 Other key points from research include:

- Different levels of support for special guardians across LAs – for instance, 55% of LAs have a support group for special guardians (DfE, 2017) – and general agreement that support is not good enough (DfE, 2014b; DfE, 2015).
- Varying use of SGOs across LAs (DfE, 2014a).
- Varying approaches to the approval of special guardians (DfE, 2014b; DfE, 2015).
- Use of SGOs "overwhelmingly for children in or on the edge of the care system" (DfE, 2014a).
- Special guardians feeling under-prepared and sometimes pressured to accept an SGO (DfE, 2014a).
- The importance of family support for special guardians. "Social workers should therefore be mindful of the need to assess the strength of these networks and, wherever possible, help guardians to strengthen them before cases are closed." (DfE, 2014a)
- "expediency may lead to all placement options not being fully explored" (DfE, 2015)
- "making SGOs quickly, before relationships have been properly tested may carry some future risk" (DfE, 2015).
- Some special guardians approved who are only just "good enough": *"More fragile SGO assessments are being sanctioned by the court. You have done the assessment, and think it's just good enough to look after the child; the threshold is just good enough. It's because of the emphasis on Re B-S and a focus on placing with kinship, which is explored first. Under normal circumstances the carer probably wouldn't make it, but we are forced to really look at why we are ruling out a relative. More fragile SGO placements are being made rather than adoption (Manager)."* (DfE, 2014b)

- Professor Judith Harwin et al looked at trends in the making of Supervision Orders with Special Guardianship Orders between 2007 and 2015 and found a sharp increase in the making of Special Guardianship Orders compared to Placement Orders since 2012/13 and by 2014/15 the proportions and numbers of the 2 orders were converging. There was a particular increase in the use of SGOs for children under 1 year old so by

2015 they comprised 30% of permanency orders for children in that age group.
- Clarity around financial support is a particular issue (Ombudsman, 2018).

1.3 Note that guidance and research has since 2014 strongly recommended that SGOs should not be made until the placement has been monitored for a trial period:

"Time for preparation is accepted as good practice in fostering and adoption. Adoption orders are not made without a prescribed period of monitored 'settling in'. No equivalent provision exists for SG, in large part because it was assumed that SGOs would be made for children living in settled homes and with already established relationships with their carers. However, this is not always the case. A sizeable minority of children in our survey (17 per cent) only moved to live with their guardian at the time of the SGO and, as we have seen, one-quarter of cases arose in the context of care proceedings. The potential of SG to build on existing relationships is an important strength. Where a close relationship is lacking, however, greater caution should be exercised, as strength of the pre-existing bond between child and carer was a key predictor of later disruption …. In these circumstances, therefore, there is an argument for relationships to be first tested (perhaps under fostering regulations) before a move to SG is made." (DfE, 2014a)

1.5 *"Wade and colleagues suggest that making SGOs quickly, before relationships have been properly tested may carry some future risk and that 'a period of time in which these relationships can be tested before moving to a final order is to be recommended'* (Wade *et al*, 2014: 234). *At the very least, where there is no long-term relationship between the child and the special guardian there should be provision for a period of preparation and settling in prior to the order being made, similar to that which is routinely available for adopters."* (DfE, 2015)

1.6 Since the original draft of this report, there have been several significant reports on SGOs. These have continued to report that:

Most children in SG placements are **safe, cared for and make good developmental progress**. Educational outcomes are better than those of children looked after. SGOs mostly result in stable placements, with a lower breakdown rate than that of adoptions. Outcomes are better when the child and carer have a strong pre-existing relationship (Nuffield Foundation, 2019). Older children are more at risk of placement breakdown (Centre for Child and Family Justice Research, 2019). Children are likely to have a higher level of need than their peers who are not the subject of SGOs, but the data are difficult to unpick as they include children who have been adopted (average Strengths and Difficulties score of 19 for children receiving support from the Adoption and Special Guardianship Support Fund compared to 8 for all children in the population – DfE 2021).

There is **regional variation** in the number / rate of SGOs made, and in the proportion where a supervision order is also made (70% of SGOs made in the

North had an attached supervision order, compared to 30% in the South) (CCFJR, 2019).

The **quality of assessments** for prospective special guardians, and of **support plans**, are inconsistent and often poor (Family Justice Council, 2020; Family Rights Group, 2020). Court timescales are not long enough for comprehensive assessments (FRG, 2020; CCFJR, 2019). The framework and forms for the assessment are overly focussed on the prospective special guardians rather than the needs of the child (CCFJR, 2019). Some professionals report "a significantly lower standard of assessment for family members compared to other placement options such as adoption or fostering ... [and] a general assumption that special guardianship placements do not require the same rigour and depth of information on the child, their history and future needs and the fit between those needs and the prospective special guardian's parenting capacity and resources as is required in adoption or fostering" (FRG, 2020). Assessments do not consistently include full exploration with the prospective SG of their past and current personal and family experiences" (FJC, 2020). The amendments made to the legislation following the 2015 DfE report have had little impact (FJC, 2020). One research report found that 10 of 50 reviewed SG arrangements were not likely to meet the child's long-term needs, particularly where the prospective SGs had health or social problems or where children had experienced abuse or had complex difficulties (Cafcass 2015 report quoted in FRG, 2020). Family Group Conferences are not routinely held when planning for the child (CCFJR reports 37%). Children on whom SGOs are made are often (CCFJR found 31%) not placed with the prospective special guardian until after the order has been made, so the placement is untried: the CCJFR highlights that "it is only through the testing of placement that the support needs of the SGO carers/placement becomes clear".

Support for special guardians is not good enough. SGs are not always given all the information they need to make the decision to become a special guardian or to care for the child effectively (NF, 2019). Assessments are effectively one-way and do not offer prospective SGs the opportunity to understand the challenges of the task (Family Rights Group, 2020). Few SGs are offered training (CCFJR, 2019). Support is often short-term (NF, 2019). Financial support is unclear and inadequate (NF, 2019). Where support is provided as part of a supervision order, the frequency of visits and of child in need reviews varies considerably, and the quality of CiN reviews is often poor (CCFJR, 2019).

There is some evidence that special guardians may be more likely than other people to have had difficulties in their lives. The Centre for Child and Family Justice Research (2019) found that 14% had previously experienced domestic violence, 13% had a history of mental health problems, 20% had current physical health issues, 20% had current financial difficulties, 23% had conflict within the extended family and 25% had housing difficulties (the latter unclear whether it relates to overcrowding post-placement). Comparable data on this for the whole population are not available, however. Special guardians also report that their mental and physical health, and financial situation, are badly affected by the court process, difficulties with contact, managing the child's

needs and what they often find an intrusive and unsupportive experience with social workers (CCFJR, 2019).

There is not enough **evidence-based information about what works**. The Family Rights Group (2020) identifies a lack of research into professional doubts about placements, how these are addressed and whether they are associated with poorer outcomes; one research project found that, where practitioners had concerns, "most of the specific concerns identified did not materialise, while the issues which did arise had not usually been predicted". The report also notes that we have very little information about children's experiences of SGOs; the Nuffield Foundation (2019) finds the same and adds that we do not have a good understanding of what works in managing contact. The Centre for Child and Family Justice Research (2019) notes that some local authorities have put in place or are considering particular approaches to SGOs (for example: work on disguised compliance; framing post-SGO support around a child protection planning model) but these are not yet evidence-based.

2 References:

Centre for Child and Family Justice Research (2019) *The contribution of supervision orders and special guardianship to children's lives and family justice*
https://www.cfj-lancaster.org.uk/files/documents/SO_SGO_report.pdf

DfE (2014a) *Investigating special guardianship*

https://www.gov.uk/government/publications/investigating-special-guardianship

DfE (2014b) *Impact of the Family Justice Reforms on Front-line Practice Phase Two: Special Guardianship Orders: Research report*

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/450252/RR478B_-_Family_justice_review_special_guardianship_orders.pdf.pdf

DfE (2015) *Special guardianship: qualitative case file analysis*

https://www.gov.uk/government/publications/special-guardianship-qualitative-case-file-analysis

DfE (2017) *Children's Services Omnibus: Wave 1 Research Report*

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/634696/DfE-CSO-Wave_1_Final_Report.pdf

DfE (2021) *Adoption support fund: baseline survey of families*
https://www.gov.uk/government/publications/adoption-support-fund-baseline-survey-of-families

Family Rights Group (2020) *Two decades of UK research on kinship care: an overview*
https://frg.org.uk/wp-content/uploads/2020/12/Overview-research-kinship-care.pdf

Family Justice Council (2020) *Recommendations to achieve best practice in the child protection and family justice systems: Special guardianship orders*
https://www.judiciary.uk/wp-content/uploads/2020/06/PLWG-SGO-Final-Report-1.pdf

Harwin, Judith *et al* (nd) *Supervision Orders and Special Guardianship*

http://www.nuffieldfoundation.org/supervision-orders-and-special-guardianship

Nuffield Foundation (2019) *Special guardianship: a review of the English research studies*
https://www.nuffieldfjo.org.uk/wp-content/uploads/2021/05/Nuffield-FJO_Special-guardianship_English-research-studies_final.pdf

Ofsted (2014) *Children and Family Court Advisory and Support Service Advisory (Cafcass): Inspection of Cafcass as a national organisation*

https://reports.ofsted.gov.uk/sites/default/files/documents/cafcass-reports/national_report_2014/Cafcass%20national%20inspection%20report%202014.pdf

Ombudsman (2018) *Firm foundations: complaints about council support and advice for special guardians*
https://www.lgo.org.uk/assets/attach/4320/FR%20-%20SGO%20-%20FINAL.pdf

3 SGOs in Birmingham:

Data:

3.1 The only data available relating to the numbers of SGOs made in Birmingham are on children looked after who left care because an SGO was made:

Year	Number of children ceasing to be looked after - SGOs made to former foster carers	Number of children ceasing to be looked after - SGOs made to carers other than former foster carers	Total SGOs made for children looked after	Total children leaving care	% SGOs
2013/14	32	30	62	758	8%
2014/15	17	42	59	764	8%
2015/16	18	46	64	887	7%
2016/17	6	6	12	724	2%

From 2017/18 this was broken down differently in published data:

Year	SGO made to …				Total SGOs	Total children leaving care	% SGOs
	Former FC, not Connected Person	Former FC, is Connected Person	Not former FC, not Connected Person	Not former FC, is Connected Person			
2017/18	suppressed	suppressed	6 in total		8-14	689	1-2%
2018/19	suppressed	suppressed	suppressed	8	11-20	661	2-3%
2019/20	suppressed	7	0	6	14-17	681	2%

The DfE suppresses any figures higher than zero but lower than 5. This means we have very patchy data for the last three years.

3.2 % of children leaving care on SGOs for Birmingham, Statistical Neighbours, West Midlands and England

	2013	2014	2015	2016	2017
Birmingham	**7%**	**8%**	**8%**	**7%**	**2%**
Derby	4%	4%	6%	12%	7%
Enfield	7%	5%	5%	6%	16%
Luton	7%	10%	19%	17%	13%
Manchester	11%	5%	6%	11%	11%
Nottingham	11%	18%	15%	8%	5%
Sandwell	7%	6%	14%	9%	7%
Slough	10%	15%	6%	17%	14%
Walsall	8%	13%	15%	13%	15%
Waltham Forest	8%	11%	9%	11%	17%
Wolverhampton	9%	11%	6%	9%	5%
Statistical Neighbours	**8.2%**	**9.8%**	**10.1%**	**11.3%**	**11%**
West Midlands	**9%**	**10%**	**11%**	**10%**	**7%**
England	**10%**	**11%**	**11%**	**12%**	**12%**

(https://www.gov.uk/government/collections/statistics-looked-after-children)

	2019			2020		
	Former FC – not Connected Person	Former FC – Connected Person	Not former FC – Connected Person	Former FC – not Connected Person	Former FC – Connected Person	Not former FC – Connected Person
Birmingham	-	-	1%	-	1%	1%
Bradford	0%	8%	-	0%	10%	3%
Derby	-	-	-	-	-	-
Enfield	-	-	6%	-	6%	9%
Luton	15%	0%	4%	-	6%	6%
Manchester	2%	12%	5%	-	9%	4%
Nottingham	-	3%	-	-	6%	-
Sandwell	-	4%	0%	-	8%	0%
Walsall	-	11%	3%	5%	9%	-

Waltham Forest	-	4%	-	-	6%	4%
Wolverhampton	8%	0%	4%	6%	-	-
Statistical Neighbours	6.25	5.25	3.67	3.67	7.50	4.33
West Midlands	2%	6%	1%	1%	7%	1%
England	**1%**	**8%**	**4%**	**1%**	**7%**	**4%**

(Source: Local Authority Interactive Tool – 2018 not published)

3.3 These figures show the number of SGOs in Birmingham as very consistent between 2011 and 2016, dropping sharply from the end of 2015/16, possibly as part of changing local policy in response to the death of Shi-Anne Downer in September 2015. They have never risen to the number / proportion that they were since that time.

3.4 The % of children leaving care on SGOs is consistently lower in Birmingham from 2013 onwards than in the region and its SN group. This pattern is striking – children in Birmingham are generally not leaving care on SGOs at the rate of other LAs. We cannot tell from the data here whether that means they are less likely to leave care or less likely to achieve permanence.

3.5 The Cafcass report notes the following figures for Birmingham:
% of children removed from parents and placed with family on SGOs or CAOs by BCCS: 2013 it was 26.7%; 2014 it was 24.2%; 2015 20.8% 2016 21.3%. BCC has a higher %ge of SGO/CAOs than neighbouring Las: 2016 Dudley had 11.2%, Sandwell 5.8%, Walsall 13.1%. These figures suggest that Birmingham has a significantly higher rate of SGO and CAO than its neighbouring authorities.

3.6 It has not proved possible to verify this data from government statistics, and it may be that there is a particularly high level of CAOs in Birmingham which would account for the discrepancy.

4. SGOs in Serious Case Reviews

4.1 In addition to the SCR published by Birmingham LSCB on Shi-Anne Downer in February 2017 (https://www.cscb-new.co.uk/wp-content/uploads/2017/04/Birmingham-SCR-BSCB-2015-162.pdf), there are a number of recently-published SCRs involving young children placed with relatives on SGOs. Those where the circumstances and findings may be relevant are:

4.2 "Bonnie", Devon (published 2016): a two-year-old who was the subject of an SGO to her grandmother, and was subsequently sexually abused by her grandfather. The report notes, among other findings, that:

- predictive analysis of risk must include the history of family relationships and events to identify unresolved risks rather than submit to a rule of optimism;
- there is a need for vigilance against the potential for disguised compliance.

(https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C5975&_ga=2.170254051.213636357.1530108306-392135669.1530108306)

4.3 Child J, Nottingham (published 2017): a seven-year-old who died following injuries caused by her aunt and grandmother, having been the subject of an SGO to her aunt as a five-year-old. The report notes, among other findings, that:

- SGO and FAO support plans must include details about how support will be delivered; they must have clear outcomes, aims, timescales and monitoring arrangements, and should be multi-agency;
- supervision must ensure that professionals are able to reflect on fixed views they may hold about children and their carers, and how confirmatory bias may be affecting their views.

{https://library.nspcc.org.uk/HeritageScripts/Hapi.dll/search2?searchTerm0=C6460&_ga=2.112055367.213636357.1530108306-392135669.1530108306)

4.4 Children A and B, Oxfordshire (published 2017): two children aged under five who were the subject of an SGO to a distant relative, and subsequently sexually and physically abused by the relative's husband. The issues in this SCR do not strongly reflect those in the current SCR, as the Oxfordshire case involved complex legal proceedings and the children had disabilities and complex needs. However, the SCR author's statement "Overall the desire for the placement to be successful inappropriately affected child protection processes" may have some relevance.
(http://www.oscb.org.uk/case-reviews)

4.5 The murder of 18-month-old Elsie Scully-Hicks by her adoptive father (https://www.theguardian.com/uk-news/2017/nov/07/matthew-scully-hicks-jailed-for-life-daughter-elsie) may also have some relevance to this SCR. A child practice review was undertaken by Cardiff and Vale of Glamorgan Regional Safeguarding Children Board. The report (2018) noted that "*paediatricians are key professionals in recognising the possibility of injuries being caused deliberately".* The board went on to recommend that *"a child placed for adoption, who presents at hospital with an injury, should be overseen by a paediatrician with safeguarding experience and training*" This recommendation could usefully be extended to SGOs.

4.6 Child LH, Lewisham and Harrow (published 2019): child aged four who was placed with extended family on an SGO and abused. Learning relevant to this SCR includes: inadequate background checks during SG assessment; lack of independent scrutiny of SG assessments; lack of an SGO support plan. Recommendations include: training on governance of different placement types; review of SGO processes; SGO assessments and support plans to be presented to the permanency panel.
http://www.harrowscb.co.uk/wp-content/uploads/2019/09/Child-LH-LewishamHarrow-Overview-Report-for-Publication-4.7.19.pdf

4.7 Family M, Surrey (published 2020): six children placed with extended family on SGOs, where they were abused. Learning relevant to this SCR includes: “view that placement with family is best, without critical thinking”; failures to share information between agencies; inadequate assessment relying on self-reported information. Recommendations include increased focus on voice and lived experience of the child; improved supervision.
https://www.surreyscp.org.uk/wp-content/uploads/2021/04/Family-M-SCR-2018-Final.pdf

4.8 Megan, Gloucestershire (published 2020): child aged six who was placed with extended family on an SGO and abused. Learning relevant to this SCR includes: inadequate assessment; not hearing the voice of the child; not recognising signs of abuse; professional optimism and lack of curiosity. Recommendations include pathway for SGO application where the prospective SG does not have an existing relationship with the child – placements in this situation always to be interim kinship care; use of family group conferences; better information sharing between agencies; training on disguised compliance.
https://www.gscb.org.uk/media/2097918/0215-scr-megan.pdf

4.9 Child O, local safeguarding practice review, Bexley (published 2021): child aged four placed with extended family on SGO, accidentally swallowed drugs when alone with his mother (this situation being contrary to the SGO agreement). Learning relevant to this SCR includes: quality of the support plan and of actual support; domestic abuse; management oversight. Recommendations include training for staff on governance of different placement types.
https://bexleysafeguardingpartnership.co.uk/wp-content/uploads/2021/04/Child-O-Report-SHIELD-Final.pdf