Herefordshire Council

Corporate Support Centre
Andrew Lovegrove and Claire Ward,
Acting Deputy Chief Executives

To: All members of the Council

our ref: Council - 27 April 2021
contact: Matthew Evans, Democratic Services
telephone: 01432 383690
email: matthew.evans@herefordshire.gov.uk

20 April 2021

Dear Councillor,

You are hereby summoned to attend the meeting of the Herefordshire Council to be held on **Tuesday 27 April 2021** at the Online meeting at **10.00 am** at which the business set out in the attached agenda is proposed to be transacted.

Yours sincerely

Kate Charlton

Kate Charlton

Monitoring Officer

Herefordshire Council

AGENDA

Council

Date:	**Tuesday 27 April 2021**
Time:	**10.00 am**
Place:	**Online meeting**
Notes:	Please note the time, date and venue of the meeting. For any further information please contact: **Matthew Evans, Democratic Services** Tel: 01432 383690 Email: matthew.evans@herefordshire.gov.uk

If you would like help to understand this document, or would like it in another format or language, please call Matthew Evans, Democratic Services on 01432 383690 or e-mail matthew.evans@herefordshire.gov.uk in advance of the meeting.

Agenda for the Meeting of the Council

Membership

Chairman	**Councillor Sebastian Bowen**
Vice-Chairman	**Councillor Kema Guthrie**

Councillor Graham Andrews	Councillor Paul Andrews
Councillor Polly Andrews	Councillor Jenny Bartlett
Councillor Chris Bartrum	Councillor Christy Bolderson
Councillor Dave Boulter	Councillor Tracy Bowes
Councillor Ellie Chowns	Councillor Pauline Crockett
Councillor Gemma Davies	Councillor Barry Durkin
Councillor Toni Fagan	Councillor Elizabeth Foxton
Councillor Carole Gandy	Councillor John Hardwick
Councillor John Harrington	Councillor Liz Harvey
Councillor Jennie Hewitt	Councillor Kath Hey
Councillor David Hitchiner	Councillor Phillip Howells
Councillor Helen I'Anson	Councillor Terry James
Councillor Peter Jinman	Councillor Tony Johnson
Councillor Graham Jones	Councillor Mike Jones
Councillor Jim Kenyon	Councillor Jonathan Lester
Councillor Trish Marsh	Councillor Bob Matthews
Councillor Mark Millmore	Councillor Jeremy Milln
Councillor Felicity Norman	Councillor Roger Phillips
Councillor Tim Price	Councillor Paul Rone
Councillor Alan Seldon	Councillor Nigel Shaw
Councillor Louis Stark	Councillor John Stone
Councillor David Summers	Councillor Elissa Swinglehurst
Councillor Paul Symonds	Councillor Kevin Tillett
Councillor Diana Toynbee	Councillor Ange Tyler
Councillor Yolande Watson	Councillor William Wilding

Agenda

Pages

1. APOLOGIES FOR ABSENCE

To receive apologies for absence.

2. DECLARATIONS OF INTEREST

To receive declarations of interest in respect of Schedule 1, Schedule 2 or Other Interests from members of the Council in respect of items on the agenda.

3. QUESTIONS FROM MEMBERS OF THE PUBLIC

To receive questions from members of the public.
Deadline for receipt of questions is 5:00pm on Wednesday 21 April 2021.
At extraordinary meetings of Council questions must relate to reports on the agenda.
Accepted questions and answers will be published as a supplement prior to the meeting. Please send questions to councillorservices@herefordshire.gov.uk

4. QUESTIONS FROM MEMBERS OF THE COUNCIL

To receive any written questions from members of the Council.
Deadline for receipt of questions is 5:00pm on Wednesday 21 April 2021.
At extraordinary meetings of Council questions must relate to reports on the agenda.
Accepted questions and answers will be published as a supplement prior to the meeting. Please send questions to councillorservices@herefordshire.gov.uk

5. HIGH COURT JUDGEMENT RELATING TO CHILDREN AND FAMILIES 9 - 124

To receive a report on the Judgement of The Hon Mr Justice Keehan, following recent children's social care proceedings heard in the Family Division of the Royal Courts of Justice regarding a family known to Herefordshire Council since 2010. This Judgement was published at 14.00hrs on 16th April 2021.

In accordance with Part 4 paragraph 4.1.13 of the Council's constitution, the Acting Joint Chief Executives requested, on behalf of cabinet, the Monitoring Officer to a call an extraordinary meeting of the Council due to the public interest in these matters.

This report summarises the issues raised in the judgement and sets out a strategy for assuring the current social care service is safe in the immediate term and then improves in the future

The Seven Principles of Public Life

(Nolan Principles)

1. Selflessness

Holders of public office should act solely in terms of the public interest.

2. Integrity

Holders of public office must avoid placing themselves under any obligation to people or organisations that might try inappropriately to influence them in their work. They should not act or take decisions in order to gain financial or other material benefits for themselves, their family, or their friends. They must declare and resolve any interests and relationships.

3. Objectivity

Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.

4. Accountability

Holders of public office are accountable to the public for their decisions and actions and must submit themselves to the scrutiny necessary to ensure this.

5. Openness

Holders of public office should act and take decisions in an open and transparent manner. Information should not be withheld from the public unless there are clear and lawful reasons for so doing.

6. Honesty

Holders of public office should be truthful.

7. Leadership

Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

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YOU HAVE A RIGHT TO: -

- Attend all Council, Cabinet, Committee and Sub-Committee meetings unless the business to be transacted would disclose 'confidential' or 'exempt' information.
- Inspect agenda and public reports at least five clear days before the date of the meeting.
- Inspect minutes of the Council and all Committees and Sub-Committees and written statements of decisions taken by the Cabinet or individual Cabinet Members for up to six years following a meeting.
- Inspect background papers used in the preparation of public reports for a period of up to four years from the date of the meeting. (A list of the background papers to a report is given at the end of each report). A background paper is a document on which the officer has relied in writing the report and which otherwise is not available to the public.
- Access to a public register stating the names, addresses and wards of all Councillors with details of the membership of Cabinet and of all Committees and Sub-Committees.
- Have a reasonable number of copies of agenda and reports (relating to items to be considered in public) made available to the public attending meetings of the Council, Cabinet, Committees and Sub-Committees.
- Have access to a list specifying those powers on which the Council have delegated decision making to their officers identifying the officers concerned by title.
- Copy any of the documents mentioned above to which you have a right of access, subject to a reasonable charge (20p per sheet subject to a maximum of £5.00 per agenda plus a nominal fee of £1.50 for postage).
- Access to this summary of your rights as members of the public to attend meetings of the Council, Cabinet, Committees and Sub-Committees and to inspect and copy documents.

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- The Shire Hall is a few minutes walking distance from both bus stations located in the town centre of Hereford.

Recording of meetings

- Anyone is welcome to record public meetings of the council using whatever, non-disruptive, methods you think are suitable. Please note that the meeting chairman has the discretion to halt any recording for a number of reasons including disruption caused by the recording, or the nature of the business being conducted. Recording should end when the meeting ends, if the meeting is adjourned, or if the public and press are excluded in accordance with lawful requirements.

- Anyone filming a meeting is asked to focus only on those actively participating.

- If, as a member of the public, you do not wish to be filmed please make a member of the governance team aware.

FIRE AND EMERGENCY EVACUATION PROCEDURE

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You should vacate the building in an orderly manner through the nearest available fire exit and make your way to the Fire Assembly Point in the Shire Hall car park.

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The Chairman or an attendee at the meeting must take the signing in sheet so it can be checked when everyone is at the assembly point.

Herefordshire Council

Title of report: High Court Judgement April 2021 relating to Children and Families

Meeting: Council

Meeting date: 27 April 2021

Report by: Acting Joint Deputy Chief Executives and Interim Director Children Services

Classification

This report is open.

Decision type

This is not an executive decision

Wards affected

All Wards

Purpose

To receive a report on the Judgement of The Hon Mr Justice Keehan, following recent children's social care proceedings heard in the Family Division of the Royal Courts of Justice regarding a family known to Herefordshire Council since 2010. This Judgement was published at 14.00hrs on 16th April 2021.

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This report summarises the issues raised in the judgement and sets out a strategy for assuring the current social care service is safe in the immediate term and then improves in the future.

Recommendation(s)

That:

a) **Note the contents of this report;**

b) **Note the Judgement set out in appendix 1 of this report;**

c) **Note the Assurance and Improvement Strategy set out in appendix 2;**

d) **Agree the establishment of an Improvement Board**

e) **Approve the appointment of an Independent Chair for the Children and Families Improvement Board;**

f) **Note the Secretary of State will approve the appointment of a DFE advisor to act as the Independent Chair of the Children and Families Improvement Board;**

g) **Approve the commission of External Reviews as determined necessary by the head of paid service; and**

h) **Approve the Financial Provision to support the Review and Improvement Strategy, as set out in para 24 and appendix 3 of this report.**

Alternative options

1. Without the development of an independently chaired improvement board and improvement plan, together with undertaking external reviews where applicable, the Council cannot be confidently assured that there is evidence of sustainable and improved frontline practice across children's social care and that the safeguarding needs of children and young people are being appropriately met.

2. The council rightly needs to understand how we have failed these children and their families in order to make the required changes needed within the children's services directorate. Such changes need to be delivered at pace and to ensure that sustained improvements in practice and procedure, which, includes a co-ordinated multi agency working response, with our partners, to ensure we are fully and effectively together meeting the needs of children and young people in Herefordshire.

Key considerations

3. Complex and sensitive High Court proceedings were heard by His Hon Mr Justice Keehan at the Royal Courts of Justice Family Division between 22 February and 19 March 2021 and were held remotely. The proceedings concerned social care practice and procedure for 4 children, their birth mother and the children's foster carers between 2010 and 2020.

4. As these proceedings were heard in the family court then they were held in private. Mr Justice Keehan describes the circumstances this family encountered, whist under the care of Herefordshire Council, as 'in the whole of my professional life I have rarely

encountered such egregious and long-standing failures by a local authority'. The judgment is distressing and of great concern.

5. Set out below, is a summary of the history of the relationship between the council and this family between 2010 to date and a summary of the key findings against the council and a summary of the key observations and conclusions of Mr Justice Keehan.

6. Summary of key dates and background (this is set out in more detail at paragraphs 12 - 81 of the Judgement);

a) The Court proceedings concern four children, aged 17, 13 and 11 and one child who in June 2019, sadly died aged 15 years.

b) The children have been the subject of full care orders since 27 January 2014 placing them in the care of Herefordshire Council. They were first known to the council from 2010 and as a result of care proceedings in 2012 they have been living with their current foster carers since September 2012.

c) In 2013, HHJ Rundell Worcester Family court directed that the local authority seek urgent professional support and/or counselling to understand why the children made allegations about inappropriate physical and sexual behaviour by the parents, extended family members and those whom the parents associated with. Whilst the Judge raised concerns about general sexual behaviour of the children's parents he made no findings in respect of direct sexual harm to the children.

d) Following the courts judgement a psychiatrist Dr Asen was instructed to provide an assessment of each of the children and to advise how they could best be informed of the outcome of the fact-finding hearing of HHJ Rundell.

e) In 2014, HHJ Rundell, approved a final care plan for these children so that the current foster carers became the long term foster carers for the children and that 'life story' work was to be undertaken by a social worker. Life story work is to help the children understand their experience and family background and to explain this is a fundamental part of them understanding who they are. In addition, he directed that contact arrangements should be considered with the family members of the children.

f) Following the conclusion of care proceedings in 2014 the local authority had a continuing responsibility to engage with the children's mother within the Looked after Children process which included the provision of updating information about the children's welfare, ascertaining her views and sending her minutes of LAC meetings

g) In 2015 the children's maternal grandmother made an application for contact with the children. The maternal grandmother raised concerns that Herefordshire Council had not done enough to promote contact between the children and their family.

h) During these proceedings, the foster carers complained that they had not been made aware of the judgement from the initial care proceedings (2013) until a day before they had a meeting with a psychiatrist in September 2016 and they also

contended that they had sought information from the local authority but this had not been forth coming.

i) In April 2016, HHJ Plunkett made further orders regarding a plan of future contact between the children and family members , disclosure of information to the foster carers including the 2013 judgement of HHJ Rundell and therapy and life story work to be prepared by the local authority.

j) Within these proceedings, the mother of the children confirmed that she was willing to wait until the children wanted to see her and was willing to participate in indirect contact until that point.

k) In April 2017, because no life story work or therapy had been undertaken, HHJ Plunkett (Worcester), approved a detailed amended care plan to include future contact, therapy and life story work for the children.

l) Between 2014–2017, various matters were raised with the council. The children sought the progress of their permanency plans including the change of their surname, complaints were received by the local authority in relation to its handling of the LAC process and the maternal family sought contact with the children. This latter matter was considered by the court in the 2015 proceedings

m) During 2018, as part of the Looked after Children process, the council considered the discharge of the current care orders and undertook an assessment for special guardianship orders in favour of foster carers.

n) And in early 2019 the foster carers were assessed by the council to become special guardians for the 4 children. However, the outcome of the assessment was delayed due to the sad death of the second eldest child in June 2019.

o) Tragically on 6 June 2019 aged 15 years, the second eldest child died.

p) This child had been experiencing varying degrees of ill health from approximately March 2019 for which she was seen by her General Practitioner, CAMHS, and an admission to Hereford Hospital from where she was transferred to Birmingham Paediatric intensive care unit.

q) On 27 May 2019, the Head of Service gave consent for heart surgery to take place if necessary. Unfortunately her condition deteriorated and she was placed on a ventilator under an induced coma. Eventually the hospital sought consent to redirect her treatment to one of palliative care. The Director of Children Services provided consent on 6th June 2019 to her life support machine being turned off. The local authority was advised at 08.39 am on 6th June 2019, that the hospital was seeking consent to remove life support; an hour later the mother was advised of this. The mother arrived at the hospital after her daughter had died.

r) In September 2019 an application was made by the mother of the children for contact with her children.

s) The local authority progressed its Special Guardianship Assessment in respect of the foster carers by making an application to discharge those care orders already in place.

t) At the first court hearing heard at Worcester County Court in November 2019 the children's mother confirmed that she opposed the making of a Special Guardianship Order (SGO) in favour of the foster carers. Directions were made by HHJ Plunkett, for the local authority to file and serve documents held in relation to the death of the eldest child.

u) The local authority made an application on 3 December 2019 for the children's surname to be changed to that of the foster carers' surname. The children's mother raised concerns about the foster carers referring to the children by their own surname and that the local authority had failed to act to deter this.

v) On 8 January 2020 the council's application for the discharge of care order was heard again by HHJ Plunkett at Worcester County Court. Due to the seriousness of the allegations being made by the children's mother against the foster carers, Herefordshire Council made an application for the carers to become 'interveners' in proceedings held in December 2019. This was to enable the foster carers to respond directly against the allegations being levelled against them. The local authority agreed to fund the foster carers' legal representation on the basis that the court was considering the council's application for a special guardianship in their favour and the foster carers of the children are the council's approved foster carers.

w) At that hearing, HHJ Plunkett also determined that the nature and seriousness of the case was such that the matter should be re-allocated to the Royal Courts of Justice to be heard by his Lordship Mr Justice Keehan.

x) Herefordshire Council have been represented by Queen's Counsel, and Junior counsel since proceedings commenced in the Royal Courts of Justice in February 2020 and through to the conclusion of the current proceedings and the judgement.

y) A senior solicitor previously employed by Herefordshire Council provided incorrect legal advice regarding the authority of the council, as corporate parent to consent to turning off of life support It was important that at no time during the care proceedings was any conflict issue likely to arise, because of this erroneous legal advice and because Herefordshire Legal Services continued to have conduct of these proceedings. Therefore, Wolverhampton City Council Legal Services were asked to take responsibility for primary day to day conduct of the proceedings, along with support from a locum solicitor in Herefordshire Council Legal Services

Summary of Key Findings

7. These findings are based on findings of fact agreed by all the parties including Mr Justice Keehan, and those findings of fact which Mr Justice Keehan found proved, having heard evidence from a number of council witnesses:

a) Herefordshire Council failed to use HHJ Rundell's 2013 fact-finding judgment (Worcester Court) as a basis for challenging and changing the children's distorted perceptions of their family.

b) Herefordshire Council failed to promote contact between the children and their mother.

c) Herefordshire Council acted in breach of its duty under section 34(1) Children Act 1989 to refuse contact between the children and the mother

d) For the period 2013 - 2019, Herefordshire Council failed to use life story work and therapy effectively in order to dispel the children's misconceptions about their birth family.

e) Herefordshire Council did not properly engage with the mother within the Looked after Children (LAC) process.

f) Herefordshire Council failed to manage the foster-placement properly and to ensure the children's emotional needs were met.

g) Herefordshire Council failed to take any or any sufficient steps to preserve the children's sense of identity with and connection to their family.

h) Whilst the second eldest child was hospitalised, Herefordshire Council marginalised the mother and failed to accord her parental responsibility the weight and respect it deserved

i) Herefordshire Council provided incorrect legal advice regarding the authority of the council, as corporate parent to consent to turning off of life support.

j) Herefordshire Council did not have any policy in place defining its procedures where issues of consent arose in respect of medical treatment, and palliative care for looked after children

k) Herefordshire Council did not refer the matter of turning off the life support machine to the Court, for a best interest decision.

l) Herefordshire Council failed to undertake a sufficiently robust assessment as part of the LAC Review in 2017.

m) Herefordshire Council failed in timely steps in its approach to permanency planning for the children.

n) Herefordshire Council demonstrated indecision, poor planning, and complicity and was breach of its statutory duty in allowing the children to use the foster carers surname; it took 5 years before the matter was considered by the court.

o) Herefordshire Council failed to undertake a robust and evidence based reliable special guardianship assessment of the children's carer when recommending special guardianship orders (SGO's).

p) Herefordshire Council failed to ensure that there was a proper management and/or supervision structure so that failures in the SGO assessment process were recognised or remedied before they were relied on for permanency planning.

q) Herefordshire Council does not have proper recording mechanisms of social care records and the late and incomplete disclosure of relevant documentation in the proceedings made the case more complex and challenging for all parties.

8. The key observations of Mr Justice Keehan (judgement paragraph 220- 238) are summarised as follows:

a) *The children have been utterly failed by this local authority. By its actions, failures and omissions over the course of the last eight years it has compounded the emotional and psychological harm the children have suffered. The local authority has ignored, indeed, challenged the advice of a hugely experienced child psychiatrist for reasons which I do not begin to understand. It has treated with contempt the clarion call of a senior family judge for the local authority to re-evaluate its approach to these children, to the family and to the carers* (para 220).

b) *I can only hope there is now the time and the opportunity to repair this damage and to give the children a positive sense of their identity, of their family and to enable them to have meaningful, positive and beneficial contact with their mother and their wider family* (para 221).

c) *My strongest criticism must be directed at this local authority. In the whole of my professional life I have rarely encountered such egregious and long-standing failures by a local authority. The worst of it is, I cannot after the closest possible enquiry, understand why or what motivated the local authority to fail these children, this mother and the interveners as appallingly and for as extended a period of time. The whole history of the role of this local authority in the lives of these children is highly inexplicable. The only matter which is clear to me is that it did not have the welfare best interests of the children at the heart of its decision-making, such as it was* (para 226).

d) *This must call into question whether this local authority's children's services department is fit for purpose. That is a question which is not for me to answer. I can say that they had failed these children in an extraordinary manner over a prolonged period of time* (para 227).

e) *The local authority's actions, omissions and failures in this case have been spread over a period in excess of eight years. Mr Baird readily accepted and described the conduct of the children's services department in the lives of these children as appalling. He was plainly right to do so* (para 234).

f) *I am told and accept that the mother and the interveners have been shocked by the evidence they have heard over the course of this hearing and I well understand why this is the case.*

g) *I concluded the hearing by thanking the mother, her husband and the foster carers for the great dignity and composure they had each demonstrated throughout this hearing but most especially at times when particular distressing episodes were being dealt with, most obviously the death of their daughter. I repeat my sincere*

gratitude to each of them. On any level these proceedings have been immensely stressful for all four of them.

Correspondence with Council and Mr Justice Keehan

11. On 17 March 2021, the Acting Joint Chief Executives, wrote to Mr Justice Keehan apologising unreservedly for the failures of the council, and the distress this had caused the mother, children and foster carers. The letter recognised the need for the Council to commission without delay, an external review of the service with an Improvement Board, led by an Independent Chair and the Chief Executive to drive and deliver improvements needed in the Children and Families directorate. A copy of the letter is attached at Appendix 4.

Private Judgement

12. Following the conclusion of the proceedings on 19 March 2021, a Private, judgement which was embargoed to the both the Press and Public was 'handed down' by Mr Justice Keehan on 30 March 2021. The only persons who were able to see this private judgement were the main parties to the proceedings including certain council officers, including the incoming chief executive Paul Walker and the Leader Councillor David Hitchiner and the Cabinet Member for Children and Families Councillor Felicity Norman. The court also ordered that the council should forward a copy of this judgement to the following:

    i. Secretary of State Education, Mr Gavin Williamson

    ii. Chief Social Worker

    iii. Children's Commissioner for England and Wales

    iv. Chief Inspector Ofsted.

Corporate Response

a) This judgement is not at all what children and families in Herefordshire deserve. Whilst it raises significant legacy issues, it is recognised and accepted that we need to know now what is the cause, why did it happen, could the same failings be present in other cases and capable of happening again. Significant improvements in practice must be achieved now and at pace.

b) The attitudes, culture and professional social work practice in this judgment is shocking and well below the standards we expect. Appropriate action will be taken on the conclusion of our investigations, in accordance with the council's HR procedures, any relevant professional body requirements, and the law. The outcome of these investigations is a matter for the Head of Paid Service or the employment panel (as set out in the council's employment rules) to determine.

c) In the meantime, there are social workers who continue to do their best, often in very difficult circumstances, to support families and protect vulnerable children in our community. We will ensure our staff have the support they need and the

confidence and commitment to report any concerns as we make significant and lasting improvements to Herefordshire Children's Services.

d) Anecdotal evidence from members, strongly suggests that evidence which focuses on the quality of services provided and the outcomes being achieved have not been correct or are in complete at the time of reporting to them, particularly at Performance Challenge Meetings and/or Scrutiny meetings. We absolutely recognise the need to rebuild member trust and confidence in the service and how members can rely on the performance and delivery data for children in care. And so the strategy below sets out below how both members can get involved in the improvement journey including challenging and relying on robust objective data.

Recommended Assurance and Improvement Strategy

a) The objective of this Strategy is to provide assurance that service risks are being effectively managed and mitigated, that children and families are at the centre of all identified actions which have a positive impact on outcomes for children and for an Improvement Board to oversee and monitor the implementation of a Children's Services Improvement Plan.

b) This improvement strategy is different to previous promises of improvement following the 2018 judgements as early engagement with the regulators has already taken place advising them of the issues and risks in this judgement and how the council proposes to respond. The commission of an external review, as discussed earlier is now required. The improvement required is a corporate priority and will be led by the incoming Chief Executive and not by the Directorate. It will require an independent chair of an Improvement Board to lead and monitor the required improvement journey with an update report to full council in September/October 2021. The membership of the Improvement Board will include external partners to provide objective challenge to the intended deliverables and achieved outcomes

c) During February and March 2021, statutory officers including the incoming Chief Executive along with Assistant Director People have monitored the issues arising from the proceedings, including monitoring new and emerging other high risk 'looked after care' issues and engaged early with the Local Government Association (LGA) and the statutory regulators and the chair of the joint safeguarding partnership board.

d) Appendix 2 sets out the recommended Review and Improvement Strategy.

e) The recommended Strategy is in four parts, the here and now, once we were aware of the issues emerging in the case, what to do Pre and Post publication of the judgement, and Post May 2021 when Paul Walker the new chief executive starts.

<u>Stage 1 - Here and Now</u> - assurance that service risks are being effectively managed and mitigated

i. All proposed SGOs since March 2021 have been monitored by way of Quality Assurance which has been subject to legal advice and a Panel

approval system is currently being established with Service leads and Legal Services to ensure that they are fit for purpose and designed to achieve positive outcomes for children. A new assurance process of SGOs ready to be presented to the court, is set out at Appendix 5 .While we seek to understand the full extent of past decisions made within Children's Services, we regret that, during this current assurance phase we may find further instances that do not meet the required practice standards

ii. During February and March 2021, regular engagement with the Childrens Social Care leads for the LGA, DFE, Ofsted and Safeguarding Partnership and the Joint Deputy Chief Executives and incoming chief executive.

iii. An interim statutory Director of Children Services has been appointed to lead the assurance process and the required improvement work.

Stage 2 - Pre Publication - of Judgement

iv. 6–9 April 2021, DFE commissioned Essex Children Social Care to undertake an immediate helicopter review of looked after care service to identify issues/risks. Essex reviewed 19 cases, which they selected independently from a full case list and reported that there were no red flags in these 19 cases. The outcome of their visit is set out in more detail at Appendix 6 & 7

v. Terms of Reference for Improvement Board will be agreed with the DFE.

vi. Agreed with DFE the appointment of an advisor who will also chair the Improvement Board and we are awaiting approval by the Secretary of State as to who will be appointed.

vii. Commission a third party provider to undertake a review of leadership and management in the Children Social Care service. The Council has commissioned an independent forensic deep dive of the services including the leadership and management within children's social care to be undertaken by two former HMI inspectors as part of our on-going assurance and to inform the improvement plan. This review will report their findings to the current Interim DCS and the Improvement Board in May 2020.

Stage 3 + 4 - Post Publication of Judgment

viii. Extraordinary Full Council meeting to approve the recommendations.

ix. New chief executive in post as from 3 May 2021 who will be leading this strategy and jointly leading the Improvement Board with the Independent Chair.

x. Continue to work with Ofsted through fortnightly meetings and the annual statutory conversation.

xi. Consider commission of further external reviews as identified by the improvement board and/or through on going assurance work.

xii. Establish the Improvement Board and any supporting working groups, including member representation/involvement.

xiii. Explore with LGA, Children Scrutiny Peer Review / External LA Peer to rebuild and reframe member confidence in effective Children Social Care Scrutiny challenge.

xiv. Findings of external review/deep dive/next steps will be reported back to both to the Improvement Board and another Full Council meeting September/October 2021.

Regulators

13. The LGA, DFE and Ofsted have welcomed the council's early engagement and approach. The 4 stage strategy has been shared with them and they are supportive of the approach taken.

14. The annual conversation with Ofsted is due on 11 June, Ofsted will be reviewing their risk assessment of our service based upon the judgement findings and we have agreed fortnightly meetings with Ofsted as part of the on-going assurance work.

15. The DFE are currently considering what action they are required to take to ensure children receive the services they deserve. The type of intervention is dependent on the severity of the situation, how long the authority has been underperforming, and the perceived capacity for improvement. We recognise that the DFE have a difficult decision to make.

Nomination for Chair of Improvement Board

16. Once approved by the Secretary of State Department of Education, the DFE will procure and commission an advisor for Herefordshire. The detail of that appointment is yet to be determined but a sample Role Descriptor is attached Appendix 8.

Community impact

17. The recommended decisions within this report will have both a direct or indirect effect on the lives of both current and future children in care in Herefordshire.

18. When a child comes into care, the council becomes the Corporate Parent.

19. The term 'corporate parent' means the collective responsibility of the council, elected members, employees, and partner agencies, for providing the best possible care and safeguarding for children who are looked after by the council. Being a good corporate parent means we should; accept responsibility for children in the council's care; make their needs a priority; and seek for them the same outcomes any good parent would want for their own children.

20. Corporate parenting responsibilities are both the responsibility of elected members and council officers. All officers share the responsibility to promote the needs of looked after children. Key responsibilities of all officers are: to promote the life chances of

looked after children and care leavers in their area of responsibility; and to consider the impact of decision making on looked after children and care leavers.

Environmental Impact

21. There is no environmental impacts as a result of the recommendations or issues discussed in this report.

Equality duty

22. Under section 149 of the Equality Act 2010, the 'general duty' on public authorities is set out as follows:

    A public authority must, in the exercise of its functions, have due regard to the need to:

    a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

    b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

    c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

23. The Equality Act 2010 established a positive obligation on local authorities to promote equality and to reduce discrimination in relation to any of the nine 'protected characteristics' (age; disability; gender reassignment; pregnancy and maternity; marriage and civil partnership; race; religion or belief; sex; and sexual orientation). In particular, the council must have 'due regard' to the public sector equality duty when taking any decisions on service changes

Resource implications

24. There are significant revenue resource implications of the recommendations included in this report. There are no expected capital resource implications.

25. The council's base revenue budget includes suitable budgets to cover the agreed staffing establishment, and other recurring and one off costs to deliver children's social care, this report recommends the development and implementing of an assurance and improvement strategy. The resource implications are not included in the base budget. As detailed below the anticipated additional resource requirement for the next two years is £5.222m.

26. Included in the estimates are appropriate amounts to support training, retention and recruitment of staff to deliver the assurance and improvement strategy as well as additional staffing resource to provide additional capacity to the service.

27. Subject to confirmation of council's decision in relation to this report, cabinet will exercise its authority to allocate ear-marked reserves required to fund the implementation of the

assurance and improvement strategy. The improvement board will receive monthly reports monitoring spend incurred in delivering the assurance and improvement strategy.

28. The council holds a range of ear marked reserves at the end of March 2021 the council held ear marked reserves in excess of £60m

29. It may be that additional resources are required, both interim and recurring may be required in future years, these requirements will be considered as part of the council's normal budget setting process.

Revenue cost	**2021/22**	**2022/23**	**Future Years**	**Total**
	£000	£000	£000	£000
Improvement board	130	130	-	260
Support for family's	100	100	-	200
Legal	551	551	-	1102
External legal fees	525	325	-	850
Human resources support	364	289	-	653
Assurance and transformation	292	85	-	377
interim Staffing	890	890	-	1,780
TOTAL	**2,852**	**2,370**		**5,222**

Funding streams	**2021/22**	**2022/23**	**Future Years**	**Total**
	£000	£000	£000	£000
Ear marked reserves	2,852	2,370		5,222
TOTAL	**2,852**	**2,370**		**5,222**

Legal implications

30. The judgement was delivered in private on 30 March 2021. The public version was published on 16 April 2021 at 14.00pm on www.bailli.gov.uk

31. This public version preserves the confidentiality of and privacy of the mother, the children and the foster carers. All persons including representatives of the media must ensure that this condition is adhered to. Any disclosure of this confidential and private information may amount to contempt of court which could result in a fine or imprisonment.

32. Both previous and current council employees who provided evidence, by way of a witness statement and/or oral evidence at the high court hearing have by direction of Mr Justice Keehan been named in this judgement. All persons must ensure that any

comments, discussion or reporting of this judgement is not of a vexatious, defamatory, libellous or discriminatory nature towards these named individuals.

33. S18 Children Act 2004 requires every upper tier local authority to appoint a Director of Children's Services.

Incorrect Legal Advice

34. The judgment also identified incorrect legal advice being given to management. This advice was plainly wrong. There have been significant changes made to the management and staff within the Children's Legal Team and also new protocols and training to ensure processes are observed and advice is sound.

Special Guardianship Orders

35. Special Guardianship Orders were introduced in 2005 as an amendment to the overarching legislation Children Act 1989 and its purpose is another permanency option. They are a means of providing permanency for the children who cannot live with their parents and for whom adoption would not be appropriate. Unlike adoption the order retains the basic legal link with the parents. They remain legally the child's parents, though their ability to exercise their parental responsibility is limited.

a) The Children Act 1989 at sections 14A-F set out the following -

- Who may apply for a special guardianship order
- The circumstances in which a special guardianship order may be made
- The nature and effect of special guardianship orders
- Support services for those affected by special guardians

b) The order enables the current holder of a care order to exercise parental responsibility to the exclusion of others with parental responsibility. At the same time as making a special guardianship order, the court may also give leave for the child to be known by a new surname.

c) The court should also consider whether a contact order should be made at the same time as the special guardianship order. A contact order may be made, for example, to require continued contact with the child's parents.

d) Since the implementation in December 2005 of SGOs a review was undertaken in 2015 by the DFE. The review focussed on growing concerns of rushed or poor-quality assessments, risky placements and inadequate support for SG's. The matters that a local authority must address in a special guardianship report are set out in the Special Guardianship Regulations, reg 21. The Schedule to the 2005 Regulations (as amended by the 2016 Regulation).

e) This legal framework fundamentally requires an evidence-based assessment that results from the child have been cared for by the applicant 24/7 for at least a year. This evidence will focus on a range of core components such as the integration of the child into the new family, the way the child's needs have been met across the range of typical issues that parenting and family life addresses.

f) In June 2020, the Public Law Working Group Family Justice published its recommended best practice for SGO's, introduced by Mr Justice Keehan.

Next Hearing

34. The judgement considers the manner in which the care plans of the children have been handled by the local authority and furthermore the legal position on ending life sustaining treatment of a child in care. The Judge has adjourned the welfare aspect of proceeding. A further hearing has been listed following the filing of a report by Dr Williams who is undertaking an agreed assessment of the children, the mother and the foster carers. The next hearing shall be held in private.

Misuse of s.33 (3) Children Act 1989 / Ending Life Sustaining Treatment for a LAC Child

35. Section 33(3) Children Act 1989 provides that while a care order is in force with respect to a child, the local authority designated by the order shall –

a) have parental responsibility for the child; and
b) have the power (subject to the following provisions of this section) to determine the extent to which
c) a parent…..may meet his parental responsibility for him

36. The above power given to the local authority is subject to Section 33(4) CA 1989 which states that " The authority may not exercise the power in subsection (3)(b) unless they are satisfied that it is necessary to do so in order to safeguard or promote the child's welfare."

37. The issue of the exercise of parental responsibility by a local authority which had a care order in respect of a child was considered by the Court of Appeal in *Re C (Children)* [2016] EWCA 374. The court in requiring a local authority to invoke the jurisdiction of the court in relation to a serious medical issue stated it was not conferring power upon a local authority, rather that the High Court was using its inherent jurisdiction to limit, circumscribe or sanction the use of the power which the local authority already has by virtue of s.33(3)(b) of the 1989 act. The judge concluded in paragraphs 98 and 104 as follows:

"In the medical treatment cases the decisions to be made may well be a matter of life and death. In the present case, the limitation on the exercise of parental responsibility proposed by the local authority, whilst not life threatening, is life affecting. Further such a decision potentially involves such a serious invasion of the Article 8 rights of the mother that I am satisfied that the court should invoke its inherent jurisdiction in order that it may

either sanction the local authority's proposed course of action as in the interests of the children or, alternatively, to refuse to sanction it as for example being in breach of Article 8." "I have reached the conclusion that there is a small category of cases where, notwithstanding the local authority's powers under section 33(3)(b) CA 1989, the consequences of the exercise of a particular act of parental responsibility are so profound and have such an impact on either the child his or herself, and/or the Article 8 rights of those other parties who share parental responsibility with a local authority, that the matter must come before the court for its consideration and determination."

38. So the profound life and death decision to consent to the withdrawal of life support should be the subject of an application to the High Court.

39. The legal advice given in June 2019 was wrong and an inappropriate use of the local authority's power under s.33 of the 1989 Act.

Changing Surname of a Looked After Child

40. The law is governed by s.33(7) Children Act 1989. The legislation states that while a care order is in force with respect to a child no person may –

    i. Cause the child to be known by a new surname or

    ii. Remove him from the United Kingdom

41. Without either the written consent of every person who has parental responsibility for the child or the leave of the court (court granted application).
42. It would therefore be contrary to the above legislation to allow children to be known by their foster carers surname without the consent of parents or a court order. This would also represent poor social work practice.

43. A single joint improvement plan between the CWB Assurance team, led by Dr Andy Gill Assistant Director and Legal Services is being devised with the overall aim of raising standards and changing culture within CWB. The overall aim being to improve the lives of children in the County of Herefordshire. There will be an in-depth review and auditing exercise arising from matters raised in the previous 3 judgements in 2018 and this judgement from Mr Justice Keehan. The plan will include a review and change exercise across all areas in the service identified which requiring strengthening. The plan will also include an analysis of the impact to social work practice in Herefordshire following a greater amount of remote working due to Covid-19.

44. The outcomes from this plan will be reported to the Improvement Board for monitoring performance and delivery.

Risk management

45. Increased financial risks arising from increased potential human rights claims; current known risks have been reflected in the legal and corporate performance risk register and any new risks to the council as a result of the historic practice identified in this judgment will be monitored and reported through the corporate performance reporting arrangements.

46. If the DFE decide to intervene in the authority this is likely to be a non statutory notice for improvement this will include the provision of external consultancy, advisory or peer support, the establishment of improvement boards, enhanced monitoring and challenge. Statutory improvement notices can also be issued and more critical or enduring underperformance may necessitate the use of Statutory Directions compelling the council to take certain actions. In extreme cases the DFE can direct partial or complete outsourcing of children services to a third party or the establishment of a children's trust.

Consultees

47. The Leader, Councillor David Hitchiner and all Cabinet members have been advised of the contents of this judgement by direction of Mr Justice Keehan. The Chair and Vice Chair of the Children and Young People Scrutiny committee have been kept informed of the case as it progressed through the court. All members were provided with briefings upon publication of the judgement.

Appendices

1. Public Judgement: Re YY (Children: Conduct of the Local Authority)
2. Review and Improvement Strategy
3. Resources Plan
4. Letter from Herefordshire Council to Mr Justice Keehan dated 17 March 2021
5. New SGO Assurance Process
6. Essex Review (6–9 April 2021) Key Lines of Enquiry
7. Essex Review (6–9 April 2021) Summary of Findings
8. Example Job Description Chair Improvement Board

Background papers

None identified'.

Please include a glossary of terms, abbreviations and acronyms used in this report.

Neutral Citation Number: [2021] EWHC 749 (Fam)

Case No: WR19C00221

IN THE FAMILY COURT
SITTING AT THE ROYAL COURTS OF JUSTICE

Royal Courts of Justice
Strand, London, WC2A 2LL

Date: 26/03/2021

Before :
MR JUSTICE KEEHAN

- -

Re YY (Children: Conduct of the Local Authority)
Between :

Herefordshire Council	**Applicant**
- and -	
M	**1st Respondent**
-and-	
F	**2nd Respondent**
-and-	
Child A and Child B YY	**3rd and 4th Respondents**
-and-	
Child D YY	**5th Respondent**
-and-	
Mrs XX and Mr XX	**1st and 2nd Interveners**

- -
- -

Miss L Meyer QC and Miss L O'Malley (instructed by **Legal Services**) for the **Applicant**
Mr N Goodwin QC and Miss F Farquhar (instructed by **Child Care LLP**) for the **1st Respondent**
The 2nd Respondent did not attend and was not represented
Miss E Isaacs QC and Mr M Maynard (instructed by **Whatley Recordon**) for the **3rd and 4th Respondents**
Mrs J Crowley QC and Mr M Cooper (instructed by **Waldrons**) for the **5th Respondent**
Miss K Skellorn QC and Miss D Thornton (instructed by **Humfrys & Symonds**) for the **1st and 2nd Interveners**
Hearing dates: 22nd February to 19th March

- -

Approved Judgment

I direct that pursuant to CPR PD 39A para 6.1 no official shorthand note shall be taken of this Judgment and that copies of this version as handed down may be treated as authentic.

.....

This judgment was delivered in private. The judge has given leave for this version of the judgment to be published on condition that (irrespective of what is contained in the judgment) in any published version of the judgment the anonymity of the children and members of their family must be strictly preserved. All persons, including representatives of the media, must ensure that this condition is strictly complied with. Failure to do so will be a contempt of court.

The Hon Mr Justice Keehan :

Contents of Judgment

Introduction

1. In this matter I am concerned with three young people, Child A who is 17 years old, Child B, who is 13 years old, and Child D, who is 11 years old. They had a sister, Child C, who tragically died on 6th June 2019 when she was 14 years of age.

2. The mother of the children is M, she is the First Respondent. The father of the children is F, he is the Second Respondent. He has, however, played no active role in these proceedings nor is he legally represented.

3. The children were placed with local authority foster carers on 24th July 2012. They moved to live with alternate foster carers, Mr XX and Mrs XX, on 15th September 2012, where they have remained to date.

4. All four children, including Child C, were made the subject of care orders on 27th January 2014.

5. Early in their placement with Mr and Mrs XX, the children made serious allegations of sexual abuse against their mother, their father and others within, and associated with, their extended family. These allegations were the subject of a fact-finding hearing before HHJ Rundell, the then Designated Family Judge of Hereford and Worcester in 2013. In his judgment of 26th July 2013 he did not find the children's allegations established on the balance of probabilities, but he did find that the children had been exposed to sexual activity when they had been living with their parents.

6. Over many years the children persisted in their accounts of abuse perpetrated by their parents and other members of their wider family. They each held increasingly entrenched negative views of their mother, their father and the wider family. Mr and Mrs XX adopted the stance of believing the children. In consequence, the mother and the father have not seen the children since late 2012 and the maternal grandmother has seen them on just two occasions in 2017.

7. I have three substantive applications before me:

    i) the mother's application to spend time with the children (contact) dated 23rd September 2019;

    ii) the local authority's application to discharge the care orders – on the basis that the court would be invited to make special guardianship orders in favour of Mr and Mrs XX – dated 8th November 2019; and

    iii) the local authority's application to change the children's surnames from YY to XX dated 3rd December 2019 – by consent I granted this application in respect of Child A alone on 20th August 2020.

8. At a hearing on 7th August 2020 I was invited to direct that Child A and Child B should be separately represented on the basis that:

    i) they had been assessed to be Gillick competent; and

    ii) they wished to be separately represented from their children's guardian.

I so directed. Accordingly, only Child D was represented by the children's guardian's legal team.

9. In preparation for this final hearing the mother sought findings of fact in respect of the alleged actions and failings against:

   i) the local authority; and

   ii) the fosters carers, and prospective special guardians, Mr and Mrs XX.

   Moreover, Child A and Child B sought findings of fact in respect of the alleged actions and failings of the local authority. I, therefore, gave directions for the filing and serving of schedules of the findings sought and for responses to be filed and served by the local authority and Mr and Mrs XX.

10. On 8th January 2020, HHJ Plunkett directed that Mr and Mrs XX be joined as interveners to these proceedings.

11. This hearing was listed as a composite fact-finding and welfare hearing. For reasons which emerged during the course of this hearing and to which I will refer later in this judgment it only proved possible to conclude the fact-finding element of this hearing. I gave directions to enable this matter to be listed for a final welfare hearing later this year.

Background

The Original Proceedings

12. The children originally became known to the local authority in 2010 in respect of mother's concerns of their sexualised behaviour, which included strategy discussions on 21st June 2010 and 2nd July 2010 and an Initial Child Protection Conference on 29th July 2010. During the period of 2010-2012, the children were at times accommodated by family members and, for a short period, with local authority foster carers as concerns in respect of the mother's mental health and the father's behaviour were investigated. On 24th July 2012, they were accommodated pursuant to section 20 and placed with the foster carers, Mr and Mrs QQ. Thereafter, they moved to their current placement with the interveners on 15th September 2012.

13. Care proceedings were issued by the local authority on 20th December 2012. On 21st December 2012 the children were made the subject of interim care orders. At this time, the children's social worker was Lynnette Chan. The children continued to have positive supervised contact with their mother until December 2012, at which time the children alleged past sexual and physical abuse within the care of their birth family. Since then, there has been no direct contact at all and very limited indirect contact.

14. In its threshold schedule, the local authority alleged that the children had been sexually abused, that their parents were both within the pool of potential perpetrators and that their maternal grandmother was aware of the abuse. The local authority also alleged physical abuse by various individuals including the parents.

15. A fact-finding hearing took place in July 2013 over a period of eight days before HHJ Rundell. Within his judgment of 26th July 2013, the judge found in summary:

i) the allegations of sexual abuse were not proved;

ii) the allegations of physical abuse were not proved; save that the mother had hit Child B on one occasion and both parents had used physical chastisement;

iii) the mother had behaved in an inappropriate sexual manner in relation to other men whilst the children were present in the home;

iv) the mother had a history of poor mental health, which compromised her ability to meet the children's needs consistently, as well as episodes of heavy drinking; and

v) the father presented a risk of significant harm to the children in relation to sexual matters.

16. HHJ Rundell was satisfied that the carers had:

> "faithfully recorded what the children did and said. They are not to blame for the present situation; they have provided love and devotion in the care of these four children. They are to be commended for the work they have undertaken".

The learned judge found that

> "the children now urgently require professional support; probably in the form of therapy and/or counselling. It is important to understand why they have made these allegations, which I have not been able to accept… I invite the local authority, in conjunction with the parents and the Guardian, to act swiftly to arrange such professional intervention as is considered appropriate."

17. Following the court's judgment, Dr Asen was instructed to provide an assessment of each of the children and to advise how they could best be informed of the outcome of the fact-finding hearing. In his report, dated 11th November 2013, he advised that:

i) the children's allegations could be explained in psychological terms by their growing up in a confused and unboundaried family setting;

ii) an agreed script with precise wording be used to inform the children of the outcome of the fact-finding hearing;

iii) the placement with the XX' had resulted in each of the children making remarkable progress;

iv) all four children were in need of therapeutic help in the long-term of varying nature and degrees but that this should await a decision about their permanent placement. He specified individual work for one child together with a psychotherapeutically led programme for the whole sibling group and their carers once permanency was achieved; and

v) the enforcement of direct, supervised contact "at this stage" contrary to their wishes and feelings would be likely to trigger their anxieties and risk destabilising the placement. However, once permanency decisions were made, "consideration [would] need to be given to promote face-to-face supervised contact with members of their family…". Direct contact was generally desirable unless there were strong arguments to the contrary.

18. On 6th December 2013, Dr Asen and the guardian discussed the finding of fact outcome with the children by way of a script drafted by professionals.

19. On 19th December 2013, the mother filed her final statement, recognising the excellent care that the XX had provided but emphasising her concern that the script provided by Dr Asen and the guardian omitted reference to the absence of proven sexual abuse by her, in the same way extended family members were confirmed not to have perpetuated abuse. Her hope was that this would be rectified.

20. On 19th January 2014, the then children's guardian, Mr Webb, filed his final analysis. He supported final care orders in relation to each child, on the basis that they were to remain in their current placement. On 22nd January 2014, the local authority's placement panel approved the interveners as the long-term carers for the children. On 27th January 2014, HHJ Rundell made final care orders in relation to all four children. The care plans provided for life story work to be undertaken by the social worker. The children's understanding of their life story would also be facilitated by the interveners' use of information and photographs provided by the social worker and parents in the form of a life story book.

Following the Original Proceedings

21. In April 2014, Rebekha Phillips became the allocated social worker. The following month, she approached the Head of Service, on the advice of the independent reviewing officer ('IRO'), to discuss gathering views about whether the children could be known informally as XX. On 12th November 2014, she requested legal advice in relation to changing their surname, for which the local authority had received written consent from the father.

22. The social worker, Ms Philips provided a social work report for the LAC review on 30th October 2014. In the period between this LAC review and the next review on 6th March 2015, the local authority (together with the carers) was to give consideration to securing the placement of the children via either a special guardianship order ('SGO') or adoption. Direct contact with the birth parents was not taking place. No professional-led life story work, in respect of the children's experiences before being placed in care, or work around the fact-finding judgment had taken place since the making of the final care orders. Indirect contact was planned but the social worker agreed with the children she would not tell them that letters had arrived for them, given their opposition to reading them. Instead, the IRO would ask them twice a year if they would like to change their minds about receiving them. This change of care plan received managerial approval. These recommendations were also set out in the social work report for the LAC review on 6th March 2015.

23. Although Lynnette Chan had referred the children to CAMHS on 18th January 2014, there were significant delays in starting the work. Rebekha Phillips attended an initial

consultation with the interveners on 1st May 2014. Child D had his first session on 21st October 2014, a decision having been taken by CAMHS and the social worker that the children would receive therapy consecutively. The interveners questioned that plan as opposed to a service for the sibling group. In her letter to the children's GP dated 29th April 2015, Wendy Healey (CAMHS psychologist) referred to "the profound and detrimental impact of sexual, emotional, physical abuse and neglect upon all the children" as well as "toileting problems…linked to anal abuse". The local authority did not seek to correct that narrative. Child C and Child B were referred to CAMHS on 23rd July 2015 and Child A on 17th November 2015. Despite the referrals, CAMHS did not challenge the children's resistance to talking about their past life experiences.

The Second Set of Proceedings

24. On 18th May 2015, the maternal grandmother, MGM lodged an application for permission to apply for a contact order pursuant to section 34(3). Permission was subsequently granted on 26th July 2015.

25. On 20th May 2015, the supervision record for Rebekha Phillips records that the legal department had advised that the children's request for a change of surname could be considered at the time of the carers' application for an SGO.

26. In July 2015 the local authority made a referral to the Therapeutic Intervention Support Service ('TISS').

27. On 22nd September 2015, HHJ Rundell gave a judgment in this second set of proceedings, noting that therapy had been slow to start and Dr Asen's further assessment of the children should await its completion. On 6th November 2015, the proceedings were adjourned until June 2016 for this work to take place. The court noted that Dr Asen's recommendation for therapy had been put into effect in a limited way, through the CAMHS referral but the work he had advised had not been done. An adjournment was "the least worst outcome".

28. On 17th November 2015, Child A commenced attendance at CAMHS, and the social worker started to receive advice from TISS.. Child C and Child B did not receive input from CAMHS. Rebekha Phillips began life story work, in consultation with TISS, but this was superficial, appearing not to address the children's "false narrative" and did not involve discussion and challenge about their life pre-care.

29. The matter came before HHJ Plunkett for the first time on 20th June 2016. The proceedings were again adjourned and a further order on 5th July 2016 directed a further report from Dr Asen. Within his preliminary report, dated 30th September 2016, Dr Asen indicated that all four children had made great progress in their emotional and social development since they were last assessed and were well settled in their placement. They wished to be known as XX. Dr Asen recorded that the children's positions as to contact with the birth family had not changed in the period since his previous assessment and that the children had not changed their beliefs and narratives as to what had happened prior to their removal. Their past experiences and false narrative had not been discussed or further explored with them in the intervening 3 years, either therapeutically or via professional-led life story work. In his view it was:

> "…essential for each child's self-image and identity formation, to have balanced views, including positive ones, about members of the birth family whom they literally - and collectively - appear to demonise. In the long-term the likely impact of holding such negative feelings and views of the maternal extended family is harmful for their psychosocial development and also their future ability to form and sustain trusting relationships. It is for this reason alone very important that all four children remember and recover positive attributes and memories of their birth family. Indirect and direct contact would assist this process."

30. Dr Asen raised concerns that the interveners had not been equipped by the local authority to provide positives about the birth family and their only information about the past had been the children's ongoing, negative narrative about their past. The interveners had not been provided with a copy of the fact-finding judgment and had not been reacquainted with it over the past few years, nor had they been given a copy of Dr Asen's 2013 report. The life story work undertaken to date had not focused on the children's lives prior to removal from their mother's care and so could not equip them to focus on positives about their birth family.

31. On 6th October 2016, HHJ Plunkett, following consideration of the interim report, gave directions for the disclosure of certain key documents to the interveners, including the 2013 fact-finding judgment. An addendum report was ordered for 28th November 2016. Dr Asen met Mrs XX and her daughter Miss XX on 10th November 2016 to discuss the fact-finding judgment. Both indicated that they found it difficult to reconcile the judgment with their experience of the children's behaviour in placement and the allegations they had made. They explained that they had only had the 2013 judgment for one day. Dr Asen recorded that the interveners would require time, guided reading and professional support to access the documents fully.

32. From an early stage, the mother had indicated that she would not force the issue of contact against the children's wishes and, accordingly, the focus was on re-establishing contact with the maternal grandmother within the framework of her application. Dr Asen proposed a period of preparatory work with a view to direct contact taking place in mid-February 2017.

33. An Issues Resolution Hearing was listed on 2nd December 2016 before HHJ Plunkett. On that occasion, the court, dismayed by the lack of progress, recorded in a recital to the order that:

> "it is concerned about the surprising degree of resistance to accept the clear judgement from the fact finding hearing by the Foster Carers and raises the option to move the children to Foster Carers who understand and support the reality as letting the children grow up not knowing the truth is likely to cause them emotional harm".

34. At a further hearing before HHJ Plunkett on 12th January 2017, the local authority produced a plan to progress contact, which the court endorsed. Further work by the local authority was also endorsed by the court at the hearing on 22nd February 2017.

In or around January 2017, the case was reallocated to Janet Watkins. She began her work with the interveners that month, followed shortly thereafter by work with the children. Direct contact took place on 21st April 2017. Ms Watkins' work discussed the 2013 judgment in detail, provided reassurance that the court was not suggesting the children were deliberately lying and explored reasons why the accounts the children have given were inaccurate. Mrs XX acknowledged that the children's presentation had affected her and perhaps coloured her view of the birth family.

35. The second set of proceedings concluded at a hearing before HHJ Plunkett on 28th April 2017. The local authority provided a detailed amended care plan to include future contact, therapy and life story work for the children. The maternal grandmother's application for contact was dismissed with no defined contact order.

Following the second proceedings

36. On 15th May 2017, Janet Watkins requested further legal advice regarding the change of surname. Gill Cox (Head of Service) agreed, on 21st July 2017, that the local authority should make an application to bring this about.

37. On the 31st July 2017, Victoria Leader became the Team Manager (Looked After Children team).

38. During the summer of 2017, input was provided by Dr Ali Davies (Clinical Psychologist, Action for Children) to Mrs XX for support with therapeutic parenting.

39. In the updated September 2017 care plans it was recorded that permanency by SGO was being considered.

40. In October 2017 the children had requested a new social worker. The case was reallocated to Hannah Ellis. During the period of involvement of Janet Watkins and Hannah Ellis there was further collation of birth family photographs, the children sent a card to their mother and had asked to visit places from their past and received a photograph from their mother. There was, however, no further professional-led life story work undertaken to address the children's understanding of their lives pre-placement once Janet Watkins' involvement ceased. On 13th July 2018, the children had a second contact with the maternal grandmother.

41. At the March 2018 LAC review it was recorded that the interveners had wanted to care for the children under an SGO for some time, but this had not been progressed during the previous contact proceedings. The local authority was to fund legal advice for the interveners and seek its own legal advice in relation to the change of surname.

The May 2018 Child and Family Assessment

42. On 3rd May 2018, Hannah Ellis completed a Child and Family Assessment. This recorded the children's wishes to be adopted by the XXs. Hannah Ellis gave her full support to SGOs, with an assessment to commence without delay. This would include work with the children and carers to support family contact.

43. Kathryn Straughan was allocated from the fostering team to undertake this assessment, to supplement her role as the fostering link worker. In accordance with

Herefordshire County Council policy, the special guardianship support plan was completed first, prior to the special guardianship assessment.

44. The July 2018 LAC review further recorded the local authority's plan for SGO assessments to be completed and presented to the court by the end of September 2018.

45. In February 2019, Child C was unwell with a high temperature and headache. She suffered intermittent symptoms throughout March and April 2019 and the interveners sought appropriate medical attention.

46. On 22 March 2019, Florence Kandodo became the allocated social worker for the children.

Child C's Illness and the Events of 2019

47. On 28th April 2019, Child C's health deteriorated, and she experienced involuntary muscle movements and tics. The interveners took her to hospital in Hereford that evening, having first spoken to the NHS 111 service. She was noted to be awaiting review by CAMHS but now needing an urgent review. She was referred to the CLD Trust's counselling service and her carers sought an expedited review.

48. On 2nd May 2019, she was taken to hospital a second time, was admitted to the Children's Ward at Hereford County Hospital for overnight observations but was discharged the following day. On the 3rd May 2019, Child C was urgently referred to CAMHS by Kirstie Gardner, specialist nurse for children in care.

49. On 10th May 2019, the local authority special guardianship assessment was completed by Kathryn Straughan and Florence Kandodo, recommending that all four children be made the subject of special guardianship orders. This was in accordance with their wishes and feelings. The assessment also recorded that the children wished to be known by the surname XX.

50. On 13th May 2019, Florence Kandodo referred Child C to CAMHS.

51. On 14th May 2019, Child C had an appointment with CAMHS and was diagnosed with anxiety and PANDAS (Paediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infection). She was prescribed various medications and was to return to school and there would be further referrals to a paediatric neurologist/immunologist. However, she continued to be very unwell and was unable to return to school.

52. On 26th May 2019, Child C was again admitted to Hereford County Hospital. She was suffering with chest pains, left side paralysis and tics. The following day she was transferred to Birmingham Children's Hospital where the seriousness of her condition became rapidly apparent. By the evening of 27th May 2019, she was placed in an induced coma, suffering from severe sepsis. At approximately 23:00 hours, medical consent for a potential operation to replace her aortic valve was provided by Gill Cox (Head of Service), subject to the medical team deciding that it was necessary. The operation took place on the afternoon of 28th May 2019.

53. On 28th May 2019, the mother attended the hospital for her first visit to see Child C. No social worker was present, and she was met by Mrs XX and her daughter. The following day, MGM and F were due to have had contact, but these visits did not go ahead despite the maternal grandmother attending the ward. MGM had a supervised visit to Child C on 30th May 2019.

54. By 3rd June 2019, the hospital confirmed to the local authority that Child C remained on life support and there had been no real change in her condition since 31st May 2019.

55. On 5th June 2019, Birmingham Children's Hospital reported that Child C condition had deteriorated. A CT scan identified multiple areas of infarcts in many organs, clots in her left ventricles, blood collecting in her stomach, fluid in her pleural cavity and active bleeding in her stomach. Her condition was described as unstable.

56. On the morning of 6th June 2019, Birmingham Children's Hospital contacted the local authority with the information that the hospital was seeking consent to redirect the pathway for Child C to remove life support.

57. The agreed timeline of events that occurred on 6th June 2019, is set out in paragraphs [104]-[120] below.

58. At 11.05am on 6th June 2019, Chris Baird (Director of Children and Families) gave written consent to stop ongoing care for Child C and to redirect to palliative care. Child C died at 11.54am that day.

Events Following Child C's Death and the Further SGO Assessment

59. On 17th June 2019, the local authority reallocated the case from Florence Kandodo to Claire Wilce. A strategy meeting was convened on 11th June 2019. The chair's summary included the recommendation that the SGO report be revisited and amended if required.

60. On 13th June 2019, case records detail a meeting between the foster carer, Alison Forshaw (Fostering Team Manager) and Karen Brooks. The interveners were informed that the new fostering link social worker would be Suzanne Musgrove. Kathryn Straughan remained the assessing fostering worker. Concern was noted about Mrs XX' emotional state and ability to respond calmly to LA professionals at that meeting. Other conversations in the period after Child C's death raised similar concerns.

61. On 17th June 2019, Clare Wilce and Karen Brooks visited the children in their foster-placement. Child A withdrew from the meeting in distress and all three children subsequently reported being upset as a result of the meeting. On 19th June 2019 Child A, Child B and Child D spoke to their advocate, Claire Harris, and made a complaint about Clare Wilce and Karen Brooks. As part of the complaint, the children again raised their wish to change their surname.

62. A further local authority meeting was convened on 20th June 2019, involving Gill Cox, Alison Forshaw, Carol Moreton, Claire Wilce and Karen Brooks to consider the issues in the relationship between the local authority and the interveners and any

impact upon the children. Gill Cox decided that a strategy meeting was not an appropriate response to the children's circumstances and the deterioration in the interveners' relationship with the local authority. However, it was recorded that those working with the family were already sharing information and other options existed such as a Looked After Children Core Group or a Looked After Children Review, if necessary.

63. On 21st June 2019, the IRO met with the interveners and briefly with the children. HHJ Plunkett wrote to the local authority following receipt of a letter from the maternal grandmother. The local authority updated HHJ Plunkett with the procedures in place to consider the impact of Child C's death on the other children and stated that there were no concerns regarding the care Child C had received from the interveners.

64. On 24th June 2019, a supervision meeting took place between Gill Cox and Vicky Leader. Gill Cox indicated that

> "it cannot be in the children's interests to be LAC given their very clear views that they do not wish to be and the very limited change that we have achieved in moving the children's or carers' views about the birth family".

The possibility of a further psychological assessment was discussed.

65. Following the meeting on 24th June 2019, Vicky Leader wrote to HHJ Plunkett informing him that:

> "The local authority does currently hold concerns around some aspects of the care being provided to the children. These concerns have become more evident during the period of Child C's hospitalisation and thereafter. There is no doubt that the carers are committed to the children and have fully supported Child C to the point that she sadly lost her battle. However, the concerns that were raised during the court proceedings of 2016 have been magnified in respect of the foster carers views towards the birth family. This will need further robust assessment and consideration within the updating SGO assessment."

66. On 27th June 2019, a discussion took place between Suzanne Musgrove and Alison Forshaw. A "chronology of concerns" was to be drafted for the foster-carers' panel review. The following day, Vicky Leader wrote to the interveners and confirmed that the local authority would update the SGO assessment in a timely way. A referral was made to Phoenix Bereavement Services.

67. Child C's funeral took place on 5th July 2019.

68. At a meeting convened on 16th July 2019, the local authority decided that Alison Forshaw would work with Kathryn Straughan to plan the updating SGO assessment.

69. On 19th July 2019 the mother emailed the local authority to set out her opposition to the potential SGO.

70. It emerged during the course of the evidence that the local authority operated a 'LAC reduction policy' whereby certain children's 'looked after' status would be reviewed with the aim of moving them on, for example, to a special guardianship order or rehabilitation home, where this was warranted. On 24th July 2019, a meeting took place between Chris Baird, Liz Elgar and Gill Cox to discuss the policy: "it needs now to be taken forward with much more drive than it has been".

71. Kathryn Straughan's personal supervision with Alison Forshaw took place on 26th July 2019. It was recorded that the LAC team was drafting a "chronology of concerns".

72. On 2nd August 2019, Suzanne Musgrove emailed Kathryn Straughan setting out her concerns about the carers, albeit noting she had only met them three times and had not been involved in "the conflict between other professionals leading up to and at the time of [Child C's] death". There are no other recordings evidencing the process by which Kathryn Straughan gathered information for her assessment. Her evidence is that she conducted her assessment from the *Mosaic* recordings on the system.

73. On 27th September 2019, the mother made an application for contact with the children pursuant to section 34(3).

74. On 10th October 2019 at 22.36pm, Kathryn Straughan emailed Alison Forshaw in the following terms:

> "I have completed the YY assessment with the view that I cannot recommend a SGO at this time due to concerns in relation to contact and identity issues. Following your comments Thursday I have also drafted an alternative ending recommending a sgo with a tight support plan. Could you see what you think of this. Gill would need to agree it. I am considering putting both stances to the court and inviting the court to choose between the two. I remain of the view that it is too soon to recommend a SGO but feel that this may be an acceptable alternative???"

75. On 11th October 2019 at 11.16am, Kathryn Straughan emailed Alison Forshaw enclosing a copy of the SGO assessment. This assessment (and those that followed) was conducted on a "paper only" basis, without the assessing social worker speaking to the interveners or the children directly. This unequivocally recommended that SGOs should not be made and that the care orders should not be discharged. The email was, however, accompanied by a second message attaching a document entitled 'Alternative Recommendations'. At 17.06pm, Alison Forshaw emailed Kathryn Straughan and asked her to "revisit" the SGO assessment and make a recommendation.

76. On 11th October 2019 at 17.24pm, Kathryn Straughan emailed Alison Forshaw informing her that she was resigning from her position.

77. On 16th October 2019, the interveners were reapproved by the local authority's fostering panel.

78. On 22nd October 2019, there was a further personal supervision between Kathryn Straughan and Alison Forshaw. The SGO assessment was discussed.

79. On 29th October 2019 at 10.47am, Alison Forshaw emailed Gill Cox and Vicky Leader with what was described as the "amended assessment" of Kathryn Straughan.

80. On 8th November 2019, the local authority issued its application for discharge of the care orders in relation to all children. On 3rd December 2019 it issued its application to change the children's surnames.

81. On 29th January 2020, a family meeting took place between Claire Wilce, the mother and her husband and the interveners.

The Law – Fact Finding

82. In family proceedings there is only one standard of proof, namely the balance of probabilities. This was described by Denning J in *Miller v Ministry of Pensions* [1947] 2 All ER 372:

> "If the evidence is such that the tribunal can say: "We think it more probable than not", the burden is discharged but, if the probabilities are equal, it is not.

83. In *Re B (Care Proceedings: Standard of Proof)* [2008] UKHL 35, [2008] 2 FLR 141, Baroness Hale, while approving the general principles adumbrated by Lord Nicholls in *Re H and Others*, expressly disapproved the formula subsequently adopted by courts to the effect that 'the more serious the allegation, the more cogent the evidence needed to be to prove it'. Baroness Hale stated:

> "[70] My Lords, for that reason I would go further and announce loud and clear that the standard of proof in finding the facts necessary to establish the threshold under s 31(2) or the welfare considerations in s 1 of the 1989 Act is the simple balance of probabilities, neither more nor less. Neither the seriousness of the allegation nor the seriousness of the consequences should make any difference to the standard of proof to be applied in determining the facts. The inherent probabilities are simply something to be taken into account, where relevant, in deciding where the truth lies.
>
> [71] As to the seriousness of the consequences, they are serious either way. A child may find her relationship with her family seriously disrupted; or she may find herself still at risk of suffering serious harm. A parent may find his relationship with his child seriously disrupted; or he may find himself still at liberty to maltreat this or other children in the future."

84. The inherent probability of an event remains a matter to be taken into account when weighing the probabilities and deciding whether, on balance, the event occurred: common sense, not law, requires that in deciding this question regard should be had,

to whatever extent appropriate, to inherent probabilities – per Lord Hoffman in *Re B* at paragraph 15.

85. The rule of *R v Lucas* [1981] QB 720 was adopted in the family courts in *A County Council v K, D and L*. The principle is that if the court concludes that a witness has lied about one matter it does not follow that he has lied about everything. A witness may lie for many reasons, for example out of shame, humiliation, misplaced loyalty, panic, fear, distress, confusion and emotional pressure.

86. In the criminal courts a lie can only be used to bolster evidence against a defendant if the fact-finder is satisfied that the lie is deliberate, relates to a material issue and there is no innocent explanation for the lie.

87. The court has considered the case of *Re: H-C (Children)* [2016] EWCA Civ 136, in particular paragraphs 98 to 100 of the decision of Lord Justice McFarlane, as he then was, where he said:

> "98. The decision in *R v Lucas* has been the subject of a number of further decisions of the Court of Appeal Criminal Division over the years, however the core conditions set out by Lord Lane remain authoritative. The approach in *R v Lucas* is not confined, as it was on the facts of Lucas itself, to a statement made out of court and can apply to a "lie" made in the course of the court proceedings and the approach is not limited solely to evidence concerning accomplices.
>
> 99. In the Family Court in an appropriate case a judge will not infrequently directly refer to the authority of *R v Lucas* in giving a judicial self-direction as to the approach to be taken to an apparent lie. Where the "lie" has a prominent or central relevance to the case such a self-direction is plainly sensible and good practice.
>
> 100. One highly important aspect of the Lucas decision, and indeed the approach to lies generally in the criminal jurisdiction, needs to be borne fully in mind by family judges. It is this: in the criminal jurisdiction the "lie" is never taken, of itself, as direct proof of guilt. As is plain from the passage quoted from Lord Lane's judgment in Lucas, where the relevant conditions are satisfied the lie is "capable of amounting to a corroboration". In recent times the point has been most clearly made in the Court of Appeal Criminal Division in the case of *R v Middleton* [2001] Crim.L.R. 251.
>
> In my view there should be no distinction between the approach taken by the criminal court on the issue of lies to that adopted in the family court. Judges should therefore take care to ensure that they do not rely upon a conclusion that an individual has lied on a material issue as direct proof of guilt".

88. I respectfully agree.

The Law – Welfare

89. When considering making decisions and orders in respect of children their welfare best interests are the court's paramount consideration: s1(1) Children Act 1989 ('the 1989 Act'). I take account of those relevant factors set out in the welfare checklist: s1(3) of the 1989 Act.

90. I have regard to the Article 6 and 8 rights of each child, the mother, the father and of the interveners, as the prospective special guardians. Where, however there is a tension between the Article 8 rights of a child, on the one hand, and of an adult or carer, on the other, the rights of the child prevail - *Yousef v The Netherlands* [2003] 1 FLR 210.

91. The legislative provisions relating to special guardianship orders are set out in ss14A-14C and 14F of the 1989 Act:

> "Special guardianship orders
>
> (1) A "special guardianship order" is an order appointing one or more individuals to be a child's "special guardian" (or special guardians).
>
> (2) A special guardian—
>
> (a) must be aged eighteen or over; and
>
> (b) must not be a parent of the child in question, and subsections (3) to (6) are to be read in that light.
>
> (3) The court may make a special guardianship order with respect to any child on the application of an individual who—
>
> (a) is entitled to make such an application with respect to the child; or
>
> (b) has obtained the leave of the court to make the application, or on the joint application of more than one such individual.
>
> (4) Section 9(3) applies in relation to an application for leave to apply for a special guardianship order as it applies in relation to an application for leave to apply for a section 8 order.
>
> (5) The individuals who are entitled to apply for a special guardianship order with respect to a child are—
>
> (a) any guardian of the child;
>
> (b) any individual who is named in a child arrangements order as a person with whom the child is to live;

(c) any individual listed in subsection (5)(b) or (c) of section 10 (as read with subsection (10) of that section);

(d) a local authority foster parent with whom the child has lived for a period of at least one year immediately preceding the application.;

(e) a relative with whom the child has lived for a period of at least one year immediately preceding the application.

(6) The court may also make a special guardianship order with respect to a child in any family proceedings in which a question arises with respect to the welfare of the child if—

(a) an application for the order has been made by an individual who falls within subsection (3)(a) or (b) (or more than one such individual jointly); or

(b) the court considers that a special guardianship order should be made even though no such application has been made.

(7) No individual may make an application under subsection (3) or (6)(a) unless, before the beginning of the period of three months ending with the date of the application, he has given written notice of his intention to make the application—

(a) if the child in question is being looked after by a local authority, to that local authority, or

(b) otherwise, to the local authority in whose area the individual is ordinarily resident.

(8) On receipt of such a notice, the local authority must investigate the matter and prepare a report for the court dealing with—

(a) the suitability of the applicant to be a special guardian;

(b) such matters (if any) as may be prescribed by the Secretary of State; and

(c) any other matter which the local authority consider to be relevant.

(9) The court may itself ask a local authority to conduct such an investigation and prepare such a report, and the local authority must do so.

(10) The local authority may make such arrangements as they see fit for any person to act on their behalf in connection

with conducting an investigation or preparing a report referred to in subsection (8) or (9).

(11) The court may not make a special guardianship order unless it has received a report dealing with the matters referred to in subsection (8).

(12) Subsections (8) and (9) of section 10 apply in relation to special guardianship orders as they apply in relation to section 8 orders.

(13) This section is subject to section 29(5) and (6) of the Adoption and Children Act 2002"

"Special guardianship orders: making

(1) Before making a special guardianship order, the court must consider whether, if the order were made—

(a) a child arrangements order containing contact provision should also be made with respect to the child, . . .

(b) any section 8 order in force with respect to the child should be varied or discharged.

(c) where a provision contained in a child arrangements order made with respect to the child is not discharged, any enforcement order relating to that provision should be revoked, and

(d) where an activity direction has been made—

(i) in proceedings for the making, variation or discharge of a child arrangements order with respect to the child, or

(ii) in other proceedings that relate to such an order, that direction should be discharged.

(1A) In subsection (1) "contact provision" means provision which regulates arrangements relating to—

(a) with whom a child is to spend time or otherwise have contact, or

(b) when a child is to spend time or otherwise have contact with any person;

but in paragraphs (a) and (b) a reference to spending time or otherwise having contact with a person is to doing that otherwise than as a result of living with the person.

(2) On making a special guardianship order, the court may also—

(a) give leave for the child to be known by a new surname;

(b) grant the leave required by section 14C(3)(b), either generally or for specified purposes"

"Special guardianship orders: effect

(1) The effect of a special guardianship order is that while the order remains in force—

(a) a special guardian appointed by the order has parental responsibility for the child in respect of whom it is made; and

(b) subject to any other order in force with respect to the child under this Act, a special guardian is entitled to exercise parental responsibility to the exclusion of any other person with parental responsibility for the child (apart from another special guardian).

(2) Subsection (1) does not affect—

(a) the operation of any enactment or rule of law which requires the consent of more than one person with parental responsibility in a matter affecting the child; or

(b) any rights which a parent of the child has in relation to the child's adoption or placement for adoption.

(3) While a special guardianship order is in force with respect to a child, no person may—

(a) cause the child to be known by a new surname; or

(b) remove him from the United Kingdom, without either the written consent of every person who has parental responsibility for the child or the leave of the court.

(4) Subsection (3)(b) does not prevent the removal of a child, for a period of less than three months, by a special guardian of his.

(5) If the child with respect to whom a special guardianship order is in force dies, his special guardian must take reasonable steps to give notice of that fact to—

(a) each parent of the child with parental responsibility; and

(b) each guardian of the child, but if the child has more than one special guardian, and one of them has taken such steps in relation to a particular parent or guardian, any other special guardian need not do so as respects that parent or guardian.

(6) This section is subject to section 29(7) of the Adoption and Children Act 2002"

"Special guardianship support services

(1) Each local authority must make arrangements for the provision within their area of special guardianship support services, which means—

(a) counselling, advice and information; and

(b) such other services as are prescribed, in relation to special guardianship.

(2) The power to make regulations under subsection (1)(b) is to be exercised so as to secure that local authorities provide financial support.

(3) At the request of any of the following persons—

(a) a child with respect to whom a special guardianship order is in force;

(b) a special guardian;

(c) a parent;

(d) any other person who falls within a prescribed description, a local authority may carry out an assessment of that person's needs for special guardianship support services (but, if the Secretary of State so provides in regulations, they must do so if he is a person of a prescribed description, or if his case falls within a prescribed description, or if both he and his case fall within prescribed descriptions).

(4) A local authority may, at the request of any other person, carry out an assessment of that person's needs for special guardianship support services.

(5) Where, as a result of an assessment, a local authority decide that a person has needs for special guardianship support services, they must then decide whether to provide any such services to that person.

(6) If—

(a) a local authority decide to provide any special guardianship support services to a person, and

(b) the circumstances fall within a prescribed description, the local authority must prepare a plan in accordance with which special guardianship support services are to be provided to him, and keep the plan under review.

(7) The Secretary of State may by regulations make provision about assessments, preparing and reviewing plans, the provision of special guardianship support services in accordance with plans and reviewing the provision of special guardianship support services.

(8) The regulations may in particular make provision—

(a) about the type of assessment which is to be carried out, or the way in which an assessment is to be carried out;

(b) about the way in which a plan is to be prepared;

(c) about the way in which, and the time at which, a plan or the provision of special guardianship support services is to be reviewed;

(d) about the considerations to which a local authority are to have regard in carrying out an assessment or review or preparing a plan;

(e) as to the circumstances in which a local authority may provide special guardianship support services subject to conditions (including conditions as to payment for the support or the repayment of financial support);

(f) as to the consequences of conditions imposed by virtue of paragraph (e) not being met (including the recovery of any financial support provided);

(g) as to the circumstances in which this section may apply to a local authority in respect of persons who are outside that local authority's area;

(h) as to the circumstances in which a local authority may recover from another local authority the expenses of providing special guardianship support services to any person.

(9) A local authority may provide special guardianship support services (or any part of them) by securing their provision by—

(a) another local authority; or

> (b) a person within a description prescribed in regulations of persons who may provide special guardianship support services, and may also arrange with any such authority or person for that other authority or that person to carry out the local authority's functions in relation to assessments under this section.
>
> (10) A local authority may carry out an assessment of the needs of any person for the purposes of this section at the same time as an assessment of his needs is made under any other provision of this Act or under any other enactment.
>
> (11) Section 27 (co-operation between authorities) applies in relation to the exercise of functions of a local authority in England under this section as it applies in relation to the exercise of functions of a local authority under Part 3 and see sections 164 and 164A of the Social Services and Well-being (Wales) Act 2014 for provision about co-operation between local authorities in Wales and other bodies"

92. The essential features of an application for a special guardianship order and which the court must scrutinise with care before making the order are:

    i) a thorough, comprehensive and evidence-based assessment of the children and of the prospective special guardians; and

    ii) a comprehensive Special Guardianship Support Plan which sets out the services and support to be provided to the children and the prospective special guardians: see the Public Law Working Group's Best Practice Guidance in respect of Special Guardianship Orders.

93. A key element of the support plan is the arrangements for contact between the children and their mother, father and family and the support the local authority will provide to arrange and support contact: see also s.14B of the 1989 Act.

Findings of Fact

94. The principal findings of fact sought by the mother against the local authority were as follows:

    i) the local authority failed to use HHJ Rundell's 2013 fact-finding judgment as a basis for challenging and changing the children's distorted perceptions of their family;

    ii) the local authority failed to promote contact between the children and their mother;

    iii) the local authority failed to use life story work and therapy effectively in order to dispel the children's misconceptions about their birth family;

iv) the local authority did not properly engage with the mother within the LAC process;

v) the local authority failed to manage the foster-placement properly and to ensure the children's emotional needs were met;

vi) the local authority failed to take any steps to preserve the children's sense of identity with and connection to their family; and

vii) whilst Child C was hospitalised, the local authority marginalised the mother and failed to accord her parental responsibility the weight and respect it deserved.

95. The principal findings of fact sought by the mother against the interveners were as follows:

i) the interveners failed to accept the court's 2013 judgment and did not give each child an accurate narrative of their family life based on the facts found by the court;

ii) the interveners formed an entrenched negative view about the biological family that influenced the children's response to contact; and

iii) the interveners overstepped the boundaries of their role and considered that the parental responsibility delegated to them as foster-carers gave them superior rights over the children without proper recognition of the parental responsibility retained by the mother.

96. The principal findings of fact sought by Child A and Child B against the local authority were as follows:

i) the LA failed to progress permanency planning for the children adequately;

ii) and/or sufficiently in a timely manner for the children, in contravention of their wishes and feelings, culminating in a delay of over six years. In particular, the LA's actions were characterised by a lack of communication, a lack of proper planning, and a lack of proper oversight of the children's recorded wishes and feelings over many years; and

iii) the LA failed to progress changing the children's surnames adequately and/or in a timely manner, in contravention of their wishes and feelings, culminating in a delay of over five and a half years before finally issuing an application on 3rd December 2019. In particular the LA's actions were characterised by a lack of communication, a lack of proper planning and a lack of proper oversight of the children's recorded wishes and feelings over many years.

97. In light of the concessions made by the interveners in respect of the findings of fact sought by the mother, the local authority made further concessions in the following terms:

i) we have already made concessions within the most recent response to mother with regard to issues surrounding delegated authority;

ii) the local authority will accept that important documents were not always provided to the interveners at an appropriate time, promptly or sufficiently in advance for them to consider, understand and assimilate the contents without feeling rushed or under pressure;

iii) that the number of different social workers for the children over the period of their placement would have added to communication difficulties, leading to a feeling that the children and carers were having to repeat information and further increased the risk of important information being overlooked. It would also inevitably have led to the need for the interveners and children to rebuild fresh relationships with professionals; and

iv) we have already made concessions within the response to mother with regard to there being a breakdown in trust in the relationship between local authority and interveners.

98. In each schedule of findings of fact sought the principal findings were supported by particulars of events or omissions which it was submitted provided the factual matrix for each finding.

99. Prior to the start of this hearing various concessions and/or responses were filed and served by the local authority and by the interveners. During the course of the early part of this hearing extensive negotiations and discussions took place between the parties. The outcome of the same was that the findings of fact to be made by the court were agreed.

100. The findings of fact are, given the very lengthy history of this case, very substantial. In essence, each of the principal findings sought by the mother and Child A and Child B (set out in paragraphs 95 and 98 above) were agreed and I had no hesitation in making each of those findings of fact. The agreed schedules are appended as follows:

i) the findings sought by the mother and agreed by the local authority are set out in Appendix 1;

ii) the findings sought by the mother and agreed by the interveners are set out in Appendix 2; and

iii) the findings sought by Child A and Child B and agreed by the local authority are set out in Appendix 3.

101. During the course of this hearing, in circumstances which I shall describe later in this judgment, an issue arose about the provenance of the special guardianship assessment report dated 22nd October 2019. I heard oral evidence from the fostering social worker, Kathryn Straughan, the fostering team manager, Alison Forshaw, and from the Head of Service, Gillian Cox.

102. In light of the evidence received by the court from these witnesses and on the basis of the disclosure of additional documents, the respondents and the interveners all invited me to make findings of fact in respect of the production of the special guardianship assessment report. The schedule of findings of fact sought is set out in Appendix 4 to this judgment. The local authority did not oppose the agreed findings of fact sought.

103. I shall consider the making of findings of fact on this issue when I have reviewed the oral evidence I heard at this hearing and the documents which were provided to me.

Child C and 6th June 2019

104. In May 2019 Child C became unwell with a suspected streptococcal infection. She deteriorated and was admitted to the emergency department of Hereford County Hospital on 26th May 2019. The following day she was transferred to the paediatric intensive care unit ('PICU') at Birmingham Children's Hospital ('BCH'). She was diagnosed with septicaemia, myopathy and multiple organ dysfunction. By the evening of 27th May 2019 Child C was unconscious, in an induced coma, on a life support ventilator.

105. The interveners and the other children were present at BCH. Arrangements were made for the mother to visit Child C but not the other children: none of whom she had seen in over seven years.

106. Various issues arose between the interveners and the mother about her visits to see Child C. I have not heard evidence from either the mother or the interveners. Accordingly, I do not consider it appropriate or necessary to set out in this judgment the competing accounts of events which took place at BCH. Suffice it to say that it was an extremely stressful and distressing time for all.

107. Over the succeeding days Child C remained in a stable but critical condition.

108. The mother and the father were not involved in any meetings with the treating clinicians nor forewarned by the doctors of the potential outcome that Child C may die and/or that a decision may need to be made to withdraw life support.

109. Child C's condition significantly deteriorated over the night and early morning of 5th and 6th June 2019.

110. At 8:39am on 6th June the treatment coordinator nurse at BCH spoke with Vicky Leader to inform her that Child C was deteriorating; the life support machine was simply delaying the inevitable outcome. The treating clinicians had agreed a plan to remove life-support ('ECLS') from her but this would need consent.

111. Vicky Leader spoke with Liz Elgar, one of the applicant's assistant directors of children's services, who said the hospital would need to set the position out in writing and the authority would need to seek legal advice. It was agreed the parents needed to be informed and that they should be given the opportunity to have a goodbye contact.

112. At 9:34am Vicky Leader telephoned the mother to tell her that the hospital planned to withdraw Child C's life support and that the mother may consequently want to seek legal advice. The mother said she wanted what was best for Child C and that she wanted to come to say goodbye to her daughter. She told Ms Leader that she and her husband were on their way to BCH.

113. At 9:42am Ms Leader telephoned the father who said he was in agreement with what was proposed but he did not wish to see Child C in her current state and he, therefore, did not wish to have a goodbye visit.

114. At 9:51am Dr Zafurallah, one of Child C's treating consultants, sent an email to Ms Leader and the Head of Service, Gill Cox, in which he concluded that:

> "due to the urgency of the matter and her continued rapid deterioration, I am unsure how long more she will survive. "

This email was forwarded by Ms Leader to Mr Baird, the director of children's services, noting that the information in this email would need to be given to the parents and that

> "mum is making her way to Birmingham and Karen Brooks will support her to say goodbye. Dad has decided not to attend for contact. We will now need to plan how this will be managed sensitively as the carers and siblings will also be present."

At 10:04am Ms Leader recorded that the mother would be arriving at the hospital about 11:30am to 12:00pm.

115. At 10:24am Ms Leader spoke with the mother to give her the information from Dr Zafurallah. The mother said that she did not want Child C to suffer any longer and that she was in agreement with the doctors. In a separate phone call the father gave the same response to Ms Leader.

116. At 10:40am Mr Baird sent a draft response to Dr Zafurallah to the local authority's legal department for approval. At 10:43am Tim Marks one of the then local authority solicitors replied to Mr Baird as follows:

> "discussed this with Liz and we agreed birth parents need to be informed about the medical advice. We need to consult with them but my legal advice is our duty as corporate parents is to accept the medical advice and avoid unnecessary suffering. If this is contrary to the parents wishes it is unfortunate but we need to take that course"

As I shall set out shortly this legal advice, as Mr Baird now accepts, was wrong.

117. At 10:57am Ms Leader spoke to Ms Elgar about who should be present when the life support machine was switched off. Her note of this conversation reads

> "agreed with Liz that if the carers and siblings are able they should be a priority to be present with Child C when the life support machine is switched off. Mum should then be the next to say her goodbye to Child C before MGM, Uncle M and Aunt M are given this opportunity. Agreed that I need to check with hospital if it would be possible to delay the surgery to remove the pipes to enable the mother to say her goodbye before she dies."

At 11:05am Mr Baird's email, giving the local authority's consent to withdrawing life-support, was sent to the BCH. The email included the following

> "My colleagues are also working with Child C's foster carers and birth family at this time and we hope we will be able to sensitively arrange for people to be able to say goodbye. We also appreciate Child C condition and the rapid deterioration that you set out"

At 11:08am in a telephone call between Ms Leader and members of the nursing team it was indicated that the process of withdrawing life-support had commenced and the surgeons would be removing the medical equipment from Child C's heart at midday during which procedure she would die.

118. At 11:22am Ms Leader spoke again with the treatment coordinator nurse to enquire if there was any scope for delaying the medical procedure given that the mother was so close to arriving at the hospital. The nurse replied that it would be difficult from a health perspective to further delay these procedures.

119. At 11:48am Ms Leader passed this information to the mother who said she was close to the hospital.

120. At 11:54am Child C's life support machine was switched off and she died immediately.

121. Shortly thereafter the mother arrived at BCH and was told Child C had died.

122. The surgical procedure to remove the medical equipment from Child C's heart was undertaken. She was then prepared to be seen by her family. Child A, Child B, Child D and the interveners saw Child C first. The mother was then able to see and spend time alone with Child C.

123. Unfortunately, the funeral which was principally arranged by the mother was not without incident. I propose to say no more on this subject for three reasons:

    i) it was a deeply distressing time for the children, the mother, the father and the interveners;

    ii) I have not heard any oral evidence from the mother or from the interveners and consider it would be unfair for me to rely solely on the written evidence of the social workers who attended the funeral and/or case recordings; and

    iii) the focus of the lay parties is and should be on the future rather than the troubled past.

124. For completeness I should record that Mr Baird as the director of children's services, members of the management team and a number of past and current social workers attended Child C's funeral to pay their respects.

Consent to Withdraw Life Support and other Life Sustaining Treatment - The Law

125. Ms Meyer QC and Ms O'Malley, leading and junior counsel for the local authority, provided me with comprehensive submissions on the statutory provisions and the extensive case law in respect of a local authority exercising its parental responsibility to consent to medical treatment for children in its care. With due acknowledgement to

the considerable amount of time Ms Meyer QC and Ms O'Malley must have devoted to drafting these legal submissions, I do not consider this judgment to be an appropriate vehicle for a lengthy exegesis on the law in this area. I will confine myself to the facts of and events in this case.

126. The effect of a care order being made in respect of a child is set out in the provisions of s.33 of the 1989 Act which provides:

> "Effect of care order.
>
> (1) Where a care order is made with respect to a child it shall be the duty of the local authority designated by the order to receive the child into their care and to keep him in their care while the order remains in force.
>
> (2) Where—
>
> (a) a care order has been made with respect to a child on the application of an authorised person; but
>
> (b) the local authority designated by the order was not informed that that person proposed to make the application, the child may be kept in the care of that person until received into the care of the authority.
>
> (3) While a care order is in force with respect to a child, the local authority designated by the order shall—
>
> (a) have parental responsibility for the child; and
>
> (b) have the power (subject to the following provisions of this section) to determine the extent to which —
>
> (i) a parent, guardian or special guardian of the child; or
>
> (ii) a person who by virtue of section 4A has parental responsibility for the child,
>
> may meet his parental responsibility for him.
>
> (4) The authority may not exercise the power in subsection (3)(b) unless they are satisfied that it is necessary to do so in order to safeguard or promote the child's welfare.
>
> (5) Nothing in subsection (3)(b) shall prevent a person mentioned in that provision who has care of the child from doing what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting his welfare.

> (6) While a care order is in force with respect to a child, the local authority designated by the order shall not—
>
> (a) cause the child to be brought up in any religious persuasion other than that in which he would have been brought up if the order had not been made; or
>
> (b) have the right—
>
> (i)
>
> (ii) to agree or refuse to agree to the making of an adoption order, or an order under section 84 of the Adoption and Children Act 2002, with respect to the child; or
>
> (iii) to appoint a guardian for the child.
>
> (7) While a care order is in force with respect to a child, no person may—
>
> (a) cause the child to be known by a new surname; or
>
> (b) remove him from the United Kingdom,
>
> without either the written consent of every person who has parental responsibility for the child or the leave of the court.
>
> (8) Subsection (7)(b) does not—
>
> (a) prevent the removal of such a child, for a period of less than one month, by the authority in whose care he is; or
>
> (b) apply to arrangements for such a child to live outside England and Wales (which are governed by paragraph 19 of Schedule 2 in England, and section 124 of the Social Services and Well-being (Wales) Act 2014 in Wales."

127. Subject to the provisions of ss.33(b) and ss.33(7), there is no limit or restrictions placed on the extent to which the local authority may exercise its parental responsibility for a child.

128. The issue of the exercise of parental responsibility by a local authority which had a care order in respect of a child was considered by the Court of Appeal in *Re C (Children)* [2016] EWCA 374. King LJ said the following at paragraph 57 to 62 of the judgment:

> "57. It is common ground that the effect of the making of a care order or interim care order by virtue of section 33(3) CA 1989 grants a local authority parental responsibility.

Section 33(3)(b) goes further, as it not only allows a local authority to share parental responsibility with a parent, but gives it the power to:

> "determine the extent to which a parent may meet his parental responsibility for the child."

58. That power is however subject always to section 33(4) CA 1989 which states:

> "(4) The authority may not exercise the power in subsection (3)(b) unless they are satisfied that it is necessary to do so in order to safeguard or promote the child's welfare."

59. A local authority can, by virtue of the power conferred upon it by section 33(3) CA 1989, therefore limit the power of a parent to make major decisions regarding a child's life. The local authority effectively holds a 'trump' card, which it can choose to play, in the decision making process in relation to a child in care subject to section 33(4) CA 1989. An example of the use to which this power is routinely (and appropriately) put is in deciding where a child in care is to live.

60. In private law cases, some issues are considered so fundamental to a child's wellbeing that, even if a parent has a child arrangements order stating that the child is to "live with" them (an old terms residence order), that parent cannot make certain decisions without the written consent of every person who has parental responsibility or the leave of the court, including, under section 13 CA 1989, changing a child's surname.

61. Similarly, where there is a care order in place, the power conferred upon a local authority by section 33(3)(b) CA 1989 excludes certain circumstances where Parliament was of the view that the issue in question is too significant to be determined without either consent or a court order. These matters are set out in subsections (6) and (7) of section 33 CA 1989 and include at section 33(7)(a) CA 1989, causing the child to be known by a new surname.

62. Nowhere in the Act is there a similar restriction preventing a local authority from using its powers under section 33(7) CA 1989 to overrule a parent in relation to a forename, whether in relation to the naming of a new born baby who has been taken into care shortly after his or her birth, or at all.”

129. A little later in the judgment, King LJ made the following observations at paragraphs 90 and 91:

> "90. Whilst I may not necessarily agree with the precise way that jurisdictional issues have been approached or expressed in these very difficult cases, what is clear is that there is a cohort of cases where the common theme is that a party (whether it be a local authority or, often, an NHS Trust) has sought to bring an issue before the court, believing it to be of too great a magnitude to be determined without the guidance of the court, and without all those with parental responsibility having an opportunity to express their view as a part of the decision making process.
>
> 91. Most commonly, examples are found in the so called 'medical treatment' cases where, either an NHS Trust seeks a declaration from the court that they would not be acting unlawfully in pursuing or desisting from a form of treatment notwithstanding the parent's refusal to consent, or alternatively, a local authority seeks to invoke the inherent jurisdiction of the court and thereby to submit to the court's jurisdiction notwithstanding that care proceedings may have been open to them"

130. She then noted that in requiring a local authority to invoke the jurisdiction of the court in relation to a serious medical issue the court was not conferring power upon a local authority, rather that the High Court was using its inherent jurisdiction to limit, circumscribe or sanction the use of the power which the local authority already has by virtue of s.33(3)(b) of the 1989 act: see paragraph 97. She concluded in paragraphs 98 and 104 as follows:

> "In the medical treatment cases the decisions to be made may well be a matter of life and death. In the present case, the limitation on the exercise of parental responsibility proposed by the local authority, whilst not life threatening, is life affecting. Further such a decision potentially involves such a serious invasion of the Article 8 rights of the mother that I am satisfied that the court should invoke its inherent jurisdiction in order that it may either sanction the local authority's proposed course of action as in the interests of the children or, alternatively, to refuse to sanction it as for example being in breach of Article 8."
>
> "I have reached the conclusion that there is a small category of cases where, notwithstanding the local authority's powers under section 33(3)(b) CA 1989, the consequences of the exercise of a particular act of parental responsibility are so profound and have such an impact on either the child his or herself, and/or the Article 8 rights of those other parties who share parental

> responsibility with a local authority, that the matter must come before the court for its consideration and determination."

131. I was helpfully referred by Ms Meyer QC and Ms O'Malley to two later decisions of the Court of Appeal which approved and reinforced the observations of King LJ in *Re C* (above), namely:

    i) *Re E (A Child)* [2018] EWCA Civ 550, [2019] 1 WLR 594; and

    ii) *Re H (A Child) (Parents Responsibility: Vaccination)* [2020] EWCA Civ 664.

132. I have taken account of all three cases and respectfully agree with the observations of the Court of Appeal on the proper ambit and use of powers granted to a local authority under a care order by virtue of the provisions of s.33(3) of the 1989 Act.

133. In Child C's case, therefore, the profound life and death decision to consent to the withdrawal of life support ought to have been the subject of an application to the High Court either by BCH or by the local authority. It was wrong and an inappropriate use of its powers under s.33 of the 1989 Act for the local authority to have exercised its powers to consent to the withdrawal of Child C's life support.

134. Both the mother and the father told Ms Leader on the morning of 6th June 2019 that they agreed with the decisions of the treating clinicians. The local authority has now accepted that given:

    i) neither parent had had any contact with any of the children, including Child C, since late 2012;

    ii) neither had been involved in any meeting or discussion with treating clinicians at BCH; and

    iii) the circumstances in which they were told of the parlous state of their daughter on early morning of 6th June;

    I could not accept or find that either parent had given informed consent to the withdrawal of Child C's life support.

135. It is, to say the very least, extremely regrettable that the mother was not able to say goodbye to her daughter before she died. It may well have been the case that even if life support had not been withdrawn at 11:54am on 6th June Child C may still have died before her mother was able to see her. We shall never know.

136. I must emphasise, for the avoidance of any doubt, that this court does not, and no party to the proceedings asserted that, the decisions made by and medical treatment given to Child C by the treating medical team at BCH should be impugned or criticised in any way.

137. In June 2019 the local authority did not have a policy or protocol for the actions to be taken in response to a child requiring serious medical treatment or requiring the withdrawal of life sustaining treatment and the giving or obtaining of consent for the same. There is now a policy in place which is compliant with the guidance given in the case of *Re C (Children)* above.

Special Guardianship Assessment Report

138. In May 2018 the then children's social worker completed a children and family assessment which recommended that a special guardianship assessment should be undertaken in respect of the children and the interveners. Kathryn Straughan, the interveners' fostering social worker, completed that special guardianship assessment in May 2019. It is recommended that special guardianship orders ('SGO') should be made in respect of (then) all four children in favour of the interveners.

139. After Child C's death on 6th June 2019 it was decided that the special guardianship assessment report should be updated by Ms Straughan who, shortly after Child C's death, had been replaced as the interveners' social worker by Suzanne Musgrave. The updated assessment dated 22nd October 2019 was signed off by senior managers and was filed with the court in November 2019. It also supported the making of an SGO in favour of the interveners.

140. Shortly prior to the commencement of this hearing an unsolicited statement was provided by Ms Straughan to the local authority. As a result of this statement a number of issues arose in respect of the updated special guardianship assessment report, namely:

    i) Ms Straughan asserted that she had been instructed by her manager, Alison Forshaw, that she was to undertake the updated assessment as a solely paper-based exercise. She said she had been instructed not to undertake any visits to, or to have any discussions with, the interveners or the children for the purposes of preparing an updated report;

    ii) Ms Straughan asserted that she had produced a first version of the updated assessment dated 11th October 2019. In section C of this assessment report there were highly critical and negative observations and reports on the views of the interveners about the children's mother and wider family and about their abilities to promote the children's sense of identity and contact with the family. It was recommended that the care orders in respect of the three children should not be discharged and SGOs should not be made in favour of the interveners; and

    iii) Ms Straughan asserted that, in consequence of the local authority's looked after children ('LAC') reduction policy, she, and other social workers had been placed under pressure to recommend that SGOs were made in favour of foster carers and/or kinship carers. Further, she said she had come under pressure to recommend a SGO be made in respect of these children.

141. The issue of the disclosure of relevant documents proved to be very considerable and caused very significant delays in the conduct of this hearing. I shall refer to this later in the judgment, but the ongoing, very late disclosure of documents had two immediate consequences:

    i) firstly, the court did not start to hear oral evidence until day 9 of this 20-day fixture; and

ii) secondly, the delay in commencing oral evidence and the impact of the ongoing disclosure enabled the parties to narrow the issues in dispute between the mother and the local authority; the mother and the interveners and between Child A and Child B and the local authority.

142. Accordingly, by day 11 all issues on the findings of fact sought by the mother and by Child A and Child B had been agreed and I was provided with agreed concessions as referred to in paragraph 101 above and as set out in Appendices 1, 2 and 3.

143. The remaining disputed issues related to the updated special guardianship assessment report. The respondents and the interveners jointly sought findings of fact on these issues as set out in the findings sought at Appendix 4.

144. The evidence called at the hearing was limited to these findings and Mr Baird gave evidence about the actions and the role of the local authority more generally.

145. Kathryn Straughan had been the interveners' social worker but was reassigned in June 2019. After Child C's death she was asked to update her May 2019 special guardianship assessment report by her team manager, Alison Forshaw. She had instructed her to undertake the update as a paper-based exercise and that she was not to visit the interveners.

146. Ms Straughan believed there were some positives about the children's placement with the interveners: the children were settled and felt part of the family, the children, however, struggled with their sense of identity, with their views about their parents and wider family and with the issue of contact. These concerns and the concerns about the attitude and approach of the interveners towards the birth family escalated after Child C's death. Ms Straughan did not consider that the interveners genuinely believed that contact with the parents and their wider family was in the best interests of the children.

147. She told me that she had real reservations about SGOs being made in favour of the interveners. She did not consider this order to be in the best interests of the children.

148. As foreshadowed in a supervision meeting with Ms Forshaw on 3rd October 2019, on 10th October Ms Straughan sent her updated assessment report to Ms Forshaw by email. The body of the report was largely negative about the interveners. She concluded with a recommendation that the children should remain the subject of care orders, not SGOs. She asked Ms Forshaw whether she could leave the alternative to the court of making SGOs on the basis of a comprehensive and detailed special guardianship support plan.

149. On 11th October 2019, Ms Forshaw emailed Ms Straughan in response and said she had to 'make a recommendation'. Ms Straughan then resigned. Consequently, Ms Straughan, without materially changing the body of her first updating report, changed the recommendation of the report to one of supporting the making of SGOs. This was sent to Ms Forshaw on 28th October 2019.

150. She told me she had the clear impression that Ms Forshaw and Ms Cox supported the making of SGOs in favour of the interveners. She felt she had been directed to

recommend SGOs to be the right solution and she had changed her recommendation so that it was aligned with the 'local authority's view'.

151. I note that when Ms Forshaw emailed the updated report on 23rd October to Ms Cox, she had replied that she was pleased that Ms Straughan had made a recommendation.

152. I further note that Ms Straughan told me that this was the first and only time she had been asked to prepare a paper-based special guardianship assessment report or an updated report.

153. Ms Forshaw stated that concerns about the children's placement with the interveners were magnified after June 2019. In response to the question that these concerns were incompatible with an SGO she replied, '…it feels like that now!' I do not understand why 'it did not feel like that' in October 2019.

154. She said she could not recall instructing Ms Straughan to confine her updating assessment report to a paper-based exercise. She continued that she had no view on what the ultimate recommendation should be and that she had not put pressure on Ms Straughan to make a recommendation in favour of SGOs. When pressed on this issue by Mr Goodwin QC, leading counsel for the mother, Ms Forshaw accepted that in her first updating report Ms Straughan had made a clear recommendation, namely that the children should remain the subject of care orders. So, Mr Goodwin QC asked why in her email of 11th October 2019 she had asked Ms Straughan to make a recommendation? The best Ms Forshaw could do was to say that now her request did not make sense, but she added she had not led Ms Straughan to make a recommendation in favour of the making of SGOs.

155. Ms Forshaw told me that she felt the first version of the updating report had been unfair to the children and the interveners. I struggled with understanding this answer because the only substantive change between the two versions was that the later supported the making of SGOs. When asked if she considered the second version fairer only because it supported the making of SGOs, Ms Forshaw could not give a satisfactory answer.

156. When it was suggested that save for the first updating report having been emailed to Ms Cox, Ms Forshaw had sought to suppress the first version, Ms Forshaw said she thought both the first and the second updated reports had been sent to the legal department. Only the second version was filed at court and served on the parties. I have not seen any evidence of the first version having been sent to the legal department. Indeed, the first the court and the other parties knew of the first version is when Ms Straughan's statement of February 2021 was filed and served by the local authority.

157. When Ms Forshaw was asked if she had asked Ms Straughan how her visits to the interveners were progressing, she said she did not know if she had done so. When asked if she had raised with Ms Straughan why there was not a single reference to any visits to the interveners in either of the first or second versions of the report, she claimed she had. Unfortunately, she had not recorded a single one of these discussions.

158. Ms Forshaw agreed that on one view the first version was a really poor assessment report. When asked why then had she signed off the second version when it was not materially different to the first one save for its recommendation, she simply said she had been under pressure to file the report with the court.

159. Ms Forshaw was recalled to give evidence after Mr Baird had given evidence. She was asked again whether she had asked Ms Straughan about her visits to the interveners; she said she could not remember. When asked if she had asked about the interveners' reactions to her visits, she first replied no and then said she could not remember.

160. She said she did not think that Ms Straughan had changed her recommendation to appease her or Ms Cox. She was asked why she had signed off the second version when the body of the report did not support the recommendation. Once again, the best Ms Forshaw could do was to reply that the report just had to go to the court.

161. Towards the end of her evidence Ms Forshaw was pressed again about whether she has spoken with Ms Straughan about her visits to the interveners. This time she said that maybe she just did not ask her.

162. Miss Cox could not recollect (an answer frequently used by this witness) whether she had seen the first version of the updating assessment report. She could not recollect whether Ms Forshaw had told her that this first updated report did not support the making of SGOs. She said she had not read the second version of report save for reading the recommendation. Having now read this report in full she did not invite the court to rely upon this report in support of making SGOs in favour of the interveners.

163. Ms Cox confirmed that prior to early 2017 no life story work had been undertaken in the preceding five years with any of the children. She said that after a few months the work of Janet Watkins, who undertook the work with the children, was paused to give the children a break. It never restarted.

164. No therapy was ever undertaken with the children. Ms Cox was asked what oversight she had given to this case. She replied that the case had fallen off her radar because of the breadth of her workload, although she conceded this was no excuse. I do not understand how this high profile and complex case which had caused serial concerns for many professionals working with the children and with the interveners could 'fall off the radar' of the Head of Service.

165. She conceded that the children, the mother and the interveners had been badly served by this local authority. She agreed that accordingly the children had suffered for which she had real regret.

166. Like Ms Forshaw, Ms Cox was recalled after Mr Baird had given evidence. She continued to assert that as the Head of Service, she had not needed to read either the first or second versions of the updated assessment reports because they had been signed off by the team manager. When Mr Baird's dismay at this state of affairs was put to Ms Cox, she asserted that the director of children's services did not know the usual practice adopted in Herefordshire.

167. When asked whether she should have read the entirety of both versions of the updated report she said that she wished she had. Ms Cox accepted that the 'safety net' oversight (i.e. the quality assurance check), which Ms Forshaw and herself should have provided, failed in this case.

168. In light of the observations of HHJ Plunkett recorded in the order of 2nd December 2016, Ms Cox was asked what consideration had been given to moving the children to an alternative foster placement. She gave the startling and deeply concerning one-word answer, 'none'.

169. Vicky Leader was the team manager of the children's team. She played a major role in coordinating visits to Child C in hospital. She also played a key role in liaising with the parents and the hospital on 6th June 2019.

170. Whilst at the time she had considered the October 2019 updated assessment report to be fair and balanced, she now accepted it was flawed. She said she now recognised there was strong evidence against the making of SGOs.

171. She had never been sent or seen the first version of the updated assessment and had only had the opportunity to read it the day before she had given her evidence.

172. She, like other witnesses, asserted that the chronic concerns about the children's foster carers were magnified after June 2019.

173. I found Ms Leader to be a measured and reliable witness who answered all questions in an open and ready manner.

174. I formed the same impression of Ms Straughan notwithstanding the criticisms of her made by Ms Forshaw. Even if these criticisms, that Ms Straughan was a challenging individual to work with, that her performance was at times sub optimal or that she was avoiding writing the updated assessment report, about which I make no comment, were true, they would not detract from the straight forward and credible evidence given by Ms Straughan.

175. I regret I cannot make these observations about the evidence given by Ms Forshaw or Ms Cox. Where there is a conflict between the evidence of Ms Straughan and Ms Forshaw, I prefer the evidence of Ms Straughan.

176. I remind myself that Ms Forshaw had first-hand experience of difficult meetings with the interveners. She visited the interveners on 13th June 2019 with another social worker and noted with concern that Mrs XX had said that they always spoke openly and about everything in front of the children.

177. If Ms Forshaw had not instructed Ms Straughan to undertake a paper-based updated assessment report, I cannot begin to understand why she did not ask Ms Straughan about how her sessions with the interveners were progressing. I cannot accept that Ms Forshaw had simply forgotten any of these alleged conversations.

178. Ms Forshaw's evidence about why she had sent an email to Ms Straughan on 11th October 2019 asking her to make a recommendation when, as she accepted, Ms Straughan had made a very clear and strong recommendation in her first version of

the updated report, was most unsatisfactory. Her evidence leads me to only one conclusion, namely that she was directing Ms Straughan to produce a report recommending the making of SGOs.

179. I am fortified in coming to that conclusion by the fact that despite knowing the substance of the body of the second version of the updating report which did not support the recommendation made, she submitted the report to the legal department for filing at the court. She did not raise this disjoint with Ms Straughan because she had the recommendation she wanted.

180. Likewise, the only credible reason for Ms Cox limiting her reading of the second version of the updating report to the recommendation is because she had got the answer she wanted, namely a recommendation in favour of the making of a SGO. Hence her subsequent email to Ms Forshaw that she was 'pleased' that Ms Straughan had been able to make a clear recommendation.

181. If these conclusions appear a little harsh or unfair, I refer to two further matters which strongly demonstrate the approach of the senior management team of this local authority's children's services department to this case (for the avoidance of doubt I do not include Mr Baird in my reference to the senior management team for these purposes).

182. Dr Asen had from time to time, between 2013 and 2016, been instructed to advise on the way forward in this case. He is one of the most experienced and highly regarded child psychiatrists in the field of high conflict children's cases in the country. In 2014 a social work professional had recorded on the social work files that Dr Asen had expressed a view that the judgment and order of HHJ Rundell in the fact-finding hearing of 2013 was wrong and it should have been appealed. If this had been Dr Asen's view he would have expressed it in one of his reports. He did not. I do not understand the motive for this false recording, but it indicates that the same professional in the local authority was not supportive of Dr Asen's involvement in this case or of the positive change he was seeking to achieve.

183. For the purposes of the hearing before HHJ Plunkett on 2nd December 2016 when he was hearing the maternal grandmother's application for contact, the local authority filed and served a position statement which contained the following:

> "The local authority's position at the last hearing was that contact should not progress to direct contact at this stage and challenged Dr Asen's assessment. Then local authority believes that there is significant use of emotive language in Dr Asen's report, which unhelpful and can be taken out of context; this raises concerned over the impartiality of the report and the conclusions he has come to. The local authority believed that there should be some work undertaken to progress matters, but that this must be done at the children's pace and taking into consideration their very strong wishes and feelings."
>
> "The local authority believes that it can progress contact via the LAC review process. The local authority has significant concerns around the impact of direct and indirect contact and

> the children at this time, which are set out in detail within the local authority evidence. The parents are against any contact taking place between the children and their extended family; this is supported by the local authority, who share parental responsibility at this time."
>
> "The local authority wishes to progress life story work, at a pace right for the children, and in line with their emotional needs. The local authority is committed to undertaking this work and sees this as a part of the social workers role, and not of a child psychiatrist. The local authority is committed to promoting contact between the children and the extended family, but this must be in line with their emotional needs."

184. Two important points arise:

i) it is disgraceful that this local authority chose to impugn the professional integrity of a highly respected child psychiatrist on the flimsiest of evidence. There was no evidential basis upon which any reasonable person could or should have questioned Dr Asen's impartiality; and

ii) life story work may well be within the ambit of the social worker rather than a child psychiatrist, but after a few months in early 2017 the local authority did no life story work with the children.

185. In his order of 2nd December 2016 HHJ Plunkett, understandably and wholly reasonably given the history of this case, included the following recital in his order:

> "[the court] is concerned about the surprising degree of resistance to accept the clear judgment from the fact finding hearing by the Foster Carers and raises the option to move the children to Foster Carers who understand and support the reality as letting the children grow up not knowing the truth is likely to cause them emotional harm"

186. What did the local authority do in response to this very serious expression of concern by a judge that the children were suffering emotional harm in their foster placement and that consideration should be given to moving them to an alternative foster placement? Very shockingly the answer is nothing.

187. Ms Cox confirmed this in her evidence.

188. Worse still, on day 14 of this fact-finding hearing a note was disclosed of a meeting held on 13th December 2016 between Ms Cox and Mr Scott, a then assistant director of children's services. At point 12 of 12, I repeat point 12 of 12, the following is recorded:

> "YY case. In court. Challenge from Judge P re contact for relatives, 'brainwashing' by social workers/foster carers. Cafcass to visit children soon. Children plan in overview which we support. GC to discuss with AC on her return."

189. HHJ Plunkett is not just a senior and hugely experienced family judge, he is the Designated Family Judge for Hereford and Worcester. The lack of any response to, or action taken in respect of, the concerns expressed is truly woeful. The utterly contemptuous response of an assistant director of children's services of this local authority is absolutely appalling and shocking. It is completely inexcusable. However, this demonstrates the skewed and wholly inappropriate response of this local authority to the desperate needs of the children and reveals a mindset which has ultimately caused them considerable possibly irreparable emotional and psychological harm. I sincerely hope it has not.

The Director of Children's Services

190. Mr Baird commenced his evidence by saying that the conduct of his children's services department in this case had been appalling. He told the court that he was fully committed to make substantial changes to the operation of the department and that he had the support of the county's councillors to do so.

191. He explained that the LAC Reduction policy was introduced because this local authority had far higher numbers of looked after children than many comparable local authorities. He emphasised that it had been his intention that children should cease to be looked after children if that was in the individual child's welfare best interests. He denied that there was any expectation that special guardianship orders would be the vehicle by which looked after children left the care of this local authority.

192. Mr Baird described the death of Child C as a deeply distressing event for the children, her parents and the interveners. He readily acknowledged that he could and should have dealt better with the issue of giving consent to the withdrawal of Child C's life support. Further, he recognised that he should have involved the mother more in the decision-making process. Mr Baird accepted the local authority should have made an application to the High Court for permission to withdraw life support or, alternatively, should have invited the hospital trust to do so. This is now the policy of the local authority.

193. Mr Baird accepted that he should have been more proactive in assuring the quality of the work performed by his social workers, team managers and his leadership team and the quality of decision-making processes.

194. He was not in post in late 2016 when HHJ Plunkett had made his observations about the children and interveners in a recital to his order of 2nd December 2016. Indeed, he had been unaware of it until the commencement of this hearing. He would have expected the authority's legal department and Head of Service to take action on judicial observations.

195. When it was put to Mr Baird that Ms Cox, as the Head of Service, had not read the 11th October 2019 version of the SG assessment report and had only read the conclusion of the 22nd October version, he said this was deeply concerning and deeply distressing to him. He apologised to the court. He said that he would have expected a greater degree of attention by the Head of Service which he agreed was absolutely vital, especially in this case.

196. Mr Baird agreed that the process by which the updated assessment report had been prepared was appalling and shocking. Once more he apologised to the court and said he would write letters of apology to the children, the mother and the interveners.

197. He accepted there had been a complete breakdown of trust between the children, the mother and the interveners, on the one hand, and the local authority on the other.

198. I have no hesitation in accepting the evidence of Mr Baird. I do not, for one moment, doubt the sincerity of his desire to bring about real change in this local authority's children services department for the benefit of the children and families with whom it comes into contact.

199. He was appalled by the conduct of his local authority over a prolonged period of time. I accept his apologies.

200. From Mr. Baird's demeanour when giving evidence, it was plain that this case and the actions, failures and omissions of the local authority have borne down heavily on him: most especially the issue of the withdrawal of life support from Child C. I have no doubt that in his role as director of children's services he genuinely and sincerely sought to seek improvements in the performance of the department and the outcomes for Herefordshire's looked after children.

Disclosure

201. The disclosure of relevant documents and records in this case was truly lamentable. We lost the first 8 days of this fixture because vast volumes of documents were being disclosed by the local authority. The Supplemental Bundle eventually comprised over 2,000 pages of material and the fostering records bundle contained in excess of 700 pages of documents.

202. From this failure flows three important matters:

i) neither Ms Meyer QC, her junior, Ms O'Malley and the legal teams supporting them, were responsible for the almost complete failure of this local authority to make timely disclosure of all relevant documents into these proceedings;

ii) the court and the other parties owe a considerable debt of gratitude to Ms Meyer QC, Ms O'Malley and their legal teams for the colossal amount of hard work they undertook, often late into the early hours, to remedy the failure of disclosure in this case; and

iii) this exceedingly late and continuing disclosure placed an exceedingly heavy burden on leading and junior counsel for the respondents and their respective instructing solicitors to read and assimilate the information contained within the documents. It required them to reflect and decide whether the information materially altered the way in which they wished to present their respective cases to the court and/or their respective witness requirements. Coming in the midst of a 20-day hearing it was inevitable that all of these tasks had to be accomplished to very strict timelines and deadlines.

203. It is a testament to the expertise and professionalism of leading and junior counsel for all parties and their solicitors that, notwithstanding the lost days at this hearing, all necessary witnesses were heard and closing submissions completed within the 20-day fixture. I am extremely grateful to all of them. This judgment inevitably had to be reserved.

204. It is no fault of Ms Meyer QC that at the conclusion of this hearing I still do not have a complete understanding of why there was such a spectacular failure in the disclosure of relevant documents prior to the commencement of this hearing. I note this local authority had no policy relating to the disclosure into public law proceedings or, indeed, any legal proceedings. This must be remedied without delay and will no doubt be one of the subjects for the internal and external reviews, which are to be established by Herefordshire Council, to consider.

205. Two final matters on this subject:

    i) at one stage social workers were being asked to consider what records and documents should be disclosed into these proceedings. This is completely wrong and must not happen again. Social workers are not (usually) legally qualified and accordingly they do not have the knowledge and experience to identify potentially relevant material for disclosure; and

    ii) for reasons which I do not begin to understand, until a late stage in this hearing one of the local authority's solicitors was not granted access to the *Mosaic* system on which most social work recordings were stored. This was a bizarre omission/decision and it was plainly wrong.

Analysis

206. By the conclusion of the oral evidence called at this hearing all parties, including the local authority, were agreed that the court should make findings of fact in respect of the concessions set out in Appendices 1, 2 and 3. I unhesitatingly do so. I am satisfied that each concession is, on the totality of the evidence, proved on the balance of probabilities. The written evidence overwhelmingly demonstrated the failures, acts and omissions set out in these three documents.

207. The only issue in contention related to the provenance of and the circumstances in which the final updated special guardianship assessment report of 22nd October 2019 was produced. My findings of fact in relation to this issue are set out in paragraphs 177-180 above. In summary I found that:

    i) Ms Straughan was instructed by Ms Forshaw to undertake a paper only exercise in order to update the special guardianship assessment report of May 2019;

    ii) she was instructed by Ms Forshaw not to visit or contact the interveners and/or the children for the purposes of completing her updated report;

    iii) Ms Straughan came under pressure from Ms Forshaw and Ms Cox to produce an update which recommended the making of a SGO in respect of the children in favour of the interveners;

iv) I do not find she was instructed to make such a recommendation, but she knew both of them supported the making of a SGO in favour of the interveners; and

v) Ms Forshaw signed off the 22nd October 2019 report and arranged for it to be filed at court and served on the parties when she knew that the observations, opinions and conclusions set out in section C of the report did not support or provide a rational basis for the recommendation in favour of the making of a SGO. Indeed, those matters of substance set out in section C only supported the dramatically opposite recommendation that a SGO should not be made.

208. Accordingly, and for the avoidance of any doubt, I am satisfied that, on the totality of the evidence, the matters set out at paragraphs 1, 2a(i), 2(b-n) and 3 of Appendix 4 are proved on the balance of probabilities. I, therefore, make findings of fact in respect of each one.

209. During the course of closing submissions it became clear that no party invited the court to make a SGO in respect of the children in favour of the interveners nor did any party invite the court to direct a further special guardianship assessment report should be prepared, whether by this local authority or by an independent social worker.

210. All parties were agreed that, at least for the foreseeable future, the children should each remain the subject of care orders. The only issue was whether I should grant the local authority's application for permission to withdraw its application for the discharge of care orders. The local authority preferred this course and the children's guardian supported these proceedings being brought to a conclusion. The guardian considered that there were real benefits to the children, the mother and the interveners to future proposed assessments and therapeutic work being undertaken outside of court proceedings. This was a recommendation she made on a fine balance.

211. The mother, Child A, Child B and the interveners strongly opposed these proceedings being brought to a conclusion at this time. They each invited the court to adjourn the local authority's application to withdraw the application for the discharge of care orders. These applications should, they submitted, be reconsidered when Dr Williams had undertaken the agreed assessments of the children, the mother and the interveners and had commenced some therapeutic work.

212. The parties were agreed that Dr Williams, assisted by one of his colleagues would undertake psychological assessments of the mother and the interveners and he would assess the present wishes, feelings and views of Child A, Child B and Child D. He would further undertake therapeutic work with all of the children.

213. The focus of these assessments and of this work is:

i) to give the children a true sense of their identity;

ii) to assist them to have an accurate, fair and positive view of their mother, their father and of their wider maternal and paternal family; and

iii) importantly, to restore contact, be it direct or indirect, between the mother and each of the children.

214. In light of this agreed focus, it will be vital that the mother and the interveners can evolve a positive and productive working relationship. The children should be made aware of this cooperative relationship. Therefore, in due course I will proceed cautiously and temper any overall observations I make in this judgment about the role of the interveners in the children's lives since their placement with them in late 2012.

215. Earlier in these proceedings Child A, Child B and the interveners were pressing the court to bring these proceedings to an end as soon as ever possible. The volte face at the conclusion of this hearing sent a very powerful and persuasive message to the court. Sadly, but understandably, they have lost all confidence in the local authority. Accordingly, along with the mother, they wish the court to retain oversight of the work of Dr Williams until he has filed his reports and commenced therapeutic work with the children.

216. I completely understand and accept the potential benefits that ending these proceedings could bring to the children, the mother and the interveners. I agree the decision for the court rests on a fine balance as submitted by the guardian. The stance adopted by those who could potentially benefit from bringing proceedings to an end persuaded me, that in the welfare best interests of the children, the balance decisively fell in favour of adjourning the local authority's applications until Dr Williams had undertaken his assessments and has commenced therapeutic work.

217. The local authority has agreed it should bear the costs of the work of Dr Williams.

218. The local authority had also agreed to fund the costs of bereavement counselling for the children, the mother and for the interveners.

219. It is a testament of the mother's understanding of the current feelings of the children and to the child focused approach she has adopted to these proceedings that she does not pursue her application for contact at this hearing. It remains, of course, her heartfelt wish and desire that she will, in due course, be able to restore her relationship with Child A, Child B and Child D and to resume some form of regular contact with each of them.

Overall Observations

220. The children have been utterly failed by this local authority. By its actions, failures and omissions over the course of the last eight years it has compounded the emotional and psychological harm the children have suffered. The local authority has ignored, indeed, challenged the advice of a hugely experienced child psychiatrist for reasons which I do not begin to understand. It has treated with contempt the clarion call of a senior family judge for the local authority to re-evaluate its approach to these children, to the family and to the carers.

221. I can only hope there is now the time and the opportunity to repair this damage and to give the children a positive sense of their identity, of their family and to enable them to have meaningful, positive and beneficial contact with their mother and their wider family.

222. The mother has accepted her past failings in her care of the children compounded by her own experience of mental ill-health. These matters do not begin to explain or

excuse the local authority's wholesale failure to include the mother in the lives of or in the decision-making processes for her children. She was completely and exclusively side-lined by the local authority from the lives of her children. This was tragically but graphically illustrated by the events which preceded the death of Child. C.

223. I very much hope that, notwithstanding past failures, matters can now be progressed to a stage where the mother can play a meaningful role in the lives of her children. Despite the way in which she has been so badly treated by the local authority it is hugely impressive that the mother remains focused on the welfare best interests of her children. She was able to consent to the children changing their names to XX, she did not ask to disrupt the placement with the interveners, and she did not seek to pursue her application for contact. These are graphic demonstrations of her love for her children and of her desire to put their welfare best interests to the fore.

224. The interveners have, albeit at a later stage, accepted and admitted their past failings and errors. They are set out in summary at paragraph 95 above and extensively in Appendix 2.

225. These failings and errors have to be set out in proper context as counsel for the interveners was keen to stress. They were new and relatively inexperienced foster carers. They took on the care of four young and challenging children. They gave them a loving, secure and stable home. They made them feel a part of a warm and caring family unit. They were not advised by the local authority that the children's adoption of their surname is contrary to s.33(7) of the 1989 Act nor that the children calling them 'mum' and 'dad' was wholly contrary to good social work and fostering practice. I accept that they took these steps out of the best of motives. I accept that they saw themselves as champions of defending the children's expressed wishes and feelings but in doing so they in fact compounded the harm the children were suffering and would suffer from being alienated from their parents and their wider family.

226. My strongest criticism must be directed at this local authority. In the whole of my professional life I have rarely encountered such egregious and long-standing failures by a local authority. The worst of it is, I cannot after the closest possible enquiry, understand why or what motivated the local authority to fail these children, this mother and the interveners as appallingly and for as extended a period of time. The whole history of the role of this local authority in the lives of these children is highly inexplicable. The only matter which is clear to me is that it did not have the welfare best interests of the children at the heart of its decision-making, such as it was.

227. This must call into question whether this local authority's children's services department is fit for purpose. That is a question which is not for me to answer. I can say that they had failed these children in an extraordinary manner over a prolonged period of time.

228. I am told and accept that the mother and the interveners have been shocked by the evidence they have heard over the course of this hearing and I well understand why this is the case.

229. I concluded the hearing by thanking the mother, her husband and Mr and Mrs XX for the great dignity and composure they had each demonstrated throughout this hearing

but most especially at times when particular distressing episodes were being dealt with, most obviously the death of Child C. I repeat my sincere gratitude to each of them. On any level these proceedings have been immensely stressful for all four of them.

Conclusions

230. I have made the findings of fact agreed by the parties and those findings of fact which I found proved having heard evidence from a number of local authority witnesses.

231. The local authority's application for permission to withdraw the applications for the discharge of the care orders and for the discharge of the care orders are adjourned. The applications will be reconsidered by the court when Dr Williams has filed his reports and has commenced therapy with the children.

232. I make no order on the mother's application for contact with the children.

233. With the consent of all parties I gave permission for Child B's and Child D's surnames to be changed from YY to XX. I had previously given permission for Child A surname to be changed to XX on 20th August 2020. I am told the children were delighted by this news and were pleased to be told that these orders have been made with the consent of their mother.

234. The local authority's actions, omissions and failures in this case have been spread over a period in excess of eight years. Mr Baird readily accepted and described the conduct of the children's services department in the lives of these children as appalling. He was plainly right to do so. He offered to write a personal letter of apology to Child A, Child B, Child D, the mother and the interveners and will ensure this course has been taken.

235. Prior to receiving final closing submissions, I received a letter of apology to the court in respect of the local authority's conduct in the light of these children from Herefordshire Council. The letter was signed by the Chief Executive of the council and by two of the deputy Chief Executives.

236. I was told by Ms Meyer QC that the council had agreed to undertake an internal review of the council's children services department and would commission an independent external review of the same.

237. I gave permission for a copy of this judgement, once handed down, to be sent to named officers in Herefordshire Council in order to inform the reviews. Further, I was told that once an anonymised published version of this judgment was available, the Council proposed to call a full Council meeting at which the contents of this judgment would be discussed, and the way forward would be considered.

238. I have directed that a copy of this judgment should be sent by the local authority to the following:

    i) the Secretary of State for Education;

    ii) the Chief Social Worker;

iii) the Children's Commissioner; and

iv) the Chief Inspector of Ofsted.

Appendix 1

AGREED SUMMARY OF CONCEDED ISSUES
IN RESPONSE TO THE SCHEDULE OF FINDINGS SOUGHT BY MOTHER
[5th March 2021]

In summary the local authority accepts the following:
From the Schedule of Finding sought on behalf of the Mother
M/A
That it failed to use HHJ Rundell's fact-finding judgment as a basis for challenging and changing the children's distorted perceptions of their family.
In that *its approach to explaining and reinforcing the findings of HHJ Rundell of July 2013 with the children and with the foster carers was at times –*

- ***a. insufficiently robust***
- ***b. inconsistent when viewed overall***
- ***c. inadequately planned***

and that as a consequence it failed to act in a decisive manner during an early window of opportunity to effect change in this area

The local authority specifically accepts that:
Dr Asen's report of 11th November 2013 emphasised the importance of informing the children about the judgement and proposed a meeting between the foster-carers, the social workers and Guardian to formulate a script.
The script did not make clear that the Mother had not sexually abused the children and it should have done so.
In her statement of the 19th December 2013 the mother sought to have the wording of the script addressed to include specific reference to the fact that mother did not sexually abuse the children.
Although the script was drawn up between Dr Asen, the local authority and the children's guardian, an accurate script was not employed when it should have been.

The local authority accepts that:
It did not ensure that Dr Goodwin (on 18th March 2014) Sharon Rudge, Wendy Healey & CAMHS (in 2014 & 2015) had the correct background information, including the findings of HHJ Rundell. The work of CAMHS therefore proceeded on a false premise, including that of serious sexual abuse as part of the children's history.
On the 18th March 2014 Dr Fiona Goodwin saw the children, with foster carers and social worker Lynette Chan in the child development clinic and subsequently recorded in her report of the 20th March 2014 "these children have endured an extreme level of abuse which included abuse of a sexual nature so in my view it is an imperative to include CAMHS in their overall management".
On the 24th March 2015 CAMHS approached the choice appointment with Child A with their understanding that she had endured severe and complex trauma over a prolonged period of time including "severe physical sexual and emotional harm by the parents" and recorded the diagnosis of a child "with complex emotional needs as a result of very severe physical sexual and emotional abuse endured over a considerable amount of time alongside her sibling group.

On the 29th April 2015 Wendy Healey the child and adolescent psychotherapist working with Child D took sexual abuse as a given part of his background and specifically anal abuse as explaining his constipation.
The record of the looked after children's visit by Rebekha Philips of the 28th May 2015 stated that "Mrs XX and Miss XX were the people that the children chose to trust to make disclosures to about their experiences with their parents and extended family".

The local authority accepts that
Until the work by Janet Watkins and Kathryn Heath in 2017, the local authority is unable to demonstrate from the records currently available that there was any attempt made to work with the children or foster carers so as to distinguish the single occasion the mother hit Child B (coupled with other physical chastisement) found by the court and those aspects that formed part of the children's allegations but were rejected by the court and must therefore accept that no such work was undertaken.

M/A1.10/A1.11 & M/B2.5
As a result of direct work with the foster carers in January 2017 by Janet Watkins and Kathryn Heath on the fact finding judgment the workers concluded that the reading of the judgment offered Mrs XX a different view of the children's family to her and that she had made the required shift to be able to move forward in respect of contact. In the light of all the information now available, both contemporaneous and subsequently, the local authority accepts that at that time, whilst progress had been made, greater consideration as to whether such shift was fully embedded and would be an enduring one was required before it should have been regarded as reasonable to reach that concluded view.

The local authority accepts
That in January 2017 Mrs XX reported to Janet Watkins that Child D had said his family should be arrested, Child C referred to them hurting her and Child A to them abusing her.

The local authority accepts
That on the 4th April 2018 the IRO Stacie Lane expressed her own view to the mother, when discussing the past, the findings of the court and her wish for the local authority to work with the children to help them accept the judgment that "I exercised caution about trying to persuade the children that their views about their experiences are entirely wrong. I accepted that children can have experiences that sometimes can be muddled however it wouldn't be helpful for their own psychological development and wellbeing to challenge all of their experiences and explain to the children that these experiences are wrong. I accepted that the court did not find family members culpable of causing sexual harm to the children however explained that children can be sexually harmed without physical evidence being present. The children did exhibit sexualised behaviour that was unusual for their age and unexplained therefore need to be mindful that the children need to feel able to talk to those professionals around them about their experiences when they are ready to talk about them and by denying their views on their previous experiences could marginalise the children" Further the mother and IRO subsequently communicated further on this point on the 5th April 2018 with the IRO seeking to reassure the mother that the foster carer and social worker were not promoting any suggestion that the children had been abused.

The local authority accepts

That Dr Iain Evan Darwood provided the coroner with a report on the 15th January 2020 which included that Child C had been removed from her biological parents for reasons of neglect and sexual abuse, information taken from the medical records available to him.

The local authority accepts
That in the period when Child C was hospitalised and following Child C's death in June 2019 the local authority were endeavouring to manage the needs of the surviving children, the relationships with the foster carers, mother and extended maternal family whilst at the same time trying to be respectful of the impact of shock distress and grief. Whilst they continued to find ways to work through this period of heightened emotions it has to be accepted that there was a poor working relationship with the foster carers and a breakdown in trust between the carers and the authority which resulted in the local authority being unable to fulfil completely its statutory duties in the period following Child C's death.

Mother – The local authority accepts that it failed to promote contact between the children and their Mother in that *over significant periods of time it –*

a. ***failed to proactively promote contact between the children and their mother***
b. ***failed to achieve the correct balance between listening to the children with respect to their expressed views, wishes and feelings around contact and the development of clear, coherent plans to enable appropriate contact with various family members.***

Further the local authority accepts that it should have made an application pursuant to section 34(4) of the Children Act 1989 for permission to refuse contact at least at the point at which the children declined to receive the indirect contact from their Mother in October 2014 until the indirect contact was re-established in March 2017. **and therefore between October 2014 and March 2017 acted in breach of its duty under section 34(1) to allow reasonable contact between the children and their mother.**

The local authority specifically accepts:
That it failed in its February 2014 core assessments it failed to analyse the merits of contact and recommended no preparatory or substantive steps by which it might be revived.

That in the years that followed the local authority gave considerable weight to the children's expressed views and emotional presentation when ascertaining their views regarding contact, discussing contact and discussing family and allowed those two factors to become the main drivers in its approach to contact during 2014-2015. During which time they failed to explore how they children might be helped to change.

The local authority accepts:
That both the case record of Janet Watkins for the 18th January 2017 and her statement of 21st February 2017 support the fact that during discussion of paragraph [16] of the fact finding judgment, Mrs XX noted to Janet Watkins and Kathryn Heath that the children were confused over the question the social worker put to the children[on the 5th November 2012] when Child A said she wanted to see family. The statement of Janet Watkins goes on to record that Mrs XX told Janet Watkins that Child A had been clear to her that she didn't want to see the family and that Mrs XX was adamant that she would not have stopped her doing so if she said she wanted to see them and reminded the workers that she had been supportive of contact with the birth parents.

The local authority acknowledges that whilst its focus in February 2017 was in working towards contact with the maternal grandmother in line with the recommendations of Dr Asen and the plan approved by the court on the 12th January 2017 and 22nd February 2017, the fact that at this time, and throughout those contact proceedings, the Mother did not press for contact did not absolve the local authority of its duty to lay proper foundations with the children and carers to assist with the development of possible future contact with the mother. Prior to the work undertaken by Janet Watkins and Kathryn Heath it did not do this adequately, work undertaken then led to the reintroduction of indirect contact in March 2017 but was not effective in achieving direct contact in the face of the expressed views of the children.

That whilst work was undertaken after that of Janet Watkins/Kathryn Heath to help the foster carers understand the value of the mother's role in the children's lives the local authority accepts both that Vicky Leader commented to Kirstie Gardener on the 19th June 2019 that there were 'concerns about the carers not being able to be in a position to consider a different view of the children having contact with their birth family", and that she planned to discuss "emotional aspects using a soft approach" and that when seen overall this was likely to be too little, too late.

The local authority accepts that it failed to use life story work and therapy effectively to dispel the children's misconceptions about their birth family in that:
the life story work undertaken and the therapy accessed was not, when viewed over the whole period adequately planned, targeted and implemented. Despite some periods of intense focused work it was not always consistently approached. As a consequence the early window of opportunity to effect change was missed and later positive work was not sufficiently reinforced. It is accepted therefore that the local authority failed to provide adequate life story and therapeutic support to the children.

The local authority specifically accepts that:
Dr Asen recommended in his November 2013 report that Child B access individual child psychotherapy, that the other three children did not require individual therapy but psychotherapeutic work involving the foster carers was needed for them to make sense of their history. By May 2014 Dr Asen was advising that Child B no longer required any special intervention and that Child C was in need of individual child psychotherapy.
In 2014/2015 the need for life story work was identified at each Looked after children review, to be co-ordinated with CAMHS/Therapeutic work.
On 30th September 2016 Dr Asen set out the negative impact on the children of not undertaking life story work.
The failure to undertake the work identified above contributed to the breach, as set out in paragraph 2 above, of its section 34(1) duty to promote reasonable contact.
Dr Asen's recommendations were not implemented. The judgments of HHJ Rundell of the 22nd September 2015 and 6th November 2015 criticised the local authority delay and approach to life story work and therapy. The local authority does not seek to go behind those criticisms. It is accepted that between 2014 and 2017 very little meaningful or effective life story work was carried out.
On 23rd March 2015 a six step plan for contact was set out at a Looked after children review with provision for life story work as a prelude to the introduction of contact when the children were ready.
Despite that plan the local authority failed to deliver the required service in that:

(a) The direct involvement of CAMHS with Child D concluded with a final session on 24th March 2015. The report from Wendy Healy of 29th April 2015 noted that Child D had confusion and mixed emotions about his birth parents. This confusion was noted in the Looked after children's review of the 9th September 2015. In 2016 Child D questioned whether XX had given birth to him and in the core assessment issues of regarding his identity and struggle to recall his birth family composition are set out. No sufficient or effective lifestory work was undertaken until the work of Janet Watkins in 2017.
(b) No therapeutic work was undertaken with Child B or Child C. As late as 16th July 2015 CAMHS said both girls were unlikely to meet its threshold for intervention. Lifestory work was first discussed with them 11th April 2016 and only covered their period in foster care. No sufficient or effective lifestory work was undertaken until the work of Janet Watkins in 2017.
(c) Child A undertook work with CAMHS between November 2015 and June 2016. No sufficient or effective lifestory work was undertaken until the work of Janet Watkins in 2017.
(d) On the 19th September 2017 Janet Watkins noted that further lifestory was not helpful at that time, the reasoning behind which was recorded in the looked after children's review record of the same date. Work was undertaken after this date by Hannah Ellis however this work was not sufficient to prevent subsequent assessments of the children recording that "they appear not to understand their lifestory" or CAMHS from recording when Child C first became unwell in May 2019 that she has little understanding of her lifestory.

In its 5th July 2019 Looked after children report the local authority concluded that "all children appeared not to understand their life story and it is unclear how much they know about their birth family apart that they were unable to live with them safely. There is a sense, although not communicated by the children, that they fear any connection with birth family might negatively impact their current living experiences with the XX'.

The local authority accepts that it did not properly engage the mother within the Looked After Child(ren) process at all times.
Between July 2018 and May 2019 it ceased sending the mother redacted Looked After Child(ren) review minutes and stopped inviting her to meet with the IRO (without good reason).
It did not send the Mother PEP minutes, save on the 22nd March 2017.

The local authority failed to manage the foster placement properly and to ensure the children's emotional needs were met in that
there have been times when oversight of the manner in which the foster carers were dealing with particular aspects of the children's care has not succeeded in achieving the necessary joint approach towards

- The reinforcement of the judgments of the court
- The value of birth family contact and matters of the children's family identity
- The limits of delegated responsibility

The local authority specifically accepts that:
It has not been sufficiently rigorous and consistent, throughout its involvement with the children, in ensuring that staff and carers fully understood, and complied with, the limits of shared or delegated parental responsibility and the need to recognise rather than compete with the birth parents rights.

From January 2014, after Dr Asen's initial involvement in November and December 2013 in explaining the Judgment to the foster carers and to the children, insufficient work was undertaken to re-address or reinforce with the foster carers and children the Court's findings and the consequences of those findings until January 2017. The local authority therefore accepts that during this period the children's erroneous beliefs as to the nature of their treatment by their birth family were left unchallenged and allowed to become entrenched. The robust work undertaken by Janet Watkins and Kathryn Heath in 2017 was itself not then reinforced.

The work undertaken following Dr Asen's 2016 report was not sufficiently reinforced once completed in 2017.

The Local Authority accepts that in September 2019 the Head of Service (Gill Cox) authorised a change in Child D's school in the face of the mother's objection. Mrs XX took him to visit a private school on 1 February 2019 without the local authority's knowledge or agreement. The SGO assessor's view was that the foster-carer's actions placed pressure on the decision-making process. The Local Authority accepts that a consequence was that it reduced the ability of the Mother to contribute meaningfully to the decision making on the issue, it reduced the ability of the local authority to give due consideration to the Mother's view and presented the local authority and mother with a virtual fait accompli.

The local authority accepts that in the matter of arrangements for contact between Mother and Child C between 27th May 2019 and 3rd June 2019, when mother requested that her contact be supervised by a social worker rather than the foster family, in attempting to devise arrangements that would best meet Child C's previous views and the impact of her illness and surroundings upon her they did not reach the correct balance and should not have permitted the presence of the foster family or a member of the foster family under circumstances where this could not have been the subject of proper advance planning, understanding of roles and free agreement to the arrangements.

Whilst the local authority does not accept that there has been no challenge to the foster carer's antipathy towards contact nor that steps were only taken to placate the carers. The steps taken by the local authority during this difficult and emotional time for all were not sufficient to effect change.

The local authority accepts that on a number of occasions it was concerned that the decisions and actions of the foster carers demonstrated a lack of understanding for the limits of their delegated authority. The local authority however must also accept that the records demonstrate both lack of response (in the case of change of surname) and reactive rather than proactive responses to individual events by the local authority. Advice, training and proper development of delegated authority tools with clear explanations tailored to this particular foster placement should have been provided to the foster carers to enable them to understand the limits of their delegated authority and their role as foster carers and these should have been revisited on a more regular basis. Whilst it was noted that this should have been undertaken at placement planning reviews and through the updating of the delegated authority the available evidence does not provide clear evidence of the manner in which this was done, if it was done at all, prior to 2019.

The local authority accepts that on the 11th July 2019 the case summary and case direction record noted that "it is distressing for the SW to be unable to have suitable access to build a relationship with the children and to be at risk of allegations and complaint. The social worker is not prepared to enter the house without support given the level of intimidation from the carers" in the light of those observations the local authority continued to work to manage the placement however has to accept that it was not always effective in doing so at this time.

The local authority failed to take any sufficient steps to preserve the children's sense of identity with and connection to their family in that:
It failed to take any or any sufficient steps to ensure the preservation of the children's association with their surname until such time as either valid parental consent had been received or court authorisation had been granted.
It accepts that this was in breach of section 33(7) Children Act 1989.
It accepts it took no steps to prevent the foster carers from changing the Children's surnames to XX in breach of its statutory duty under section 33(7).
It accepts that as early as November 2013 the local authority was aware that the children called the foster carers mum and dad and failed to intervene, this practice was referred to without comment in the February 2014 core assessment.
It accepts that the April 2014 Looked after Child(ren)'s report by Rebecca Philips stated *"if the children want to be known by a different surname they can choose to do this without/before legal name changes are made.* and that in October 2014 the children were expressing the wish to be known by the surname XX.
The actions of the local authority relating to the use of the surname XX was not predicated upon the receipt of any valid consent by the mother.

Whilst Child C was hospitalised HCC marginalised the mother and failed to accord her parental responsibility the weight and respect it deserved in that
The local authority accepts that it did not approach the issues of parental responsibility and consent to serious medical treatment in the correct manner.
The local authority accepts that their approach, whilst not intending this consequence, would at times have resulted in the mother feeling marginalised, would have diminished her exercise of parental responsibility and was not correct.

That there should have been consultation with the mother and there was not.
That the local authority should have made it clear to the hospital that there needed to be consultation with the mother and it did not attempt to do so until 31st May 2019.
Further the local authority accepts that the absence of any established protocol or immediate forward planning upon Child C's admission to Birmingham Children's hospital for alternative situations, including deterioration of Child C's condition, made an already difficult time with heightened emotions more stressful and reactive than needed to be the case. As a result important opportunities to deal with issues in a calmer, more reflective and considered fashion were missed/lost.

The local authority specifically accepts that:
It did not have any policy in place defining its procedures where issues of consent arose in respect of palliative care for looked after children nor did it refer the matter to the Court for a best interests decision.

It gave consent to the following medical procedures for Child C without any discussion with the mother or any application to the court for a best interest's decision:

On the 29th May 2019 to heart surgery if the medical team felt she would die without it. Despite being aware of the gravity of Child C's situation and clarifying with the hospital on the 29th May 2019 of the need for them to be informed if the hospital were intending to remove Child C from life support. They did not discuss this possibility with the Mother. It gave consent to the following medical procedures for Child C without any discussion with the mother or any application to the court for a best interests decision:
On 31st May 2019 for a biopsy
On 31st May 2019 7.8 – for any medical treatment necessary to save Child C's life and to any test required to understand or treat her effectively.

It should have arranged for a meeting involving the mother and the hospital, that this was not in fact achieved before Child C's death and should have been organised earlier.

Despite agreeing, on 4 June 2019, that a planning meeting should be convened with the hospital, no such meeting took place because Child C deteriorated on 6 June 2019 and that it could reasonably have avoided such a situation if it had operated proper procedures and exercised its own parental responsibility by planning in advance for such an eventuality.

On the 6th June (after Vicky Leader spoke to and consulted with the mother at approximately 09.34 and at approximately 10.24 about the hospital proposal) at approximately 11.04 Chris Baird gave the local authority's consent to the implementation of a palliative care regime. Child C's death was recorded at 11.54. Although the mother accepts that the local authority was entitled to treat the views expressed by her over the telephone as indicative of consent it is accepted by the local authority that forward planning would have reduced stress and the sense that the process was rushed. It is accepted that the social worker was notified by the hospital at 08.39 that the hospital was seeking consent to remove life support and that an hour passed before the mother was asked for her consent. It is not asserted that this was a deliberate or callous delay, however it is accepted consent should have been sought more promptly.

The local authority accepts that failure to consult with the mother in advance about the possibility of a rapid deterioration in Child C's condition contributed to the mother not being able to say goodbye to her daughter before she died. The need to plan goodbye visits was first mooted on 29 May 2019 . Ultimately Child C's life support was withdrawn before her mother reached the hospital. This could and should have been avoided The local authority should have gained greater clarity from the hospital and offered greater clarity to the mother around the timing of the removal of life support and the possibilities available, if Child C's clinical situation allowed for this, for the delay of such step until such time as all desired appropriate goodbye visits could be made. Whilst team manager Vicky Leader raised with Margaret Farley in a call at 11.22 whether it would be possible to delay the procedure, as mother was close to arriving at the hospital, Margaret Farley advised that she would struggle from a health perspective to do so, the team manager was not able to press the point. When the social worker had discussed consent with the mother at 09.34 it was clear that she wanted to say goodbye to Child C before she died. Chris Baird has acknowledged that "*the request to move to palliative care could have been delayed, to enable M more time to travel to Birmingham Children's Hospital from Hereford*" and that any future protocol should require the local authority to work with the hospital to allow the parent time to attend unless the delay would cause the child to suffer unduly.

The Further concessions arising from the responses of intervenors to Mother's schedule.

1. We have already made concessions within the most recent response to mother with regard to issues surrounding delegated authority.
2. The local authority will accept that important documents were not always provided to the foster carers at an appropriate time, promptly or sufficiently in advance for them to consider, understand and assimilate the contents without feeling rushed or under pressure.
3. That the number of different social workers for the children over the period of their placement would have added to communication difficulties, lead to a feeling that the children and carers were having to repeat information and further increased the risk of important information being overlooked. It would also inevitably have led to the need for the foster carers and children to rebuild fresh relationships with professionals.
4. We have already made concession within the response to mother with regard to there being a breakdown in trust in the relationship between local authority and foster carers.

Appendix 2

AGREED SUMMARY OF CONCEDED ISSUES
IN RESPONSE TO THE SCHEDULES OF CHILD A and CHILD B

From the Schedule of Finding sought on behalf of Child A and Child B
Children section A: The local authority accepts that its approach to permanency planning resulted in drift and delay for the children. In particular in relation to the progression of an application for special guardianship there is a lack of evidence of consistent management, oversight and planning which has substantially contributed to the delay in bringing any application for permanency before the court for over 6 years. Over that time there has been inconsistency of communication around the progression or otherwise of the special guardianship process. As a result the local authority despite regularly inviting the children to express their views did not properly consider and weigh the children's elicited feelings and did not take prompt action upon them.

The local authority specifically accepts that:

1. On 22nd January 2014 the local authority agreed a plan whereby the children would remain living in their placement with Mr and Mrs XX
2. On the 27th January 2014 the children were made subject of final care orders and the court approved the care plans whereby they would remain living with Mr and Mrs XX
3. On 16th April 2014 Mrs XX told the social worker (Rebekha Philips) that she had been thinking about applying for an SGO for the children as she would like to care for them for the rest of their childhood.
4. On the 23rd April 2014 the social worker (Rebekha Philips) reported to the Looked After Child(ren)'s review that the local authority care plan was for the children to be looked after on a permanent basis with no return to the birth family, and that consideration of more legally secure options such as adoption or SGO should be made. It was reported that the LA wished to place the children together.
5. On 30th October 2014 the social worker (Rebekha Philips) reported to the looked after children's review that it was anticipated that the children would remain with Mr and Mrs XX for the duration of their childhood, and that the LA would give consideration to further securing the children's placement via SGO or adoption. It was recommended that the social worker (Rebekha Philips) should request independent legal advice for Mr and Mrs XX.
6. On the 12th March the social worker (Rebekha Philips) reported to the Looked after children's review that the children would remain in their long-term placement with Mr and Mrs XX for the duration of their childhood. It was reported that during the period to the next review, the LA and foster carers would give consideration to the further securing the placement via an SGO or adoption. It was reported that Mr and Mrs XX had made an application to be assessed for an SGO, but that the social worker (Rebekha Philips) was awaiting directions from her manager regarding this matter. It was reported that the placement was meeting the needs of the children, they felt happy and settled there and clearly identified themselves as being part of the XX family.
7. On the 15th April 2015 the social worker (Rebekha Phillips) conducted an interview with the children as part of the SGO assessment during which they all confirmed they wanted and SGO and that they just wanted to get on with a 'normal life'.

8. On the 28th May 2015 the social worker (Rebekha Philips) interviewed Mrs XX about the SGO application and gathered her views on contact with the children and extended family.
9. On the 13th July 2015 the children's care plans stated that Mr and Mrs XX were committed to caring for the children during their minority, that all children have expressed that they are very happy living with their carers and want to remain with them forever and that the carers would like to apply for SGOs. It was stated that this would need to be considered after the completion of the maternal grandmother's contact application.
10. On the 9th September 2015 the looked after children's review noted that the SGO application was presently on hold alongside the contact application for the extended family, that the contact arrangements and possible options for the future should be decided before proceeding with any SGO application, that the outcome of the contact application should be awaited, there should be a revised assessment of the children's support needs to feed into an SGO assessment and long term support for the carer, the foster carer had been advised to seek advice from the fostering network. The social work reported noted that the children had been upset by the delay in the SGO. The report of Rebekha Philips for the review dated 9th September 2015 included under the update in recommendations since the last review that "funding will be provided following a successful assessment". The judgement and order of HHJ Rundell of the 22nd September 2015 adjourned the contact proceedings pending the undertaking of therapy which he considered may have been delayed unduly. A similar situation was repeated with the judgement on the 6th November 2015
11. The looked after children review of 7th June 2016 noted that the SGO application had been put on hold awaiting the outcome of the extended family application for contact (due 20th June 2016). Within these contact proceedings Dr Asen was commissioned to prepare a reports and made recommendations.
12. Within the contact proceedings Court orders were made judgments provided on the 2nd December 2016 and 12th January 2017. On the 28th April 2017 the court dismissed the maternal grandmother's application for contact on the provision of a detailed plan for future contact, therapy and life story work.
13. On the 22nd August 2017 the social worker (Janet Watkins) visited the children and foster carers. The discussion included whether to apply for and SGO as this was what the children wanted and how contact with maternal grandmother could be supported through the SGO support plan. The children were very clear that they did not want contact with the maternal grandmother. The social worker was to take legal advice as to how the court would view the SGO application if the children were not having contact with the maternal grandmother as per the care plan.
14. On the 1st September 2017 the children's care plans stated that it was hoped that eventually permanency would be secured by an SGO plan which had been proposed previously but had been delayed due to the maternal grandmother's application for contact. The care plans also recorded that it is likely that the court would want to be satisfied that children's services and foster carers are undertaking the tasks they agreed to before granting and SGO.
15. On 19th September 2017 at the children's LAC review it was reported that Child B had lost trust in her social worker (Janet Watkins) and had requested a change in social worker. It was also recorded that the application for SGO had been put on hold following the court hearing in respect of contact with wider family members, and that any consideration of progression to an SGO would require a robust assessment as to the foster carer's ability to promote the children's identity within their birth family should the local

authority not be involved. It was recorded that the children had clearly told the IRO that they wished to be adopted by the foster carers and they expressed frustration and confusion about this plan not progressing. The progression of the any application for SGO did not form part of the list of recommendations.

16. The Looked after child(ren) review of 6th March 2018 recorded that the children are happy in their placement with Mrs XX, Mr XX and Miss XX and describe this as their home and their family. The children's consultation forms raised the issue of them wishing to be adopted by Mrs XX and Mr XX which the local authority saw as the children wishing to formalise their care arrangement. Mrs XX and Mr XX notified the LAC review that they would like to make an application to care for the children under an SGO, that it was noted that they had wanted to do this for some time however it had been agreed that this request would be put on hold whilst the previous court hearing (issues in relation to contact with wider maternal family) concluded. The record also indicated that the local authority did not propose any changes to the care plan at this time. The recommendations included the need for the social worker to update the child and family assessment and to review the suitability of permanency options including adoption (although the social worker had expressed the view that this may not necessarily be appropriate given the children's links to their birth family). It was recommended that the local authority should fund legal advice for the foster carers regarding their wish for an SGO to include a written advice regarding what financial support can be offered.
17. On the 9th April 2018 the social worker (Hannah Ellis) visited the children and noted that the children were happy and wished to remain in placement. She noted that consideration should be given to an SGO.
18. On 3rd May 2018 the social worker Hannah Ellis completed her review assessments of the children. She noted by this time the children had been in placement for six years., had developed a clear attachment to their carers and wanted to stay with them forever. The assessment concluded by recommending that it was in the children's best interests to remain with their foster carers under an SGO and that the SGO assessment should commence in a timely manner without drift or delay. The assessment included concern about loss of birth identity, concern that once SGO was made birth contact would not be promoted, that the SGO assessment would need to include work and support around family contact.
19. On the 24th July 2018 at the looked after children's review it was recorded that the care plan for the children was one of permanency via SGO to the foster carers. It was recommended that the LA plan was for the SGO assessment to be completed and presented to the court by the end of September 2018.
20. On the 18th September 2018 the social worker (Hannah Ellis) visited the children who stated that they wanted the SGO to hurry up. It was recorded that the local authority plan was for the SGO application to proceed, that the LA supported the application and were awaiting the foster carers means testing form to be returned in order to move forward.
21. On the 25th September 2018 the social worker (Hannah Ellis) recorded that the SGO support plan had been commenced
22. On 31st October 2018 the social worker (Hannah Ellis) wrote to the Mother informing her that the SGO plan was still under discussion with the carers and that the LA was awaiting the carer obtaining legal advice which she hoped would be completed prior to the next Looked after Children review on the 13th November 2018.
23. On 13th November 2018 the looked after children review recorded that the care plan remained that eventual permanency would be secured by an SGO plan and it was recommended that the SGO should progress swiftly to provide the children with stability and closure.

24. On 20th February 2019 the children's care plans stated that the plan was for SGO, that all the children wanted this and that they did not want to have any involvement with the local authority and would prefer not to have a social worker.
25. On the 17th April 2019 Florence Kandodo visited Child A and Child C who both said they had been wanting this for a long time and that Child C said she would love a life without social workers.
26. On the 1st May 2019 the social worker Florence Kandodo wrote to Alison Forshaw and Vicky Leader confirming that she had not yet completed her section of the SGO assessment, was unsure of some sections that included parent details and had been advised to hold off for now.
27. On 3rd May 2019 the social worker (Florence Kandodo) confirmed in supervision that she had completed her parts of the SGO plan but another part was still to be written by another worker (Kathryn Straughan). A discharge statement was to be completed once it was known that the carers were agreeing to the making of the SGO order.
28. On 9th May 2019 the social worker (Florence Kandodo) confirmed that the SGO assessment had been completed.
29. On the 10th May 2019 the IRO Louise Bath recorded that the LA plan was progressing and that it was intended that the local authority would file an application to have the children's care orders discharged in favour of an SGO to foster carers by 31/05/19
30. On the 14th May 2019 the social worker (Florence Kandodo) and other professionals agreed that the SGO should continue with a brief addendum report to reflect a significant change in circumstances since the assessment and support plan were completed.
31. On the 27th May 2019 the social worker (Florence Kandodo) filed a statement in support of the LA's application to discharge the care order and replace it with an SGO.
32. On the 4th June 2019 the Head of Service Gill Cox, in an email to maternal grandmother MGM, confirmed that the local authority was not progressing the SGO at that moment. Florence Kandodo was to amend the report to reflect MGM's views.
33. On 11th June 2019 the Head of Service Gill Cox wrote to the foster carers explaining that the SGO application would be placed temporarily on hold following Child C's death
34. On the 24th June 2019 Head of Service Gill Cox, and team manager Vicky Leader, agreed that the SGO report should be updated after Child C's funeral within 6 weeks, the SGO plans could then be updated if necessary and the application to discharge the care orders then made. On the same day the local authority updated HHJ Plunket of that plan by letter.
35. On the 28th June 2019 the social worker (Claire Wilce) visited the foster carers and said that she was the new social worker and would be progressing the SGO the visit also dealt with other matters.
36. On the 8th July 2019 the children made a formal complaint to the local authority (via the children's rights worker Claire Harris) expressing concern over the length of time that the SGO process was taking.
37. On the 11th July 2019 it was recorded in supervision that the children had been informed by the IRO that if nothing had been progressed in relation to the SGO within 6-8 weeks then they should have independent legal representation. It was agreed that the SGO paperwork should be updated and progressed by the social worker (Claire Wilce).
38. On the 19th July 2019 the LA solicitor (Tim Marks) confirmed that recent events (not connected with Child C's death) had led the social work team to consider that a review of the SGO report was necessary and that no conclusions had been reached.
39. On the 25th July 2019 the social worker Claire Wilce recorded that the care plan was for an SGO and that the LA had offered the foster carers financial assistance to support them in making their application. However it was also recorded that she was unsure about

whether an SGO was the right way forward at the time as she was not aware of the case in detail, there was no report on the cause of Child C's death and she was aware that M had made an application for contact.

40. On the 26th July 2019 the team manager (Vicky Leader) confirmed that the current position was now that the LA was not intending to apply to discharge the care orders but instead had offered to fund the carer's application for an SGO.
41. On 11th October 2019 the updated Connected Persons Assessment of the foster carers was completed by Kathrine Straughan recommending that an SGO should be granted.
42. The local authority application for discharge of the care order is dated 8th November 2019, which confirmed that this was to be replaced with an SGO. However the application was not accompanied by an application for a change of surname. On 21st November 2019 the children were wrongly informed by the social worker, Claire Wilce, that the application for an SGO and change of surname had been made at the same time. The application for a change of surname was not made until 3rd December 2019. It is accepted that when the children were informed of this on the 21st November they indicated that they were fed up it had taken so long.

<u>Children section B:</u> The Local authority accepts that in the matter of the use and change of the children's surnames it demonstrated indecision, poor planning, complicity in allowing the children to use XX in the place of YY without legal authority or proper parental consent and poor communication around the matter of use and change of surname . That although the social workers endeavoured to involve the parents in the discussion of issue, sought legal advice, despite the clearly recorded wishes of the children, it delayed in bringing the matter before the court. The indecision and delay in bringing the matter before the court spanned in excess of 5 years.

The local authority specifically accepts that

1. On the 22nd January 2014 the local authority placement panel agreed a plan whereby the children would remain living in their placement with Mr and Mrs XX
2. On the 27th January 204 the children were made subjects of final care orders and the court approved the care plans whereby they would remain living with Mr and Mrs XX
3. On 16th April 2014 when Child A first asked if she could change her surname to XX the social worker (Rebecca Philips) promised she would look into it.
4. ON the 23rd April 2014 the social worker (Rebekha Phillips) stated in here report for the looked after children review that direct work would be done with the children to help them understand what their surname means to them and that if the children wished to be known by a different surname, they could choose to do this without/before legal name changes are made.
5. On 23rd May 2014 the social worker (Rebekha Philips) approached the Head of Service (Joanne King) in respect of gathering the views about whether the children could be known informally as XX, it was noted that the children were hating the way their name sounded and that they wanted the same name as the foster carers.
6. On 28th October 2014 the social worker Rebekha Phillips stated in her report for the looked after children's review that the children had informally asked school to call them by their carer's surname which was their right to do, it was stated that there needed to be discussions with managers about their legal position of supporting the children to change their names.
7. On the 12th November 2014 the social worker (Rebekha Phillips) requested legal advice about the children changing their name.
8. On 29th November 2019 the social worker Claire Wilce, confirmed in her sworn witness statement C79, that on the 12th November 2014 the LA received written consent from

Father to change the children's surname legally. The local authority was previously unable to locate this written consent but has now done so.

9. The social work report of Rebekha Philips of the 6th March 2015 for the looked after children's review reflects that the birth father had signed a letter to agree to the children changing their name to XX and that the mother was to visit the social worker the day after the looked after children review and has agreed to sign a letter also.
10. On 12th March 2015 it was recommended at the LAC review consent as to the change of name should be completed.
11. On the 13th May 2015 the social worker (Rebekha Philips) noted that although Mother had verbally agreed to the name change she had not attended the office provide written consent. The team manager (Tudor Walters) advised the social worker (Rebekha Philips) to accept legal advice in respect of a name change and to make application alongside the SGO application. However this was not progressed at that time. *By this time the maternal grandmother's application for permission/contact was before the court.*
12. On 9th September 2015 The minutes of the Looked After Children review noted that the name change was being used informally, that Father had agreed, and that Mother was in the middle of talking to her CPN about the matter. It was also confirmed on 9th September 2015 by the social worker Rebekha Philips in her report to the Looked after Children review that as part of the SGO application a request had been made to change the children's names legally.
13. On 10th May 2016 the children remained consistent in their wishes to have their name legally changed to that of the carers.
14. On 7th June 2016 a review meeting noted that court direction was needed in respect of the name change because although father had agreed mother was changing her mind.
15. On 17th June 2016 the children's care plans noted that father agreed to the children changing their names. In the core assessment of the 23rd August 2016 noted that mother supported the SGO but is thinking about the legal name change and at times feels the children should remember the family they come from.
16. On the 15th May 2017 the social worker (Janet Watkins) requested further legal advice about the name change and was advised to make an application to court if the Head of Service agreed (Gill Cox) agreed to the proposed name change
17. On the 19th July 2017 mother agreed to the children changing their names in a meeting with the social worker (Janet Watkins) although Father was now stating that he wanted nothing to do with the local authority
18. On 21st July 2017 the Head of Service Gill Cox agreed that the local authority should make an application for the children to change their surname. However the matter was not progressed at that stage.
19. On the 21st August 2017 a letter requesting permission to change the children's names was sent to father.
20. On 1st September 2017 the children's care plans stated that the children wanted their name changed legally to XX and stated that Mother had given agreement but that no reply had yet been received from father.
21. On 19th September 2017 the looked after children review minutes noted that Child B had asked if she could change her surname from YY to XX
22. On the 19th September 2017 the looked after children review minutes for Child A noted that the local authority advised that as Mother currently retains parental responsibility her views must be ascertained; it was agreed that the issue would remain on hold at present however would be pertinent to the agenda of future looked after children reviews as an expressed consideration of the children to be considered.

23. On 6th March 2018 the Looked after children review minutes noted that the children have asked if their names can be changed to XX and recommended that the local authority should seek legal advice re pursuing the children's request and to seek consent for this if assessed a being in their best interests
24. On the 24th July 2018 the Looked after children review minutes noted that the children had expressly stated that they wanted to be known as XX and that their request would be dealt with at the same time as the SGO application. However the recommendations did not refer to any legal application having yet been made.
25. On the 18th September 2018 Child A told the social worker (Hannah Ellis) that she wanted her name changed prior to her exams and Child B said she wanted her name changed as soon as possible.
26. On the 13th November 2018 at the looked after children review it was recorded that the children wanted to change their names.
27. On the 11th January 2019 the children told the social worker (Hannah Ellis) that they wanted the speedy progression of their name change.
28. On either 22nd March 2019 or 22nd April 2019 the case was transferred to a new social worker but the local authority records are unclear about the exact date. Whilst the date of change of social worker may be unclear or inaccurate, it is accepted that change of name for all the children was one of the primary issues in the case which needed to be resolved or brought about before the court at that time.
29. On the 17th April 2019 Child A (and Child C) told the social worker (Florence Kandodo) that they wanted their surnames changed.
30. The child death review form sets out that on 26th April 2019 the children told the social worker (Florence Kandodo) that they were all in favour of a name change whilst this is not recorded in the looked after children visit record for that date it is accepted that this would have been the view of all four children.
31. On 3rd May 2019 the social worker (Florence Kandodo) agreed with her manager (Vicky Leader) in supervision that one of the actions required in the case was a surname change.
32. On the 10th May 2019 Vicky Leader asked Florence Kandodo to prioritise the preparation of the statement for the discharge of the care order so that the matter could be taken to court. She indicated that she would arrange a brief legal meeting and she asked the social worker whether she was right that the children wished to change their names and if so this needed to be included in the statement.
33. On 10th May 2019 the Looked after children review recorded that although the children had not been sent copies of the consultation form, their records and the SGO assessment clearly demonstrated that they had all consistently asked to be known by the surname XX and wished this change to be legalised.
34. On 24th May 2019 mother told the social worker Florence Kandodo that she agreed to the name change
35. On 27th May 2019 the social worker Florence Kandodo submitted a statement in support of the LA's application to change the children's surname to XX on the basis that it was in the children's best interests.
36. On 10th June 2019 a local authority planning meeting confirmed that the LA knew the children wished to have their name changed
37. On 12th June 2019 Mrs XX wrote to the LA stating that after Child C's death, it was now even more important for the children to have their names changed
38. On 19th June 2019 the children spoke to their advocate (Claire Harris) and made a complaint about the social workers (Claire Wilce and Karen Brooks) including a complaint about the local authority's progress in officially changing their names

39. On the 11th July 2019 the duty solicitor at the local authority (Tim Marks) emailed the social worker (Karen Brooks) stating that he understood the children were known on the LA system as XX and asking if this had been agreed by the parents and stating that he was worried that the LA may have changed the children's names which would be beyond the local authority power.
40. On 26th July 2019 the social worker Claire Wilce notified the team manager (Vicky Leader) that she was seeking legal advice for the children, including advice about changing their names and advice about what they could do in the event that the local authority was not acting in a timely way.
41. On the 16th August 2019 the children attended their looked after review, stated their wishes to change their surname and requested updates about progress. They enquired as to what was happening about the appointment with an independent solicitor and were informed that a local solicitor had agreed to have an initial consultation meeting with Child A and Child B and will be contacting them to arrange a date. It was noted that Child A and Child B would ideally like the meeting to take place before they returned to school. The IRO explained that the children intended to take independent legal advice. The record also notes that Vicky Leader spoke with Head of Service regarding making the application on the children's behalf and it was decided that it would not be actioned at this time by the local authority. The care plans indicated that this would be progressed following completion of the updated SGO and would be considered in the Court arena. However this was not communicated to the children at the Looked After Children review. They were simply told that the local authority was not actioning the change of name at this time.
42. On 11th October 2019 the updated connected persons assessment of Mr and Mrs XX noted that the children remain clear in their wishes to change their name surname to XX.
43. On 12th November 2019 the team manager (Vicky Leader) confirmed that the local authority would continue to make an application for a name change for the children irrespective of whether an SGO was granted.
44. On 21st November 2019 the children told the social worker (Claire Wilce) that they were fed up that the name change application has taken so long.
45. On 29th November 2019 the social worker (Claire Wilce) acknowledged that the issue of the children's name change had not been managed appropriately and should have been addressed formally through the court process since the making of final care orders in January 2014.
46. On 3rd December 2019 the LA finally issued an application for the change of surname for the children.

Appendix 3

SUMMARY OF FACTUAL CONCESSIONS AS BETWEEN THE FIRST RESPONDENT MOTHER AND THE INTERVENERS

1. The foster carers agree that they assumed the truth of the children's allegations and that they were affected emotionally by the verbal and behavioural distress demonstrated by the children in placement.
2. The foster carers were given the outcome of the finding of fact on 22.08.13. At a professionals' meeting on 27.11.13, Dr. Asen stated that the foster carers did not question the FOF outcome. The foster-carers understood that the FOF decisions were authoritative and would govern work to be done with the children under their care plans. They concede that until the completion of Janet Watkins' work in 2017 they - individually and jointly - found it extremely difficult to match up the judge's findings with what the children had alleged, how they behaved and the medical problems of toileting/soiling (all of which continued after the FOF hearing).
3. After a clinic on 18 March 2014 Dr. Fiona Goodwin (Consultant Paediatrician) wrote of *"a catalogue of significant neglect and harm within the birth family apparently involving a family network of abuse. All four children were exposed to inappropriate sexual material and all four children have disclosed penetrative sexual abuse perpetrated by both their mother and father. Child D has also disclosed that anal penetration included implements such as a knife and fork. Since being in Mrs XX care all four children have had difficulty with constipation and toileting*". Dr. Goodwin referred them to CAMHS and noted that *"these children have endured an extreme level of abuse which included abuse of a sexual nature so in my view it is imperative to include CAMHS in their overall management"*. Mrs XX agrees that she gave the information contained in the part of the letter recording Information Relating to Sexual Harm at Dr Goodwin's request and in the presence of Lynette Chan. Mrs XX cannot recall if Ms Chan added any comments. The children were not present.
4. An undated social work record (no author identified) but believed to date from February or March 2015 includes the text: *"....as soon as Child B mentioned wanting to know more about her family the carer interrupted and told me she didn't necessarily mean what I thought and that she did not always understand what she was saying. Whilst there will be an element to this which is correct, I felt this could have been said after the session and was unnecessarily controlling the response in front of the other children who would also have heard this*". The foster carers have no certain recollection of this meeting but Mrs XX accepts she may have made an intervention of this sort given a history of professionals sometimes making assumptions or mistakes about (i) what the children had asked or stated; and (ii) which family was being referred to (given the use of familiar names in placement), she may have made an intervention of this sort. As a result of the work following Child C's death, the foster-carers (and Mrs XX in particular) have taken on board the need to allow professional to lead discussions. For their part, they find it most helpful when any given professional tells them in advance whether their participation and encouragement is wanted during any discussion a social worker is having with the children.
5. The foster-carers agree that 'on the ground' they were unable to, and did not, provide information to correct or challenge the children's ongoing assertions of abuse by birth family members and the negativity towards them beyond the approach they were told to

follow in Dr Asen's script. Specifically, they only used general reminders that the children were loved by their birth family and that some family members were asking for contact. They used the scripted messages of empathy/sympathy/listening in response to the children's ongoing complaints about abusive treatment. Mrs XX was experiencing the emotions of stress, intrusion, and protectiveness and defensiveness in respect of the children and the settled state of the placement and what they felt was the children's 'recovery'.

6. With hindsight, the foster-carers realise that the structure and activities they set up for the children (which were commended as therapeutic/reparative parenting) also made it easier for them and for the children to distract themselves from and deflect difficult birth family issues. In particular, the LA's timetable (which involved the children in the period 2013-2016 being asked about/offered contact at set points in each year) was seen by the foster-carers as disrupting the children's settled state and their overall progress. The foster-carers acknowledge:
    (a) They felt that these infrequent 'contact discussions' led to a sense of stress and intrusion;
    (b) Absent any detailed therapeutic work they had no expectation that the children would change their views about contact;
    (c) They felt protective and defensive of the children's emotions. They did not want them to feel unhappy, unsafe or distressed;
    (d) They felt protective of the security of the placement and what they felt was the children's 'recovery';
    (e) They allowed the children to see the occasional 'contact discussions' with their SW/IRO as an exercise in stating their wishes and feelings before being able to move on and resume their settled life in placement;
    (f) Specifically, within that dynamic, the foster-carers did not carve out sufficient opportunities for the younger children to express thoughts or questions away from the negative views of the older children about (i) past events and /or (ii) professional visits.
7. The foster carers' emotions were made worse by their frustration about various issues already pleaded on their behalf including (i) inconsistent care planning and messages to the children; (ii) the lack of suitable therapeutic support; (iii) the lack of professionally directed life story work and information with which the foster-carers could give specific details and positives to the children about their birth family and (iii) a revolving door of professionals.
8. However justified the foster-carers' frustrations may have been and howsoever local authority staff members themselves may have demonstrated interpersonal failings from time to time, <u>for their part</u> the foster-carers agree and concede that they (and Mrs XX in particular) frequently expressed themselves in words that were too blunt and in a manner which was challenging and critical of the LA and other professionals. Those dynamics have been pronounced:
    (a) Following Child C's death when the foster-carers (Mrs XX in particular) were in a state of heightened emotion, grief, uncertainty and reactivity;
    (b) When existing SW/FSW professionals have moved on
9. At his meeting with the foster-carers on 21 November 2016 Dr. Asen noted *"She [MGM] then pleaded with the foster carers to consider that there may be other reasons as to why the children have been making the allegations. She said that one reason could be that they maybe wanted to stay with the foster carers. Mrs XX immediately rubbished this suggestion, but MGM remained calm and, a little bit later, asked the foster carers again to consider other reasons as to why the children may have been making the*

allegations. Miss XX said that she and her mother were supporting the children and had been trying to get the children's views across" . The foster-carers agree that Dr. Asen has accurately summarised what MGM said and Mrs XX said she did not agree that the children had invented sexual abuse allegations in order to stay in placement. The words extracted cannot properly be divorced from their whole context which show all three lay parties (MGM, Mrs XX and Miss XX] making significant efforts to hear each other and express their respective viewpoints:

"MGM said she was not asking the foster carers to dismiss what the children had said and that she understood that the children were adamant they had been abused by family members. She [MGM] then pleaded with the foster carers to consider that there may be other reasons as to why the children have been making the allegations. She said that one reason could be that they maybe wanted to stay with the foster carers. Mrs XX immediately rubbished this suggestion, but MGM remained calm and, a little bit later, asked the foster carers again to consider other reasons as to why the children may have been making the allegations. Miss XX said that she and her mother were supporting the children and had been trying to get the children's views across. MGM pointed out that the years before the children had come into foster care would have had an effect on their lives including positive experiences they had had. Miss XX replied that she and her mother did not know the positive things and events as the children only talk about the negative ones. Mrs XX then said that she accepted the judgement '100% but we can't ignore what the children have said and what they've put us through'. MGM repeatedly stated that the foster carers had done an 'amazing job' and that the children had come into a loving family and that the foster carers had given the children stability. She added that the children need to have 'the positives about their past remembered…to bring out good memories so that they can integrate them' and she pointed out that no life story work had been done with the children about the time before they came into foster care. At the end of the meeting - which lasted about 100 minutes - there was a collaborative conversation which resulted in Mrs XX suggesting that, with regard to the life story work, she would be willing to meet with MGM in the presence of a third party such as the children's Guardian. She acknowledged that it was very important for the children to undertake life story work and that it was important for them, the foster carers, to understand and know more about their lives with their birth family."

10. Dr Asen's report confirms that in the absence of life story work the foster-carers did not have positive information with which to supplement the December 2013 script. This meeting was one occasion upon which they sought it. Mrs XX further admits that as of this date in November 2016 she did struggle to understand the benefits for the children in wider family contact, given their stated wishes and ongoing presentation.
11. In January 2017 the social worker Janet Watkins undertook some work with the foster carers. She recorded that (as explained in HHJ Rundell's judgment in July 2013) in December 2012 Child A had told SW Lynnette Chan that she wanted to see her birth family (and had named them). Mrs XX told Janet Watkins that Child A had been confused and was in fact clear she did not want to see the family. Mrs XX' concession has been made on the basis of her best recollection of her 2017 conversation with SW Janet Watkins in which she explained her understanding of Child A's wishes in 2012 and her recollection that Child A (then aged 8**)** had told her carer that she wanted to have contact with birth family one day when she was ready and that this was something the foster-carers had been promoting and building up to but said she did not feel ready yet. The foster-carers have an open mind about the fact that Child A may have expressed different wishes and feelings at different times to different people (and especially so in

2012 around the time that she - and the other children - made allegations which were not true).

12. From January 2017, the foster-carers were provided with a clearer understanding of the FOF judgment, the court's concerns about the lack of effective LSW/contact in the period 2013-2017 and Dr Asen's recommendations for work with the children. They nevertheless acknowledge that their (productive) work with Janet Watkins work was marred by the fact that they felt under pressure of time and being told by the LA that the judge may remove the children from their care. They were aware that the children demonstrated partial engagement / partial resistance to SW Janet Watkins and her work which added to their anxiety.
13. The foster-carers acknowledge that, during all periods, their emotions, fears, frustrations were likely, at times, to have:
    (a) Been perceived by the children, despite the foster-carers' efforts to mask the same;
    (b) To have reinforced the children's own frustration with LA procedures and professionals; and
    (c) To have reinforced the children's stance on their major issue of contention with social work professionals (birth family contact and LSW). In particular:
        (a) Before Dr Asen's work in late 2016 and Janet Watkins' from January 2017 they had insufficient information or skills to support the children in taking any different view of birth family issues. The situation was made worse by the foster-carers' emotions, fears and frustrations including their sense of stress, intrusion, protectiveness and defensiveness at times when contact issues were discussed;
        (b) The children learned that their trusted carers were not challenging their ongoing narrative. Instead, they learned that they would continue to receive sympathy, empathy and attention in response to that narrative;
        (c) The occasions when the foster-carers unintentionally conveyed negative emotions to the children in respect of professionals coming to talk about contact were likely to have added to whatever complex emotions each individual child was feeling;
        (d) The occasions when the foster-carers allowed the children to see the 'contact discussions' as an exercise in stating their wishes and feelings before being able to move on and resume their settled life in placement were likely to have contributed to each child seeking to close down such discussions and to avoid whatever complex emotions each individual child was feeling;
        (e) Following Dr Asen's and Janet Watkin's work, the foster-carers had better information, knowledge and skills but have acknowledged that work was marred by feeling under pressure of time and fear that the children may be removed from their care. They were aware that the children demonstrated partial engagement/partial resistance to Janet Watkins which added to their anxiety. On occasions when those different (but still negative) emotions were unintentionally conveyed to the children by their trusted carers it was likely to have added to whatever

complex emotions each individual child was feeling and contributed to their rejecting the professionals and their work**.**

14. For the avoidance of doubt the foster-carers never gave any negative narrative to the children, nor did they ever intentionally discourage or undermine any meeting or session which sought to encourage contact or to provide the children with information about their life story, their birth family members or the love and good wishes being sent to them**.**
15. The mother has alleged that the foster-carers overstepped the boundaries of their role and considered that the parental responsibility delegated to them as foster-carers gave them superior rights over the children without proper recognition of the parental responsibility retained by the mother. The foster-carers refer to the LA's concessions in relation to the operation of its parental responsibility and delegation of authority. There was no delegated parental responsibility paperwork on file between a document in 2012 and a process to remedy this (following Child C's death). The foster-carers do acknowledge they have felt they have a superior *knowledge* of the children at any given time. They accept this may have been a contributing factor to the concessions they have already made, in particular:
    (a) The protective and defensive way in which they responded to the children's ongoing narrative (of abuse) and their general reluctance to see or to talk about their birth family members;
    (b) The emphasis they placed upon the children's stated wishes and feelings;
    (c) Communicating frustration about SW and FSW changes (and periods of non-allocation) which they perceived to have a negative impact upon the children;
    (d) Communicating frustration about changes within LA care planning which they perceived to have a negative impact upon the children;
    (e) Communicating frustration about life story work and direct contact (for MGM) being introduced under pressure of time and against a backdrop of no contact and adherence to the children's wishes (2013-2016);
    (f) Communication of distress at being told that the stability and the continuation of the placement were under threat.
16. In relation to matters of the proper use of delegated parental responsibility, the foster-carers have set out the history of the use of 'familiar' names in the placement and the use of the surname XX. There was no deliberate 'overstepping' of fostering boundaries. The foster-carers were new carers. Neither was imposed or encouraged by the foster-carers. Neither was stopped or discouraged by social workers or therapeutic professionals. To the contrary, professionals endorsed promotion of the children's wishes and the concept of 'security' and belonging. In 2019, FSW Suzanne Musgrove noted that "*the fostering service had not supported [MRS XX] to understand the boundaries that need to remain intact so that she understood the fostering role*". The delegated authority paperwork is unsatisfactory and does not seem to have been renewed until 2019, despite it being an action point in 2017 and 2018**.**
17. The foster-carers now know that the LA approval of the use of their surname, even informally and on school and LAC records, was unlawful and should never have taken place. The foster carers now know that the use of 'Mum' and 'Dad' is contrary to good fostering practice and should never have taken place. They understand the upset caused to the birth family by this issue and recognise that it was extremely unhelpful as part of a larger picture in which the FOF judgment, birth family identity, life story work and contact were not properly progressed. Child D, given his young age on coming into placement, suffered actual confusion about his birth origins.

18. The foster carers now know that, even though they understood an SGO application to have been imminent, they should not have taken Child D to visit a new school without social work agreement. They are now aware that the LA's 'best interests' decision that Child D could move school was made against the wishes of his mother. They understand that this would have caused M upset and a sense that her parental responsibility was not being respected. Insofar as their actions made it harder for the local authority to administer its joint statutory parental responsibility with Child D's parents, they apologise to the mother, the father and the local authority. They have received detailed delegated authority paperwork and guidance since 2019**.**
19. The foster carers have given a detailed account of the degree to which they were consulted, involved or not involved in arrangements for birth family members visiting Child C in hospital. They now know that all contact issues and finer details of contact - including supervision - should have been a matter between the local authority, the hospital and the family members. At no time did the foster-carers have any motive other than care for Child C and respect for what they understood to have been her wishes (hence supporting unlimited contact by her mother)**.**
20. With hindsight, they realise that (during Child C's hospitalisation) they were experiencing intense emotions including helplessness, protectiveness and defensiveness. As previously conceded, they felt that they had the best knowledge of Child C and her likely wishes and feelings and this emotion was to the fore at this time, together with a degree of frustration about lack of clarity within LA planning and a raft of new professionals.
21. During Child C's hospitalisation one of her consultants, Dr Jane Clarke, recorded on 27 May 2019 that the biological family were responsible for neglect and physical and sexual abuse. It is admitted that an entry within Child C's medical records timed at 04.10 in the morning of 27 May 2019 states: *d/w foster mum re: PMH/Social Hx biological family abused all 4 children - physical, CSA, neglect.***.** The entry goes on to record that the placement had been home to Child C and her siblings for seven years. Dr Clarke has clarified that she used 'CSA' as a medico-legal abbreviation for 'child sexual abuse'. Mrs XX does not have a clear recollection of this but accepts she told Dr Clarke the types of abuse listed (or selected/agreed with them if given a list of options by the doctor). Insofar as she stated or agreed to sexual abuse, Mrs XX was not intending to convey any untruth or sexual harm beyond that found by the court in the FOF judgment. Dr Clarke and her colleagues at Hereford (and later at Birmingham Children's Hospital) had access to safeguarding notes on the NHS file and contact details for the LA.
22. On 31 May/1 June 2019, at BCH, Mrs XX informed Nurse Clare Marshall "*that she was worried even if she was dead and biological family came in and left unsupervised, they would abuse Child C"*. Mrs XX recalls using these words within a wider exchange during which she asked Ms Marshall what the procedure would be should Child C die. She was reassured that the hospital was aware of Child C's situation as a Looked After child and given a brief overview of BCH procedures for death of a child and post-mortem visiting. Mrs XX recalls her concern was focused upon any unsupervised access by F.
23. On 13 June 2019 Mrs XX was recorded as saying to professionals visiting her home "the children know everything" and that "she intended to share everything". She accepts that her emotions in the aftermath of Child C's death and frustration with numerous recent LA exchanges led to some actions on her part which were insufficiently professional. Mrs XX' reference was to the fact that the children had already been involved in thinking about possible funeral plans (a) at the hospital with BCH staff and (b) after Ms Forshaw's suggestion on 10 June 2019 that there might be two funerals for Child C.

Nevertheless, she agrees that she should not have assumed that she knew what Ms Brooks and Ms Forshaw wanted to discuss and she should not have questioned the professionals' request to close the door.

24. The foster-carers concede that Child C's hospitalisation and death pitched them into a state of extreme anxiety and, later, grief. There were occasions when their thoughts, words and behaviours were skewed by those emotions and were not in keeping with neutral, professional behaviour. There were other times when the assumptions, words and behaviour of individual professionals (and the overbearing volume of professional contact and new professionals) caused or contributed to difficult meetings. The foster-carers acknowledge their role and their failings within those dynamics and agreed to engage in detailed work to remedy matters**.**
25. The foster-carers have reiterated their acknowledgement of, and sympathy for, the pain and distress felt by Child C's mother in circumstances where her first direct contact with her daughter in several years took place in the extremely upsetting circumstances of Child C's critical illness. Not only was the maternal grandmother in the same position, but the foster-carers now have a better understanding of the events of 29 May 2019 which resulted in MGM arriving at the hospital with Florence Kandodo but being refused access to Child C by the hospital. They acknowledge the emotional devastation which would have been felt by Child C's grandmother at that time. To the best of their understanding, F also arrived at the hospital expecting arranged contact and was unable to see Child C, with the result that his contact with her was never renewed before her death.

Appendix 4

FURTHER FINDINGS SOUGHT AGAINST THE LOCAL AUTHORITY ON BEHALF OF CHILD A AND CHILD B, M, THE INTERVENERS AND THE CHILDREN'S GUARDIAN: 12 MARCH 2021

1. Notwithstanding that a Child and Family Assessment was completed on 3 May 2018 recommending that special guardianship orders were in the welfare best interests of the children, the local authority thereafter wholly failed to undertake a robust, analytical, evidence-based and, ultimately, reliable special guardianship assessment of the children's carers.
2. In relation to (1) above, the local authority failed to ensure that there was a proper management and/or supervision structure in place such that the failures of the assessment process were not recognised or remedied by the local authority in any way. In particular:
   (a) The SGO assessment carried out by Kathryn Straughan after Child C's death was inadequate in that –
      i. Kathryn Straughan, was instructed by her manager, Alison Forshaw, to undertake a 'paper only' assessment after Child C's death; or
      ii. Kathryn Straughan carried out a 'paper only' assessment without informing Alison Forshaw; or
      iii. Alison Forshaw knew that Kathryn Straughan was carrying out a 'paper only' assessment but permitted her to continue and took no steps to intervene or direct that she should hold face to face discussions with the children or Mr and Mrs XX.
   (b) During that assessment Kathryn Straughan failed to hold any face to face discussions with the children or Mr and Mrs XX;
   (c) During that assessment Kathryn Straughan relied in part upon the written recordings entered by others on the Mosaic system;
   (d) Alison Forshaw received an SGO report from Kathryn Straughan on 11 October 2019 which advised unequivocally against SGOs but she failed to support the conclusions her social worker had reached. This prompted Kathryn Straughan's resignation on 11 October 2019;
   (e) During 2019 the local authority operated a 'LAC reduction policy' whereby all social workers, team managers and heads of service were required to consider which children could cease to be looked after. The YY children were placed, by Gill Cox, on the list of children to whom that policy applied. Senior management failed to put in place the necessary checks and balances that would ensure team managers and social workers would not feel under pressure to produce 'results' based on numbers rather than proper welfare evaluations;
   (f) From early 2019 onwards there was a tacit assumption made by many of the social workers within the Children's and Fostering teams that there should be SGOs and the May 2018 Child & Family Assessment said as much. The local authority's practice of drafting SGO support plans in advance of an SGO report contributed to the sense that SGOs were a foregone conclusion;
   (g) Alison Forshaw caused Kathryn Straughan to believe that she had to change her 11 October 2019 SGO recommendation and bring it in line with 'the local

authority's view', by impressing on her, in supervision, that she, Alison Forshaw, and Gill Cox both supported SGOs. Alison Forshaw asked her to 'revisit' it, resulting in Kathryn Straughan drafting a third SGO report in late October 2019, this time supportive of SGOs;

(h) Alison Forshaw approved the late October 2019 SGO report despite the obvious contradictions between its analysis and its conclusions;

(i) Despite being sent the 11 October 2019 SGO report by Alison Forshaw, Gill Cox did not read it [NB: to review after Friday's evidence];

(j) Despite being sent the late October 2019 SGO report by Alison Forshaw, Gill Cox only read its conclusion;

(k) The result was that the head of service, Gill Cox, gave her approval to an SGO report that she had not read and which did not reflect the actual conclusions reached by its principal author, Kathryn Straughan;

(l) The local authority (from Gill Cox, head of service, down) now accepts that recommendations for SGOs should not have been made in October 2019 and that the assessing social worker's analysis militated against such orders being made;

(m) The local authority failed to disclose the 11 October 2019 report until the second week of the 2021 hearing. Insofar as Alison Forshaw has asserted that there was a version of Kathryn Straughan's SGO report emailed to her on a date before 11 October 2019 with positive and negative recommendations presented 'in the alternative', this has not been produced by the local authority.

3. The local authority does not have proper mechanisms in place to ensure that social care records and other material from within the local authority are subject to a timely, proactive and impartial disclosure process. That lack of process has interfered with and prevented proper disclosure within these proceedings resulting in (but not limited to):

    (a) The late provision of documentation that should have been provided earlier in the proceedings.

    (b) The loss of at least eight days of court time due to the need for late disclosure to be read before oral evidence began.

    (c) Making the case advanced by those representing the respondent and interveners more complex and challenging by the continuous late provision of vital documents.

Herefordshire Council

Appendix 2

In view of the Council's commitment for an urgent and robust review of Herefordshire Childrens Social Care Services, the purpose of this strategy in advance of the publication of the judgement, is to set out certain steps that have already been taken to respond and then to plan for the necessary next steps in reforming the service.

Stage 1
Here and now - March 2021
Assurance work by Assistant Director (Quality and Assurance) - ensuring that the SGO service is robust.
Analysis of historic and current legal cases, including previous high court judgements – issues and trends.
Recruitment of Interim DCS

Stage 2
Publication of Judgement
a) On publication of the judgement, set a date for a Full Council meeting to consider the Judgement and recommended Strategy.
b) Brief all councillors on Judgement.
c) Identify immediate actions needed to respond to judgement findings.
d) Establish terms of reference and membership and appointment of a Chair for an Improvement Board.
e) Establish terms of reference for External Review.
f) Invite Ofsted to review Herefordshire Children's Social Care Service.
g) consider whether a serious child safeguarding review or Child Safeguarding Practice Review is appropriate
h) request deep dive by DFE

w/c 12 April 2021
Recommend to a Full Council meeting:
a) the establishment of Improvement Board and the appointment of an Independent Chair;
b) approve the commission of independent external review provider (LGA Peer Review/high performing local authority peer review): and
c) approve the required additional budget in order to achieve improvement required.

Stage 3 - mid April 2021
a) commission LGA / third party provider to undertake full scale service review including findings of the Judgement to commence no later than 1 May 2021. Key lines of enquiry under each heading 1). Children in need of Help and Protection 2) Children looked after or achieving permanence 3) Adoption Performance 4) Experience and progress of care leavers and 5) Leadership Management and Governance

Stage 4
a) New chief executive in post as from 3 May 2021 who will be leading this strategy
b) Work with Ofsted to review the capability of Herefordshire Children's Social Care Service.
c) findings of external review will be reported back to another Full Council meeting - anticipated by September 2021.
d) Explore LGA Peer to support Chair/panel members and officers Children Scrutiny Committee

	Yr 1	Yr 2	Total
	£'000's	£'000's	£'000's
Improvement board	130	**130**	**260**
Support for birth and foster families	**100**	**100**	**200**
Internal Legal	**551**	**551**	**1,102**
External legal fees	**525**	**325**	**850**
Human resouces support	**364**	**289**	**653**
Assurance and transformation	**292**	**85**	**377**
interim Staffing	**890**	**890**	**1,780**
	2,852	**2,370**	**5,222**

Herefordshire Council

Directorate/Division: Corporate Centre
Team: Finance, Legal and Democratic Services
Please ask for: Kate Charlton
Direct line: 01432 261906
Email: kate.charlton@herefordshire.gov.uk
Date: 17 March 2021

The Honorable Mr. Justice Keehan
Family Division
1st Mezzanine,
Queen's Building
The **Royal Courts** of Justice
Strand , London

Dear Mr. Justice Keehan

Independent Review Strategy – Herefordshire Children's Social Care
High Court Proceedings; Herefordshire Council v T (2020)

Herefordshire Council is deeply sorry that it has failed to safeguard and look after the welfare of the children and their family.

In responding to the case involving these children, their parents and their foster carers, the council recognises the need for an urgent and robust review of Herefordshire Children Services to safeguard and promote the welfare of children.

In the last few weeks we have recently established an assurance framework, so that all special guardianship orders (SGO) decisions will be ultimately signed off by Dr. Andy Gill Assistant Director Quality and Assurance (registered Social Worker). We have also created an independent assurance team who will work to Dr. Gill.

We will be implementing the strategy, as set out in the attached Appendix, that will undertake a fundamental examination of the needs, experience and outcomes of not just looked after children but also our social work practice across the whole of the children social care system and what is needed to make a real difference to safeguarding and promoting their welfare.

For all children who are referred to the children social care system, whether currently in our care or those who need our care in the future, we will expect the review to set out where we are failing and where we don't meet best practice and then set out ambitious, deliverable and sustainable reforms. We will do this by creating an Improvement Board, chaired by an independent Chair and we will also commission an external independent peer review to be provided by either a Local Government Association Peer Review, or a high performing local authority.

This strategy will also carry out a fundamental appraisal of our social work practice from leadership through to practitioner level to ensure they are each supported and enabled and that they are capable in delivering the best outcomes for the children in our care. In addition, it will examine the findings identified, not only in this judgement, but also in previous high court judgements (A & B (care orders and placement orders - failures) [2018] EWFC 72 (30 November 2018) ; BT & GT (Children : twins - adoption) [2018] EWFC 76 (29 November 2018) and Herefordshire Council -v- AB & CD [2018] EWFC

100) and in doing so, also consider whether there is need for improvement/different ways of working in other services that support the children's social care service.

What sets this strategy apart from any previous improvement commitments given by the council, is that a new Chief Executive, Paul Walker, and an independent chair of an improvement board and the chair of the children's safeguarding board, will monitor delivery of the required reforms within defined timescales and together drive and deliver the required performance and outcomes. This strategy is committed to finding the council's failings, and committed to improving outcomes for children and their families.

Yours sincerely

Paul Walker
Incoming Chief Executive Officer

Claire Ward
Head of Paid Service and Joint Acting Deputy Chief Executive

Andrew Lovegrove
Chief Finance Officer and Joint Acting Deputy Chief Executive

Herefordshire Council

Appendix 5

Independent Assurance Work – March/April 2021

What we are doing

- A lead consultant and 3 additional consultants have been appointed. The lead consultant and one of the additional consultants are in place on a part-time basis, and it is anticipated that the full team will be in place within the next two weeks
- A draft work plan has been developed, with a clear scope and objectives, shaped around two phases, 'case review and understanding' and 'improvement'. Objectives of the work plan are:
  - To assure quality and safe decision making for children in care cases that are currently before the court (particularly Special Guardianship Orders – SGOs)
  - To assure quality and safe decision making of other looked after children before they reach Court (e.g., SGO assessments and support plans)
  - To review the quality of recording on these cases, management oversight and case supervision
  - To identify areas of practice that need to improve or where systems/processes need to be robust, make recommendations, and support implementation of more robust practice / systems / processes
  - To consider whether work on reducing looked after children numbers has led to unsafe decision making for children and young people
  - To develop a single response plan with aligned work streams (practice development, workforce, communications, HR)

Case review and understanding phase (April – mid-July):

- The first area of focus for the team is Special Guardianship (SGO's), in line with the concerns raised in the current court proceedings regarding the 'T' children. Pending the publication of the judgement the team had already begun auditing case files of those children where SGO is the plan in order to be reassured of their safety and the quality of assessment and planning. The priority of the audits will be:
  - Current Special Guardianship Orders before the Court, with those soonest audited first. These will be paper audits due to the pressing need for assurance.
  - Upcoming Special Guardianship Orders, beginning with completed assessments then assessments that are in progress – this will be a more collaborative approach, which will enable action learning
  - Permanence planning where Special Guardianship Orders are included in the care plan
  - Special Guardianship Orders that have recently concluded (over the past 12 months) to assess the quality of the support offered to the special guardians and the children and young people they are looking after.

- Following publication of the judgement, the audit schedule and work plan of the team will be reviewed with more focus on:
  - A comprehensive review of the historic and more recent practice regarding the family
  - Additional areas of practice identified through analysis of the judgement and other court cases
  - Additional areas of practice identified during auditing work and speaking with practitioners (e.g., Children on placement with parents, children where revocation of the care order is planned).

Improvement phase (Mid-July – September following a 3 month stage review):

- A system has been established for gathering and analysing evidence of strengths and areas for development which will be used throughout the project
- The learning will be collated and triangulated with what is already known through the QA arrangements, practice development work and the findings of the 3 day diagnostic being undertaken by Essex during Easter week
- Recommendations for any improvement actions made will be aligned to other improvement programmes and plans across Children's Services.

Action learning approach:

- Work on the priority objectives has already begun – an audit tool has been developed and used to audit records of three families of children/young people where applications for SGO have been filed with court
- An 'action learning' approach is being taken to the work, in order to ensure that priority improvements to assurance processes are made without delay, rather than waiting for the 'improvement' phase of the work plan
- Some of the early issues identified during the audit work are detailed below, along with the improvement action that is being taken.

Immediate changes we are making:

An Improved system to quality assure and sign off any changes to care plans where special guardianship is proposed as follows:

  - Arrangements to be put in place for sign off of SGOs following audits
  - Proposals for the establishment of a panel to oversee arrangements with our legal service for discharging care orders through SGOs. The Independent Assurance Team will contribute to these developments by reviewing the terms and membership of the different panels e.g. the legal gateway and legal planning meetings to ensure arrangements are sufficiently robust and aligned.
  - The scheme of delegation is under review by the team with recommended changes, this to ensure due diligence arrangements and assurance measures are in place by senior leaders.
- A single permanency tracker to be established which aligns with developing assurance and panel processes and is kept up to date – meeting arranged for 15.04.21 to progress this work

Herefordshire Council

Appendix 6

Building on previous Essex diagnostic work (e.g. MASH, looked after children service), it would help if as part of your 3 day 'helicopter view of the children's directorate, to provide a baseline assurance to the interim DCS and Executive Leadership Team that you would consider the following Key lines of enquiry (KLOE):

1. ***Are children safe? Starting at the front door (but not excluding early help) and following the journey of the child through the children's system there is evidence of:***

    - *Children being put first and are at the heart of our decision making (consistent application of threshold) management of risks and child and family assessments, all of which evidence a child's lived experience and their voice has been captured and is reflected in the social work analysis?*

2. ***Do we have an open, albeit professionally challenging, supportive culture? That evidences:***

    - *all our social workers throughout the directorate are supported through good regular supervision, with clear management oversight within cases. specifically do staff feel listened to and able to freely contribute to care planning and future recommendations for the child/ young person? How are differences of professional opinion dealt with between staff and their line manager (following recent work is the culture becoming more enabling of reflective practice)?*

    - *our team managers are equally supported through supervision and their line manager's provide clear management direction and have good oversight of cases causing concern.*

3. ***The effectiveness of the journey of children who have come into care (Considering drift and delay) – (tracking back on their journey, including the quality and timeliness of decision making for looked after children. With a specifically focus on:***

    - *the child, care planning and review (including timeliness and IRO involvement)*
    - *achieving the best permanence outcomes, management oversight and decision making.*
    - *Supervision and line management oversight on looked after children work, including that of IRO's. Specifically do staff feel listened to and able to freely contribute to care planning and future recommendations for the child/ person? How are differences of professional opinion dealt with between staff and their line manager (following recent work is the culture becoming more enabling of reflective practice)? Including:*

        - IRO escalation/dispute resolution – how many times has this been instigated and outcome?
        - Role of the principle social worker, and how they support the social worker around escalation/dispute resolution with manager's?
        - Escalation/dispute resolution for social workers – how many times has this been instigated and outcome?

As our independent assurance team is looking at SGO cases for them not look at these to avoid duplication and confusion.

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Work proposal:
an independent, self-directed, evidence based, review of Herefordshire Children's Social Care services

Requested by Catherine Knowles
Interim Director of Children's Services
Herefordshire County Council
14 April 2021

Author… Gary Lamb
Director CURA Independent Management Consultancy Ltd
Social Work England registered, DMS and MA in Management

*Terms of Reference (Catherine Knowles Interim Director of Children's Services 14 April 2021).

Job outline
This is a twenty-day, independent, self-directed, evidence-based review of Herefordshire Children Social Care services - undertaken by two experienced former HMI Marie McGuinness and Gary Lamb (20 April to 13 May 2021).

***Aim of review… to explore the extent to which:**
- the looked after children service works effectively and supports the "welfare of the child' principal (Children's Act 1989) in permanency decision-making
- the child in need, child protection and public law outline service works effectively to protect and promote the rights and well-being of children, young people, and families including how well the support provided to children and families leads to effective change. Can we demonstrate we are improving outcomes for children, evidence of quality practice, use of single practice approach.
- senior leaders and all managers support and promote the consistency of practice through either their direct line management with staff, and/or understanding knowledge of case decision making/causing concern within their service area
- services support a learning approach – balancing accountability and learning.

Reviewers will identify:
- what would need to change to improve services for children and families
- if this is about practice, policy, or systems
- where possible identify if there is a better way of doing this
- through the next steps discussion what needs to be done to implement any proposed changes
- what the challenges are to help senior managers find solutions
- any element of the review that needs immediate action.

The scope of review
- This review is organised using the four areas of Children's Social Care business operation identified in the *Terms of Reference (TOR).

1. Strategic and operational leadership and management
2. Children in Need (CiN), Child Protection (CP) and Public Law Outline (PLO)
3. Children in Care Service including the Independent Review Service, Fostering and Adoption and Care Leavers
4. Family Support, Edge of Care, Independent Advocacy and Family Group Conferencing service offer.

*Terms of Reference (Catherine Knowles Interim Director of Children's Services 14 April 2021).

Methodology

Evaluation criteria

- Findings made by the Reviewers are underpinned by the ILACS Framework (Ofsted 2019).

Fieldwork

- **Document reading, analysis and evaluation… x2 days.**
- Read the Local Authority SEF to provide context. Examine the most recent performance data set used by managers. Examine the most recent performance report considered by the Senior Management Team. Examine the most recent QA summary report.
- Evaluate x3 audits completed in the last six months, chosen at random from across the Children's Social business operation… Family Support, Child in Need/Child Protection and Children in Care… to include x1 judged inadequate, x1 requires improvement and x1 judged good.

Interviews with Social Workers and their managers… case tracking and case sampling x16 days

- This work is conducted remotely with the Reviewers using MS Teams to interview SWs, TMs and Heads of Service… looking at case records using the share screen facility.
- Fieldwork activity is designed to meet the specific needs of the Local Authority based on the *TOR. The constructs pulled through from the *TOR will be considered by the Reviewers for each area investigation as set out below.

The constructs for the investigation

1 Strategic and operational leadership and management… judged inadequate (Ofsted June 2018)

- Consider… organisation structure… lines of decisions making and forums for management oversight to demonstrate grip… outputs on Key Performance Indicators (KPI)… performance management including data capture, retrieval, reporting, scrutiny, challenge and steer… quality assurance, audit arrangements and reporting including the timeliness of actions taken to address identified deficit areas… stability and capacity of the workforce… induction and support for ASYEs, managers span of control and caseloads… supervision including case management oversight and steer on cases… staff survey and management response… the progress of service improvements measured against Ofsted findings in the last full inspection for CiN and CP.

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2 **Children in Need, Child Protection and Public Law Outline… judged Requires Improvement (Ofsted June 2018**)

- Consider… discussion with service manager and case sampling alongside SWs… workforce, welfare and performance… quality of assessments, analysis including capturing history to inform future risk to underpin effective plans for children… threshold… voice of the child… timeliness of PLO, parallel planning, the quality of letters before proceedings… the quality of CP plans so it is made clear to parents how their behaviour is adversely impacting on their child/ren… the effectiveness of direct Social Work practice and decisions for escalation or step down of CiN and CP cases… case recording… core groups including effective partnership working… CiN meetings including effective partnership working… the progress of CiN and CP plans… the frequency and quality of supervision offered to staff including a steer on what needs to be done by when and contingency… the arrangements for case transfer from one worker to another… lessons learned and support for young people experiencing teenage pregnancy.

3 Children in Care Service including the Independent Review Service, Fostering and Adoption and Care Leavers… judged Requires Improvement (Ofsted June 2018)

- Consider… discussion with service manager and case sampling alongside SWs… workforce, welfare and performance… threshold… timeliness… visits… support for young mums including provision and take-up of advocacy and Independent Visitors… Care Plans including 'contact' with parents and extended family… placement matching including placement with siblings… professional curiosity to underpin practice, Social Worker challenge and management oversight on case decisions… drift and delay in permanence planning… case recording including the Social Work rationale for permanence plan decisions through the use of Long Term Fostering, Adoption, Kinship and/or Special Guardianship Orders… the quality of direct work with children including Life Story work… statutory reviews including the voice of the child… the role of the IRO to support effective plans, provide challenge and escalate concerns… use of Section 20 including Children with Disability… the role of the Fostering Service Supervising Social Worker in supporting effective plans for children… the frequency and quality of supervision offered to staff including a steer on what needs to be done by when and contingency… the arrangements for case transfer from one worker to another

4 Family Support, Edge of Care, Independent Advocacy and Family Group Conferencing service offer… judged Requires Improvement (Ofsted June 2018)

- Consider… discussion with service manager and case sampling alongside workers… workforce, welfare and performance… threshold… timeliness… visits… direct work… voice of the child… progress of assessments, plans, reviews… partnership work and management footprint… access to Family Support… provision for the support of young mums… the frequency and quality

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of supervision offered to staff… the prioritisation of Family Support work including management oversight of cases subject to step-up to Children's Social Care (repeat referrals) and those stepped down from Children's Social Care (drift and delay engaging families)… use of screening tools… the effectiveness of edge of care services.

Report of findings and feedback presentation x2 days

- The Reviewers keep and maintain an electronic record of their interviews gathered as part of the fieldwork so there is an audit trail of evidence to support the evaluation of findings. The record of evidence belongs to the Interim Director of Children's Services.
- The report of findings sets out the headlines including any aspects of practice that are considered to be below the line, practice strengths, areas for development and recommendations and/or must do's.
- This underpins a feedback presentation leading to a roundtable next steps discussion to help senior managers update the Local Authority improvement plan.

Programme

Date	**Activity Week One** **Strategic and operational leadership and management**	
	Gary	**Marie**
15/04/21	Half day preparation + half day reading and evaluation to shape the week four programme once the Court Judgement is published (to be confirmed).	Half day reading and evaluation to shape the week four programme once the Court Judgement is published (to be confirmed).
19/04/21	Herefordshire forward documents to Gary (password protected) • Organisation structure including lines of authority for decision making. • Workforce data… most recent reported staff turnover rate, vacancy rate, use of agency staff and the gap, sickness rate, ASYE rate. • Most recent performance data and management summary report.	

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	• x3 audits completed in the last six months chosen at random… x1 good, x1 RI and x1 inadequate. • The most recent QA audit summary report. • Staff survey… report and outcomes. • The most recent improvement plan which stems from Ofsted inspections.	
20/04/21	Gary completes document reading… x2 days • 09.00 Evaluate organisation structure, workforce data, performance data and audit. • 17.00 Gary keeps and maintains the electronic record of evidence and develops KLOE for case tracking.	
21/04/21	Gary completes document reading… x2 days • 09.00 Evaluate organisation structure, workforce data, performance data and audit. • 15.30 Interview with Heads of Service to discuss progress of the improvement plan. • 17.00 Gary keeps and maintains the electronic record of evidence and develops KLOE for case tracking.	
22/04/21	Gary case tracking… • 09.00 KIT meeting with Catherine et-al • 10.00 Interview with SW case judged good (1hr). • 11.30 Interview with SW case judged RI (1hr) • 13.00 Lunch • 14.00 Interview with SW case judged Inadequate (1hr) • 15.15 Gary keeps and maintains the electronic record of evidence. • 16.00 Heads-up meeting with Service Manager.	

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	• 17.00 Gary keeps and maintains the electronic record of evidence.	

Date	Activity Week Two Family Support, Edge of Care, Independent Advocacy and Family Group Conferencing service offer	
	Gary	**Marie**
27/04/21	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with Head of Service (Gary we don't have service managers) to explore workforce, welfare and performance including random case sampling. • 12.30 Lunch. • 13.30 Interview with SW Edge of Care… most recent child under 8yrs admitted into foster care (ICO). • 14.45 Interview with SW Edge of Care… most recent child under 8yrs admitted into care placed at home or with extended family (ICO). • 17.00 Heads-up meeting with Service Manager. • 17.30 Gary keeps and maintains the electronic record of evidence.	
28/04/21	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with worker Family Support… low level risk of CSE (CiN). • 11.15 Interview with worker Family Support… low level risk of CSE (CiN). • 12.30 Lunch. • 13.30 Interview with worker Family Support… child reported missing from home for the first time in the month of February 2021.	

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	• 14.45 Interview with worker Family Support… child reported missing from home 'the child with the most episodes in February 2021.	
29/04/21	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with SW… use of S20 placed in unregulated provision 'the YP accommodated first in January 2021. • 11.15 Interview with SW… use of S20 placed in unregulated provision 'the YP accommodated first in February 2021 • 12.30 Lunch • 13.30 Interview with SW… mop-up. • 14.45 Interview with SW… mop-up. • 17.00 Heads-up meeting with Service Manager. • 17.30 Gary keeps and maintains the electronic record of evidence.	

Date	**Activity Week Three** **Children in Need, Child Protection and Public Law Outline**	
	Gary	**Marie**
04/05/21	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with Service Manager to explore workforce, welfare and performance including random case sampling. • 12.30 Lunch. • 13.30 PLO case sampling interview with worker responsible for the maintenance of the PLO Tracker. • 16.30 Heads-up meeting with Service Manager.	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with SW… case sampling (CiN). • 11.15 Interview with SW… case sampling (CP). • 12.30 Lunch. • 13.30 Interview with SW… case sampling (PLO). • 14.45 Random case sampling using LA laptop (PLO parallel planning). • 16.30 Heads-up meeting with Service Manager. • 17.00 Marie keeps and maintains the electronic record of evidence.

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	• 17.00 Gary keeps and maintains the electronic record of evidence.	
05/05/21	• 09.00 KIT Catherine et-al • 10.00 Interview with SW case sampling letter before proceedings. • 11.15 Interview with SW CP/CiN case sampling step-up/step-down… assessments, plans and progress. • Lunch 12.30 • 13.30 Interview with SW CP/CiN case sampling step-up/step-down… assessments, plans and progress. • 14.45 Interview with SW CP/CiN case sampling partnership work Focus Groups/CiN Meetings • 16.00 Interview with SW case sampling focus on direct work. • 17.15 Heads-up meeting with Service Manager. • 17.30 Gary keeps and maintains the electronic record of evidence.	• 09.00 KIT Catherine et-al • 10.00 Interview with SW case sampling letter before proceedings. • 11.15 Interview with SW CP/CiN case sampling step-up/step-down… assessments, plans and progress. • Lunch 12.30 • 13.30 Interview with SW case sampling CP/CiN step-up/step-down… assessments, plans and progress. • 14.45 Interview with SW CP/CiN case sampling partnership work Focus Groups/CiN Meetings. • 16.00 Random sample cases using LA laptop (direct work) • 17.15 Heads-up meeting with Service Manager. • 17.30 Marie keeps and maintains the electronic record of evidence.
06/05/21	• 09.00 KIT Catherine et-al • 10.00 Interview with SW case sampling Teenage pregnancy • 11.15 Interview with SW case sampling to mop-up. • 12.30 Lunch • 13.30 Interview with SW case sampling to mop-up. • 15.30 Evaluate the evidence and discuss findings with Marie to draw out learning from this part of the investigation.	• 09.00 KIT Catherine et-al • 10.00 Random sample cases using LA laptop to mop-up. • 12.30 lunch • 13.30 Random sample cases using LA laptop to mop-up. • 15.30 Evaluate the evidence and discuss findings with Gary to draw out learning from this part of the investigation. • 16.30 Heads-up meeting with Service Manager.

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	• 16.30 Heads-up meeting with Service Manager.	

Date	Activity Week Four Children in Care Service including the Independent Review Service, Fostering, Adoption and Care Leavers	
	Gary	**Marie**
11/05/21	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with Service Manager to explore workforce, welfare and performance including random case sampling. • 12.30 Lunch. • 13.30 Interview IRO case sampling (ICO). • 14.45 Interview IRO case sampling (ICO). • 17.00 Heads-up meeting with Service Manager. • 17.30 Gary keeps and maintains the electronic record of evidence.	• 09.00 KIT meeting Catherine et-al • 10.00 Interview with IRO service Manager to explore workforce, welfare and performance including random case sampling. • 12.30 Lunch. • 13.30 Random sample cases using LA laptop (ICO). • 17.00 Heads-up meeting with Service Manager. • 17.30 Marie keeps and maintains the electronic record of evidence.
12/05/21	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with SW case sampling support for young mums in care and plans for their child. • 11.15 Interview with SW case sampling Permanence planning Fostering/Adoption/SGO. • 12.30 Lunch • 13.30 Interview with SW case sampling Permanence planning Fostering/Adoption/SGO. • 14.45 Interview with SW case sampling Permanence planning Fostering/Adoption/SGO. • 16.00 Interview with SW case sampling Permanence planning Fostering/Adoption/SGO. • 17.15 Heads-up meeting with Service Manager.	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with SW case sampling support for young mums in care and plans for their child. • 11.15 Interview with SW case sampling Permanence planning Fostering/Adoption/SGO. • 12.30 Lunch • 13.30 Random sample cases using LA laptop (Quality of direct work including Life Story work). • 17.15 Heads-up meeting with Service Manager. • 17.30 Marie keeps and maintains the electronic record of evidence.

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	• 17.30 Gary keeps and maintains the electronic record of evidence.	
13/05/21	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with SW case sampling CWD Team use of S20. • 11.15 Interview with SW case sampling to mop-up. • 12.30 Lunch • 13.30 Interview with SW case sampling to mop-up. • 15.30 Evaluate the evidence and discuss findings with Marie to draw out learning from this part of the investigation. • 16.30 Heads-up meeting with Service Manager. • 17.00 Gary keeps and maintains the electronic record of evidence.	• 09.00 KIT meeting Catherine et-al. • 10.00 Interview with Fostering Supervising SW case sampling joint work with Field SW to support effective permanence plans S20. • 11.15 Random sample cases using LA laptop to mop-up. • 12.30 lunch • 13.30 Random sample cases using LA laptop to mop-up. • 15.30 Evaluate the evidence and discuss findings with Gary to draw out learning from this part of the investigation. • 16.30 Heads-up meeting with Service Manager. • 17.00 Marie keeps and maintains the electronic record of evidence.
14/05/21	• 09.00 Individual work to evaluate the evidence and produce the written report. • 11.00 Joint work with Marie to finalise the report ready for the oral feedback presentation. • 13.00 Lunch. • 14.00 Oral presentation of the report leading to next steps discussion. • 16.00 Finished.	• 09.00 Individual work to evaluate the evidence and produce the written report. • 11.00 Joint work with Gary to finalise the report ready for the oral feedback presentation. • 13.00 Lunch. • 14.00 Oral presentation of the report leading to next steps discussion. • 16.00 Finished.

Gary Lamb and on-behalf of Marie McGuinness
15 April 2021

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Example JD DFE Advisor – Chair of Improvement Board

Note:. This isn't, however, a standard description, and would need to cover improvement needs specific to Herefordshire, but an idea of the potential role.

The adviser will support the authority in continuing to develop and implement robust, realistic and achievable plans to improve its children's social care services, in particular those areas which have been judged by Ofsted to be inadequate or where serious concerns have been identified. The adviser will provide independent scrutiny of the authority's performance and progress and will oversee implementation of the actions needed to improve the service. In particular s/he will:

- provide effective oversight to ensure the pace of improvement is appropriate and that improvements to children's social care are sustainable;
- provide support and advice as necessary when assessing and driving progress, taking account of the weaknesses identified by Ofsted and of other diagnostic work;
- apply his/her expertise and experience to support the DCS and service management team in addressing areas of weakness; this may also include working with practitioners of different levels to:
    - develop competence and improve performance; and
    - help foster a culture of reflection, challenge and support;
- make use of wider contacts to support and advise the council on potential solutions to issues and signpost examples of good practice where possible;
- work closely with any other local authority improvement partners to maximise impact of work and avoid unnecessary duplication;
- engage with the wider partnership – including with the chair of the Improvement Board;
- identify key deliverables and produce a plan detailing the outputs and KPIs which the adviser will meet over the duration of the project, and agree this with DfE within 6 weeks of appointment;
- participate in DfE's formal six monthly reviews of the authority's progress and make a recommendation to the DfE on whether progress has been sufficient; and
- provide six-weekly written reports on the council's progress to the Parliamentary Under Secretary of State for Children and Families, and more frequently if the pace of progress is not sufficient or if the Minister requires it.