Child Safeguarding Practice Review

Overview Report: Baby Lily

Author: Louise Rae

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1. Introduction

1.1 Lily (for the purpose of this review), died after her mother fell asleep with her in her mother's bed at her Mother and Baby Foster Placement. Lily was a Looked After Child, having been made the subject of a Care Order shortly after her birth and placed into the care of the Local Authority. Lily was always placed with her mother, firstly in a Mother and Baby Bridging Foster Placement and thereafter within an assessment unit, where she resided with her mother and father for a short time.

1.2 Lily's father moved into the assessment unit for the first two weeks of the assessment until he was asked to leave following a significant domestic abuse incident.

1.3 Lily's mother remained in the assessment unit with Lily and completed her assessment. The PAMS assessment identified a number of assessment areas which remained unachieved and the assessment unit expressed concerns that in the latter weeks of the placement, the mother's presentation and selfcare had deteriorated. The recommendations of the PAMS assessment were that Lily should remain with her mother and that they should move to another supported environment, such as a Mother and Baby Foster Placement until such time that the mother was ready to move into an independent placement with Lily.

1.4 Lily and her mother moved into their second Mother and Baby Foster Placement in January 2021 upon the conclusion of the assessment undertaken by the assessment unit. It was here in February 2021 that Lily died.

1.5 Working Together 2018 sets out the purpose and process of Local Child Safeguarding Practice Reviews (LCSPRs). Reviews are undertaken where a child suffers abuse, or neglect is known or suspected and the child has died or been seriously harmed. The purpose of Child Safeguarding Practice Reviews described in the statutory guidance is to enable effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to reduce the likelihood of similar harm re-occurring.

1.6 The Children's Safeguarding Assurance Partnership established a 'Case Review Panel' to oversee the Child Safeguarding Practice Review. Membership of the Panel is shown at Annex A. Neil Smith (Chair) chaired the Panel established to oversee the Child Safeguarding Practice Review. Louise Rae was appointed as the Independent Reviewer for the Child Safeguarding Practice Review (Reviewer). She has no connection to any agency in Lancashire.

1.7 The review was commissioned in September 2021 following Lily's death in February 2021. The first panel meeting took place on 23rd November 2021, the second on 9th February 2022. The review had a significant delay initially due to the ongoing criminal investigation, which prevented the Practitioner Learning Event from taking place. The review was initially paused until the Children's Safeguarding Assurance Partnership received confirmation from the Police that no charges were being brought against Lily's mother.

1.8 The Practitioner Learning Event then took place on 25th January 2023. No representative from Children's Services, the Police or Health (from Sefton) attended the Practitioner Learning Event and following the event, the Review Chair, contacted those agencies to discuss his concerns. Following this, Lancashire Police have circulated a briefing to all Police Senior Investigating Officers in relation to their responsibility to engage from the outset with practice learning reviews. This includes provision of advice and support to the independent author and panel chair in relation to what can and can't be included when there are concurrent reviews and

police investigations taking place. This will enable learning to be identified and disseminated as quickly as possible.

1.9 As there were key partners missing from the Practitioner Learning Event, the Reviewer proceeded to send out a Panel Member Analysis Report asking panel members to analysis and comment on the case and identify any learning which they would have brought to the Practitioner Learning Event.

1.10 The Reviewer met with the Health Visitor (from Sefton), Practice Manager (Childrens Social Care), Foster carers and Agency Social Worker individually in March and April 2023. Due to unforeseen circumstances, the Reviewer was unable to complete the Review until September 2023 of which National Panel were informed of.

1.11 The Panel will critically appraise and quality assure the review prior to its submission to the Children's Safeguarding Assurance Partnership for ratification and publication. The Reviewer will continue to be available following publication to speak with Lily's family to discuss the report and the learning recommendations made should they wish to meet with the Reviewer.

1.12 The Children's Safeguarding Assurance Partnership wishes to express sincere condolences to Lily's family.

2. Terms of Reference

2.1 The timeframe of the review is from 14th February 2020 until the date of Lily's death on 14th February 2021. Agencies were also asked to summarise their involvement prior to that period.

2.2 Key time-periods were identified during the review process. These are periods which are deemed to be central to understanding of Lily's journey and the care provided to her. These time-periods do not form a complete history but they were recognised as being important periods for the review to focus upon. Professionals at the panel meetings explored the following key time-periods with the Chair and the Reviewer:

Description
Lily's placement with her mother at a Mother and Baby Assessment Unit
The care planning around Lily's move to a Mother and Baby Foster Placement with her mother
Lily and her mother's lived experience of those placements

2.3 The terms of reference for the review were agreed as:

2.3.1 How effective was safeguarding children practice when considering mother and baby placements?
2.3.2 How effective was safeguarding practice in identifying and responding to alcohol and drug use?
2.3.3 How effective was safeguarding practice in identifying and responding to mental health?
2.3.4 How effective was safeguarding practice in identifying and responding to co-sleeping?

2.3.5 How effective was safeguarding practice in identifying and responding to domestic violence?

2.3.6 Did Covid 19 restrictions at the time of Lily's death have any impact on single or multi-agency response in this case?

3. Methodology

3.1 The review used a combined method of the traditional review model together with elements of the Welsh concise model[1]. Elements of the Welsh concise model, such as the use of timelines and chronologies completed by agencies were insufficient in this case, given the Practitioner Learning Event was not attended by all practitioners and agencies. Whilst ordinarily a Welsh concise model would place strong emphasis on the engagement of frontline practitioners and managers by way of a Learning Event, in this case there was no attendance at the Learning Event by the Local Authority or the child's first health authority. As such, those agencies were asked to complete agency reports to analyse their own involvement in the case and to provide an opportunity to reflect upon their own agency's learning. The reviewer also offered to individually meet with those practitioners who could not attend the Practitioner Learning Event.

3.2 Panel Members completed timelines and chronologies, which described and analysed their involvement with Lily. The Reviewer analysed the chronologies and identified issues to explore with the Panel. The Reviewer also considered available health, adult social care and partner agency records alongside the timelines/chronologies provided.

3.3 In addition, the Reviewer held interviews with Lily's foster carer and local authority staff members (Social Worker and Team Manager) who had since moved to work in other authorities. The Reviewer would like to thank them for sharing their memories of Lily, their experience of the planning around Lily's move to the placement with her mother, which was invaluable to the review process.

3.4 Family involvement in a Child Safeguarding Practice Review is an important part of the review process. The Safeguarding Partnership attempted to contact Lily's mother and members of her extended family but were unable to do so. Lily's father was notified of the review and invited to participate but he did not wish to participate in the review.

4. Analysis

4.1 Mother and Baby Assessment Unit

4.1.1 Lily was made the subject of an interim care order shortly after her birth. The concerns which had led to the local authority issuing care proceedings included a risk to Lily suffering emotional harm, her parents' lack of engagement with professionals in the pre-birth assessment and recognition of her parents' vulnerabilities as young parents who had experienced neglect in their own childhoods. There were also concerns that arguments were a feature of her parents' relationship and that Lily's father had experienced problems

[1] Bright C (2015) Review of the implementation of the Child Practice Review Framework. Welsh Government Social Research

with his mental health and the use of cannabis. Lily and her mother spent nearly four weeks in a Mother and Baby placement until a place for the family could be found within an assessment unit.

4.1.2 Lily moved with her mother and father into the Mother and Baby Assessment Unit when a place became available. She was four weeks old when the assessment started. Soon after the move, her parents were observed on CCTV, in the placement, arguing and staff became concerned around the father's mood and that verbal arguments were a feature of the parents' relationship. During the first week in the assessment unit, the mother was seen to lift Lily out of her cot by her arm and there were two co-sleeping incidents where Lily was observed to be in bed with her mother. Appropriate work was undertaken with the parents regarding safe sleeping and direct work was offered to them around their relationship.

4.1.3 Lily's father stayed with Lily and her mother for two weeks in the assessment unit. His placement was terminated due to his behaviour and following a significant domestic abuse incident which was observed on CCTV in placement and which Lily had been witness to. Increased support was provided to Lily's mother who wanted to remain in a relationship with Lily's father.

4.1.4 During the second week of the assessment, there was a further incident of co-sleeping observed which required staff intervention. Staff appropriately discussed the incident with Lily's mother and showed her a video about the risks of co-sleeping. The assessment took place Autumn 2020, and working arrangements for many professionals had changed due to the restrictions which were brought in during the Covid 19 Pandemic. That being said, support staff were on site at the placement which had 24 hour staffing and Lily's Health Visitor undertook face to face visits to the assessment unit and supported the unit's work on co-sleeping. Lily's night-time sleeping arrangements were not observed by the Health Visitor, due to working practices during the pandemic, but this didn't impact the work which was being undertaken with Lily's mother as Lily's sleeping arrangements were under 24 hour observation as CCTV cameras were in place in the flat where Lilly and her mother were staying.

4.1.5 The assessment unit undertook their 12 week assessment which incorporated a PAMS (Parent Assessment Manual) assessment, which is a practical based assessment often undertaken when a parent has a degree of learning need(s) together with observation of Lily's mother's parenting and behaviour from the residential parenting assessment. The assessment focuses on a parents' practical capabilities to meet the needs of the child. As part of the assessment process, the assessment unit held weekly progress meetings to discuss any concerns and the progress that Lily's mother was making. Those meetings took place with the key worker (from the assessment unit) who was allocated to Lily and her mother and Lily's Social Worker from the Local Authority. Review of the minutes of the progress meetings demonstrated that these were important in communicating to Lily's mother what was going well and the areas she needed to work on. They also provided an opportunity for the Local Authority Social Worker to be updated each week rather than wait for the report which would be completed at the end of the assessment period. These clearly demonstrate good practice and were consistent throughout Lily and her mother's time at the assessment unit.

4.1.6 Early in the assessment period, concerns were expressed around Lily's mother not maintaining routine and staying up late. This included Lily's mother relying on take away meals for herself, not attending to her own personal hygiene needs and not looking after her own emotional wellbeing and health. It is important that this is noted early in the review as it is a feature throughout this case. Whilst concerns were expressed around the mother's self-care, Lily's relationship with her mother was described as very positive with a warm, attentive bond. Lily's mother told professionals that she loved being a Mum and Lily was always described as a happy baby who was beautifully dressed by her mother.

4.1.7 There was a further incident of co-sleeping observed in the fourth week of placement and included Lily being handled roughly by her mother. This was the fourth incident of co-sleeping in the assessment unit at a point where the family were a third of the way through their assessment period. Appropriate work was undertaken and Lily was safeguarded as her sleeping arrangements continued to be on camera and observed by staff in the unit. Alongside this, Lily's mother was in regular contact by way of internet video calling with the father but was dishonest to professionals regarding her ongoing relationship with him. Lily's mother started a six week domestic abuse course with the assessment unit which aimed to promote awareness and recovery through engagement in group sessions.

4.1.8 Whilst in week five of the assessment, Lily's mother showed a greater awareness of safe sleeping advice and was bottle feeding at night to reduce the risks associated with co-sleeping. There continued to be concerns around rough handling of Lily and the mother's routine and diet. During the same week, a case management hearing was held in the family proceedings where Lily and her mother were reported to be doing well and the plan was for Lily and her mother to be supported to independent living if the placement was successful.

4.1.9 At the mid-way assessment point, the issues that had been identified included the rough handling of Lily (3 incidents), co-sleeping requiring staff intervention (4 incidents), concerns regarding the mother's self-care and emotional wellbeing together with a serious domestic abuse incident in the placement in which Lily's father's placement was terminated. This information was included within the 6 week report from the assessment unit but there is no evidence of any consideration around transition planning post assessment unit. There appears to be evidence of the assessment unit placement being viewed as 'pass/fail' and as such, opportunity for more nuanced planning was missed.

4.1.10 Lily's mother returned from the case management hearing and reported to professionals that she was to try to find accommodation for herself and Lily for the end of the assessment. However, concerns remained within the placement around the mother's continuing reliance on takeaways and a further co-sleeping incident observed in week six of the assessment. Whilst the assessment unit report that the co-sleeping was addressed with Lily's mother the following day, this was the fifth co-sleeping incident in the first six weeks of the assessment. Whilst appropriate safer sleeping work had been completed with the mother after each incident, there is a clear pattern of co-sleeping across the first half of the placement where guidance was not being followed. Although the risks were well mitigated whilst in placement (with staffing observation and intervention), this is clearly an identified area of risk that would require management.

4.1.11 At the six week review meeting, Lily's mother states that she discussed feeding Lily with the Health Visitor to help reduce the risk of co-sleeping. When asked during the review process, the Health Visitor was surprised to learn of the number of co-sleeping incidents which occurred in the assessment unit as she stated that she had not been aware of the later incidents. Although safe sleep was reinforced at all Health Visitor appointments, it is expected that the Health Visitor should be made aware of all incidents of co-sleeping. This is to ensure that they are able to provide appropriate planning and support for the mother. As this did not happen, there may have been missed opportunities to provide more effective support to Lily's mother.

4.1.12 No further incidents of co-sleeping or rough handing were observed by the assessment unit and it was felt that Lily's mother had made positive progress in these areas. There were however persistent concerns around the mother's own routine, her eating habits and self-care including her own personal hygiene. It isn't clear where these issues stem from and despite support in these areas including cooking skills, there was an ongoing pattern of Lily's mother neglecting her own needs. It is of note that these issues were present at the start of the assessment and included a dip in her mental health and mood near the end of the assessment process which impacted her care of Lily.

4.1.13 On 7th January 2021, at the end of the 12 week assessment, the final review meeting took place between the assessment unit, the Social Worker, and the mother. Within it, concerns were expressed that the mother still required prompts to complete tasks and that her poor routine remained an issue. Further concerns were highlighted about her emotional low mood and the impact this was having on Lily.

4.1.14 On 8th January, a multi-agency meeting was held. The meeting records that all agencies reported that the care offered to Lily was good and that several agreed actions were put in place for Lily's mother to support the care provided, by her, to Lily. These included, the mother eating three meals a day, not to be in a relationship with Lily's father and for the mother to have her iron levels checked by the GP. It was recorded that the mother was to start looking for her own independent accommodation for herself and Lily. It is not clear to what extent the consistent concerns in relation to the mother's self-care and presentation were explored at the multi-agency meeting.

4.1.15 I note that a professionals meeting was arranged to take place on 13th January to discuss the plan in more detail, but this was cancelled and did not take place. The meeting was not rearranged and the reasons for this are not known, although it is acknowledged that there was a change in social work team management and there may have been impact of the Social Worker's high caseload and the impact of the third national Covid-19 lockdown. Opportunities were therefore lost to professionally challenge and discuss the plan for this mother and her child. This may have been particularly important within this case due to outstanding identified areas of concern for the mother, including her self-care and mental health issues.

4.2 Care Planning for placement post Assessment Unit

4.2.1 The final report (prepared by the assessment unit) was produced and sent to the Social Worker on 11th January 2021. The concerns regarding the mother's emotional wellbeing and self-care remained prevalent within the report. The care afforded to Lily was said to be good. Her needs were being met by her mother and a strong bond and attachment was observed between them. Given the identified areas of concern around self-care, self-neglect, and the mother's emotional wellbeing, it is appropriate that the final report from the assessment unit recommended that the mother needed further work in some areas (9% of criteria areas needed skills to be taught immediately or within 4-8 weeks), those being in parent healthcare, abuse and safety, parental support (including housing) and independent living skills.

4.2.2 It is important to note that Lily's mother required ongoing support for those areas throughout her time in the assessment unit and those assessment areas were not achieved during the residential assessment, even with intensive monitoring and support.

4.2.3 It is clear from reading the final report that this was an assessment which highlighted many strengths and improvements but also identified significant concerns. Some of those concerns such as co-sleeping and rough handling had been present for the first half of the assessment period and others such as the mother's self-neglect and self-care had been present throughout the placement.

4.2.4 This report appears to have been interpreted as being positive by the professionals that came into contact with the case. As stated earlier in this review, it appears that professionals viewed the assessment unit as 'pass/fail'. There was an over reliance on the words 'passed' and 'positive' which impacted the planning in the case. This appears to have hindered the opportunity to focus on the areas of need and the more nuanced areas of risk.

4.2.5 The use of the phrases 'passed her assessment' and 'positive assessment' does not adequately reflect the amount of work and learning to be done and doesn't convey that Lily's mother wasn't assessed as ready to be living independently and that the consideration of this would require further assessment. It also does not appear that Lily's

mother understood that she would not be moving to independent accommodation, nor the reasons behind this. Although it is accepted that the meeting on 8th January 2021 did not have the benefit of the assessment report, it would have been prudent to either wait before asking Lily's mother to seek independent accommodation or explore other potential outcomes. There was a missed opportunity to manage the mother's expectations which may have been particularly important given her low mood and recorded levels of anxiety around the placement ending.

4.2.6 It should have been possible for the Local Authority to have been aware (prior to the receipt of the assessment report) that Lily and her mother may have required a further placement with support, given the concerns that had been raised throughout the assessment process, notwithstanding the areas that she achieved. The assessment report is very clear as to the areas of achievement and outstanding concerns. There were many positive aspects to the report and many areas where Lily's mother had completed the work needed. It is also clearly set out that Lily's mother was not ready for independent living. The report concludes *'It would not be responsible of me to recommend that Mum and Lily live independently in the community together as Mum still requires support in many areas. However, I also do not believe that they should be separated.'* The final assessment report goes onto recommend supported living, a mother and baby foster placement or living with suitable family members to continue the work that was needed in the areas identified in the assessment.

4.2.7 Transition planning for Lily started after receipt of the assessment report on 11th January 2021 and the family were required to leave the assessment unit on 18th January. At that point there was no ability for the assessment unit to keep the accommodation open as another family was moving in. This placed increased pressure onto the Social Worker and added to a rushed and poorly planned transition for Lily and her mother. It is clear the priority became about finding accommodation and, in many ways, the move was treated as an emergency rather than a planned transition. This impacted the ability to plan appropriately for Lily and her mother's needs.

4.2.8 The Social Worker informed the review that Senior Managers queried why they were being asked to agree a Mother and Baby Foster Placement for a mother who had 'passed' her assessment. Funding and agreement was obtained on the basis that the Mother and Baby Foster Placement was to be a four week placement until the mother found her own accommodation. This appears to highlight the lack of recognition of the needs detailed in the assessment report and continuance of the 'pass/fail' view of the assessment unit placement.

4.2.9 The Guardian received a telephone update from the Social Worker on 13th January and recorded that the mother's assessment was positive although noted that there were concerns about how Lily's mother may cope in the community, who would support her, her finances, and her low mood. The Guardian did not record the Social Worker discussing the history of co-sleeping or the worries regarding the mother's self-neglect and self-care which had been present throughout the placement. The Guardian received the assessment report on Friday 15th January.

4.2.10 It is of concern that the Guardian (appointed as an independent Guardian for Lily) had not spoken to or seen either parent or Lily due to the Covid 19 pandemic. Despite the restrictions in place, there was clear opportunity for Lily and her parents to be contacted remotely by the Guardian. There were opportunities here for the Guardian to independently scrutinise the decision making for Lily.

4.2.11 Lily moved with her mother to a Mother and Baby Foster Placement on 18th January. The Local Authority internally agreed to an interim plan for a Mother and Baby Foster Placement on 14th January with the fostering agency receiving the referral on 15th January (a Friday) with the family due to move on Monday 18th January. These dates highlight the rushed nature of the planning in this case.

4.2.12 The review found that no risk assessment was undertaken by the Local Authority before placing Lily and her mother in the Mother and Baby Foster Placement. The referral to the fostering agency, who provided the final placement contained some details of concerns but it was received on Friday 15th January with Lily and her mother moving on Monday 18th January. There appears to be mixed messages at this time as the fostering agency report being told that this was a *'holding placement'* whilst the mother found accommodation as she had passed her assessment. Although there is a lack of clarity around this point, the information passed appears to be consistent with the Social Worker's account of the authorisation of the placement. There was insufficient time over a weekend to properly plan the transition.

4.2.13 Prior to Lily and her mother moving to the new placement, a Placement Plan was produced. This was written prior to the Placement Planning Meeting and not was not reviewed or updated following that meeting. As the Placement Planning Meeting was not recorded, there is no record of what was discussed. At a minimum, a schedule of expectations should have been drawn up and agreed by the Foster Carers and Lily's mother prior to the placement starting. Given the clear assessment report, it would also have been good practice to share and discuss the report recommendations. The Placement Plan recorded that the placement was a *'holding placement'* and that Lily's mother had *'passed'* her assessment.

4.2.14 Within the Placement Plan, it was recorded that the foster carers were to *'make sure that mum and baby were not co-sleeping*'. However, there appears to be a lack of understanding or communication around this as the Foster Carers state that they were not asked to do this until a review meeting on 4th February 2021. There is no detail around how they were to do this.

4.2.15 The fostering agency risk assessment was completed on 19th January but didn't contain any of the concerns or recommendations from the assessment report from the Mother and Baby Assessment Unit and it's possible that this was completed prior to the assessment report being received by them. Concerns, safety, and teaching requirements were not transferred from the assessment report to risk assessment or placement plan either at all (Risk Assessment) or adequately (Placement Plan). Once the assessment report was received by the fostering agency on 19th January (the day after the placement started), no professional challenge or questions were raised and the risk assessment and plan were not updated.

4.3 The Mother and Baby Foster Placement

4.3.1 Lily and her mother moved to a Mother and Baby Foster Placement on 18th January. They arrived at night having not met the foster carers prior to the move due to the speed at which the placement had to be found. This is not usual practice and Lily and her mother should have had the opportunity to meet the foster carers. The health visitor recalled the mother being sat on her bed with all of her belongings packed around her in bin bags, not knowing where she was going to, which area or whose house she would be staying in. Given the mother's own history of neglect and parenting alongside her current low mood and anxiety, this was not trauma-informed and would have been very difficult for the mother.

4.3.2 The foster carers told the reviewer that it was quickly clear that Lily's mother could not have passed her assessment, due to her lack of self-care. They also state that they were told there was nothing for them to do as Lily's mother had passed her assessment. The concerns that were present in the assessment unit at the last review meeting continued within the foster placement with Lily's mother spending most of her time with Lily in her bedroom. She was not making herself food and not taking care of her self-care needs such as taking a shower. It is important to note that England was in a third lockdown at this point and Lily's mother was in an area that she didn't know and away from her family support. The foster carers state they tried to encourage Lily's mother to go for a walk, sit with them in the evening and even left the house to give her space to cook for herself. Time was given for the mother to settle in and five days after the start of the new placement, the foster

carers raised concerns by telephone. The Social Worker should have visited Lily in placement within five days of the placement move. This is a statutory requirement for a looked after child and did not take place. Had it done, this would have allowed for an earlier discussion of the foster carers concerns.

4.3.3 From a Primary Care perspective, Lily and her mother did not transfer GPs upon moving to their new placement, most likely because the placement was to be for a four week period. Had they done, it is unlikely that this would have had any impact on the outcome of this case and realistically the GP records would not have transferred or been reviewed before Lily's death. Lily and her mother had contact with the Health Visiting team in the new placement when issues emerged. In terms of Health Visitor involvement, there was no discussion between the outgoing Health Visitor and the Health Visitor within the new area. There was a delay in transferring Lily's health records due to workload and system difficulties. Good practice in this case (a child subject to a Care Order) should involve a handover discussion and would have been helpful to provide the background to the case and reflect some of the mother's difficulties. The reviewer also accepts that the outgoing Health Visitor was not aware of all of the information relating to co-sleeping, as explained earlier in the review.

4.3.4 Six days into the new placement, the foster carers entered the mother's room and found the mother co-sleeping with Lily. This is the first observed incident of co-sleeping seen since week six of the residential assessment. The foster carers subsequently reported this incident to the Social Worker on the following day.

4.3.5 All involved professionals including the Independent Reviewing Officer, the Guardian, the Health Visitor were made aware of concerns regarding the mother's presentation and concerns that she was deteriorating with one instance of co-sleeping being observed (although it should be noted that the foster carers were not at this point checking Lily was in her cot and there were no cameras in place as in the previous placement). The Health Visitor spoke to Lily's mother over the telephone but given the concerns raised, the new area and new placement, it would have been good practice for the Health Visitor to visit the mother at home with Lily. This would have given the opportunity to observe her directly and the sleeping arrangements, with the use of PPE, given the restrictions in place at the time.

4.3.6 A LAC meeting was held within a week of the concerns being raised and these were discussed at the meeting with the foster carer and Lily's mother in attendance. There is no recorded exploration with the mother as to the reasons behind her deterioration and lack of self-care. There was a lack of professional curiosity around the issues impacting on mother's behaviour or addressing the underlying concerns.

4.3.7 Two days later a meeting took place at the foster carers' home with a Schedule of Expectations being agreed. This included agreement that the foster carers would check every night that Lily was in her cot. The foster carers were not given permission to remove Lily from the room and were to place her back in her cot. Given the decline in the mother's presentation and the recorded observations of co-sleeping, clearer escalation plans should have been in place to deal with repeated incidences of co-sleeping or situations with increased risk. After this meeting there is no further recorded contact between the Social Worker, Lily's Mum or the foster carer and the Social Worker leaves the Local Authority the following week.

4.3.8 Following the Social Worker leaving the authority on 9th February, the case was not allocated to a new worker. There was no plan in place and the 4 week placement funding was coming to an end. The mother had not been successful in bidding for properties and this appeared to her and to the foster carers to be all the mother thought she needed to do, although the foster carers believed that the mother wouldn't be able to manage living independently. The Local Authority missed opportunities to have conversations (even internally) about how the concerns from the assessment report and foster placement

translate into a plan to move Mum onto an independent or a supported living placement with Lily.

4.3.9 The mother's presentation and engagement with the foster carers improved after the meeting on 4th February. The mother was however, found to be co-sleeping with Lily on more occasions after the meeting on 4th February. Without a camera in the bedroom, the foster carer explained it was impossible to always know that Lily was in her cot, as the mother could have picked her up after they did their final evening check.

4.3.10 On the night of 14th February Lily was found unresponsive and could not be revived. It is believed that the mother co-slept with Lily after drinking alcohol. Police investigations found a bottle of vodka in the mother's room and from the examination of the mother's phone believe that this was a single event. There is no evidence to suggest that the mother was drinking alcohol and this had not been a feature of previous concerns.

5. Findings

5.1 Not all incidents of co-sleeping were shared with Lily's Health Visitor whilst Lily and her mother were staying at the assessment unit. They should have been, as it was important that the health visiting team were aware of all issues and incidents, when planning appropriate interventions and support. Whilst the safer sleep message was taught and reinforced, had the new Health Visitor been aware of the number of co-sleeping incidents, it is likely that she would have increased her visits to Lily's mother to discuss co-sleeping and to provide increased support and guidance to her.

5.2 Placement planning from the Mother and Baby Assessment Unit to the Mother and Baby Foster Placement was rushed and poorly planned. This should not have been the case. This was a planned residential placement with a clear timeframe, ongoing assessment, and weekly meetings to review progress.

5.3 A lack of planning led to there being no induction, no meeting of the foster carer for the mother, information not being shared before placement and no risk assessment being completed prior to placement. Whilst at times such moves are necessary due to the emergency nature in which they arise, as a planned assessment with a clear timeframe, this could have been avoided. The transition for Lily's mother was not trauma-informed given her past where she had experienced repeated placements herself in childhood and the family should not have been moved with belongings in bin bags with late knowledge of where they were moving to. This has particular relevance due to her low mood and anxiety around the transition process.

5.4 The conclusion of the assessment was that Lily and her mother should be kept together and not separated. This was interpreted by professionals as 'positive' and this was interchanged with the word 'passed.' The use of this language led professionals to minimise concerns and assumptions were made that there were few concerns of note throughout the transition period. There were concerns which were relevant for both care planning, support and supervision.

5.5 There was an over reliance on there being a positive assessment despite concerns clearly set out by the assessment unit, together with the rationale for why a Mother and Baby Foster Placement was recommended. The assessment contained a clear recommendation for the Mother and Baby Foster Placement together with concerns being expressed in weekly progress meetings (which showed by the end of the placement that the mother's presentation was

deteriorating). The mother was not ready to be in a community placement on her own with the baby and this should have been clear in the planning for the Mother and Baby Foster Placement.

5.6 The lack of planning and the speed upon which a placement had to be found led to the focus shifting from what work the mother needed to do in order for her to safely care for Lily in the community to finding her somewhere to stay and it became a search for an emergency placement.

5.7 The assessment report clearly identifies safety concerns and teaching needs. The fact that this wasn't translated into planning for the mother and Lily and from speaking with professionals involved, it is clear that the word 'positive' was relied upon and not all professionals read the detail of the assessment. It is impossible to read the assessment and for a professional to form the view that this was an assessment without work still to be done.

5.8 It was not clear to the mother what she needed to do to transition to the community with Lily. She was told she had passed her assessment and therefore her focus was on finding properties to move to and she was encouraged to do this.

5.9 There was reluctance by senior management at the local authority to agree a Mother and Baby Foster Placement for a mother who had a positive assessment. This suggests a lack of understanding as to why a mother and baby placement was recommended for Lily and her mother.

5.10 A risk assessment should have been undertaken by the Local Authority before placing Lily and her mother in the Mother and Baby Foster Placement. As this was not done, it hindered support planning and risk management.

5.11 The referral to the fostering agency contained some concerns, but the information, and this, should have provided an opportunity for the fostering agency to show professional curiosity. Alongside this, there has been a lack of clarity in informal communication around the purpose of the placement.

5.12 The fostering agency risk assessment was written without having seen the assessment from the Mother and Baby Assessment Unit and as such was based on incomplete information. As a consequence, concerns, safety, and teaching requirements were not transferred from the assessment to risk assessment or placement plan either at all (Risk Assessment) or adequately (Placement Plan).

5.13 Once the assessment report was received by the fostering agency, there was a missed opportunity to professionally challenge or seek clarification. Subsequently, the risk assessment and plan were not updated by the fostering agency, after the receipt of this new information.

5.14 The Placement Plan did require the foster carers to check for co-sleeping. This wasn't understood by the foster carers who didn't start checking until 4th February after concerns had been expressed and a schedule of expectations and review meeting had been held. There appears to be a breakdown in communication and lack of clarity around this point despite it being recorded in the Placement Plan.

5.15 Daily logs were submitted by the foster carers and there was a missed opportunity for the fostering agency and local authority to identify that co-sleeping checks were not taking place.

5.16 In light of the above, there was a general lack of oversight of this case by professionals working with the family and those being in place to oversee and review the case until concerns were raised by the foster carer.

5.17 Given the concerns raised by the Mother and Baby Assessment Unit in the assessment report and progress meetings, the rushed placement and lack of clarity for the mother may have contributed to her continuing to deteriorate in personal care and feelings of isolation.

5.18 There was a lack of exploration with the mother as to the reasons behind her deterioration and lack of self-care. There was a lack of professional curiosity around the issues impacting on mother's behaviour or addressing the underlying concerns.

5.19 There was a delay in agreeing a Schedule of Expectations between the foster carers, Social Worker and mother. This was not completed until 4th February and should have been in place prior to the start of placement. This was a missed opportunity to ensure Lily's mother had greater choice and control within the placement and all parties understood what was expected of them.

5.20 At the progress meeting on 4th February, there was a lack of consideration around escalation or increased risk towards Lily or her mother. The foster carers were unable to remove Lily from her mother's care and given the deterioration in the mother's presentation, there was opportunity to explore this to provide wider support and safeguarding for Lily and to support the foster carers.

5.21 Following the meeting on the 4th February there is no further recorded contact between the Social Worker, Lily's Mother or the foster carer. Given the considerable concerns and the risk of stability of the placement, the minimum expectation would have been phone calls to the foster carer to check on how Lily and mother were doing but better practice would have been to complete a follow up visit. This is likely to be due to the fact that the Social Worker was leaving the authority the following week.

5.22 The Social Worker left the Local Authority on 9th February and the case was not allocated to a new worker. Children's Social Care system continued to record the Social Worker who had left as Lily's Social Worker until her date of death. Due to the complexities, concerns and timescales within this case, there was a missed opportunity to prioritise the reallocation of a Social Worker and provide good continuity of support. The review has identified concerns expressed by some agencies that this has been occurring more regularly due to pressures on the social care workforce and use of agency staff who can move placements quickly, sometimes hindering the ability to have an effective handover.

5.23 The co-sleeping work undertaken by health was of good quality and the correct messages were taught. It is positive that this was regularly reinforced and Lullaby Trust information was provided to the mother on numerous occasions. There has been extensive work around this message by the Safeguarding Partnership.

5.24 The risk to babies doesn't lie in the co-sleeping with one or both of their parents. Many parents choose to co-sleep with their babies. However, to co-sleep when drinking alcohol significantly increases the risk of death by asphyxiation. There was no indication that the mother was drinking to Lily's foster carers or professionals working with the mother. Alcohol had not been a previous concern in this case. The police investigation found a bottle of vodka within the room and evidence suggests this was an isolated event. The review hasn't found any opportunity to identify alcohol as an issue throughout the period of the review.

6. Learning Recommendations

These learning points are specifically in relation to planning the transition of children and their families from assessment units to mother and baby placements.

LP1: Notwithstanding emergency placements being required, placement planning from assessment units where end dates are known, should be commenced early enough to allow for smooth transition and to ensure that the transition and move is trauma informed. Consideration should be given to transition planning starting at the mid-way assessment point with management oversight to ensure appropriate planning is in place.

LP2: Where the placement proposed is for a child to be placed with a parent in a new setting, such as a mother and baby placement, care planning must run concurrently to the placement planning. Care planning should clearly set out the purpose of the placement and give a proposed exit plan. Care planning at the time of the placement request should accurately reflect the assessment which has underpinned the placement request and have a clear plan as to what needs to be assessed during placement.

LP3: Risk assessments should be completed before placement, or if not possible as soon as practicable after placement. A risk assessment should always be undertaken by the designated Local Authority regardless of whether in-house or agency placements are commissioned.

LP4: Placement paperwork including risk assessments should clearly set out any identified risks and should be regularly updated and reflected upon to ensure they are up to date. Professionals should ensure that assessments are read and understood by others working with the family and that professionals challenge plans and risk assessments which do not reflect the underpinning assessments.

LP5: The local authority should review the use of language following assessments to ensure that simplistic language such as the use of 'pass, fail, positive' does not impact on practice and decision making.

In respect of co-sleeping:

LP6: Where the local authority has accommodated a baby within a mother and baby foster placement and there have been concerns in relation to co-sleeping, these should be addressed in writing within an agreed Placement Plan prior to that placement commencing. This should include specific requirements for the foster carer to check that the baby is in its cot and what steps they should take if co-sleeping is observed or the mother is unable to care for the baby.

In respect of workforce and staffing:

LP7: Systems should be reviewed to ensure that in cases where the allocated social worker of a child leaves, appropriate allocation and a full handover takes place to ensure a smooth transition and that appropriate safeguarding is in place.

7. Annex A

The membership of the case review panel was comprised of the following representatives:

Independent Chair	**Neil Smith**
Independent Reviewer	**Louise Rae**
Business Manager	**Children's Safeguarding Assurance Partnership**
	Cumbria & Lancashire Community Rehabilitation Company (CRC)
	Lancashire Children's Social Care
	HCRG Care Group Ltd
	Lancashire Constabulary
	We Are With You Lancashire
	Blackpool Teaching Hospitals NHS Foundation Trust (BTHFT)
	East Lancashire Hospitals NHS Foundation Trust (ELHFT)
	Lancashire Teaching Hospitals Trust – Advanced Support Midwifery Team
	North West Ambulance Service (NWAS)
	Sefton Clinical Commissioning Group (CCG)
	Lancashire & South Cumbria Foundation Trust (LSCFT)
	CAFCASS
	Merseycare 0-19 Service
	Fusion Fostering