Blackpool Safeguarding Children
Multi Agency Safeguarding Arrangements

Child Safeguarding Practice Review
Child A

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Acronyms Used

CSC	Children's Social Care
FSW	Family Support Worker
SW1	The first allocated Social Worker
SW2	The second allocated Social Worker
PGM	Paternal Grandmother
IRO	Independent Reviewing Officer
Cafcass	Child & Family Court Advisory and Support Service
CSPR	Child Safeguarding Practice Review
CIOC	Children in our Care (Looked After Child)
CIN	Child in Need

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1. Reason for the Child Safeguarding Practice Review

1.1 On 10th July 2024 the father of Child A was found guilty of his murder. The circumstances of this case met the statutory criteria, as set out in *Working Together to Safeguard Children, 2023,* for a Child Safeguarding Practice Review (CSPR). Child A had lived in Blackpool. Blackpool Multi-agency Safeguarding Arrangements therefore commissioned this CSPR

2. About Child A and his life story

2.1 Child A was born on 9th July 2021. He is best described by those who knew him the most and cared for him lovingly; his paternal Grandmother (PGM), who has since passed away, and the Foster Carers who cared for Child A for nearly nine months. Child A's paternal Grandmother described her grandson as loving to play and loving to be on his bike. She said he liked to sing at the animals in her cabinet. She described Child A as having an amazing laugh when he laughed out loud. She enjoyed teaching him to count and he would count the buttons on her cardigan. Child A loved his food, he loved being outside, loved the park and loved watching television.

2.2 Child A's Foster Carers described him as "a delight" who would "light up any room with his smile and his chuckle". They said he loved bathtime and was a very sensory child, mesmerised by light and crinkle toys.

2.3 Child A was white British, with blue eyes and blond hair.

2.4 Child A had been developmentally delayed but he thrived in the care of his Foster Carers and then initially with the Father. Child A also had the love and support and support of his paternal Grandmother and other family members.

2.5 For the first ten months of his life Child A lived with his mother but he was then taken into care, along with his half-siblings, as ordered by the court, because his mother was deemed unable to care for her children.

2.6 The Local Authority had made an application to the court and on 19th May 2022 an interim care order was granted by the court and Child A was taken into the care of the Local Authority. He was placed with Foster Carers with whom he remained for nearly nine months. Just after Child A was taken into care the Local Authority tracked down his father (the Father). A DNA test confirmed this to be the case and the Father said he would like Child A to live with him.

2.7 Between 14th July 2022 and 2nd February 2023 Child A had 60 supervised sessions with the Father in the community. Each of the 60 sessions was held in the same Family Hub. The community assessment was positive and on 6th February 2023 Child A and the Father were placed in a family residential assessment setting, for a further three and a half months of assessment. Child A and the Father stayed in the residential setting, with increasing unsupervised time, both in the setting and in the community, because of how positive the ongoing assessment was.

2.8 The outcomes of these assessments, in the community and in the residential setting were extremely positive. Child A's development thrived and there was consistent evidence of Child A building a positive and strong attachment to the Father, who was rising to the challenge of caring for his son extremely well. Child A's face would light up when he saw the Father and he would hold his arms out, wanting to be lifted up by the Father. Child A would also respond with delight when they played. As a result of this the Father was initially allowed one hour a day alone with Child A, which then progressed to 4 hours a day alone with Child A, whilst in the residential setting.

2.9 On 18th May 2023 Child A and the Father moved to a privately rented flat. A Home Placement Agreement was put in place setting out that this was to be a time for further assessment of the Father by CSC and his ability to care for Child A, leading up to the final court hearing on 10 July 2023. The Home Placement Agreement also set out the support package that would be provided to the Father.

2.10 The FSW would visit every week, and a SW every four weeks. The local authority would provide funding for Child A to go to a nursery of the Father's choice two afternoons a week. The Father was signposted to and welcomed at another local playgroup in a church hall opposite his house.

2.11 The Father was also supported by Dad Matters, an organisation that sits under Home-Start, which provides support to fathers. They assisted the Father in providing some goods that the Father needed for his flat.

2.12 The PGM also helped until she became unwell. She said she went round nearly every day in May and June to help look after Child A. She would also look after Child A overnight so the Father could go out but in July, she became unwell and was not able to help the Father anymore. Child A also spent time with the Father and other family members

2.13 Child A was taken to nursery and to playgroup by the Father sporadically.

2.14 The 28th of July was the last time any professional saw Child A alive. The FSW saw him briefly; Child A was in his buggy and the Father said he was taking him to see the PGM. The FSW commented that Child A look tired. The Father said he had been up since 5 am. This was the pre-planned final visit of the FSW, whose support had been time limited.

2.15 On the 19th of August 2023 Child A's father made a call to the emergency services. Paramedics attended and Child A was taken to hospital where he was intubated and ventilated.

2.16 On the 21st of August 2023 the ventilator was switched off and Child A passed away.

2.17 What is without question is the commitment the Father demonstrated to Child A, up until towards the end of July 2023. It is the view of all the professionals that worked with the Father and Child A that there was an ever-increasing bond between Child A and the Father, and the Father consistently demonstrated his love, commitment and attunement to

Child A, up to that point. Many of the professionals spoke of the loving bond between the two and how Child A's face would light up when the Father came into the room.

2.18 Our conclusion, as a review team is, we have no doubt that, up until the end of July, which is when there is evidence of the Father starting to withdraw from services, he had every intention of being a good father and doing right by his son and was earnest and genuine in trying to achieve that.

3. Scope of the Review

3.1 Period under Review

3.1.1 The timeframe for the CSPR was agreed as being from 30th May 2022, the date it was established the Father was Child A's father and he said he would like to care for Child A, to 19th August 2023, the date of Child A was admitted to hospital having sustained the injuries that led to his death.

Chronology

Date	Event
9.7.21	Child A born
19.5.22	Child A became a child in care through an interim care order and placed with Foster Carers
30.5.22	It was established the Father was Child A's biological father
14.7.22-2.2.23	60 supervised sessions took place for Child A and the Father in a community setting
6.2.23	Child A and the Father placed in a family residential assessment setting. There until 18.5.23.
28.4.23	Family Group Conference (called Family & Friends Together in Blackpool) held
18.5.23	Child A and the Father moved from residential assessment unit to a privately rented flat
9.6.23	Last time the Father took Child A to toddler group
29.6.23	Child A was taken to hospital with fever and fitting. Discharged with no safeguarding concerns
3.7.23	Last time the Father took Child A to nursery
6.7.23	Child A seen by his health visitor for six-monthly child in care health assessment. Child A was developing well.
11.7.23	Child A and the Father seen by Cafcass Guardian at home
14.7.23	A Child Arrangement Order and Supervision Order made by the court with Child A to remain in the full-time care of the Father. Child A and the Father seen by the FSW at home
28.7.23	FSW attempted home visit. Child A, seen in his buggy, observed to look tired. The Father said they were on their way out. SW1 also visited that day but the Father said Child A was asleep and he was not seen
3.8.23	SW1 and the newly allocated social worker (SW2) attempted to see Child A but were told by the Father that Child A was out with his maternal Grandmother

8.8.23	The SW2 Contacted the Father to discuss why he had not taken Child A to his occupational therapy appointment and made an appointment to see Child A on 10th August. The Father then contacted SW2 and asked for that visit to be rearranged saying there had been a death in the family
13.8.23	PGM has a stroke and is admitted to hospital, where she remains until 23.8.23, having been unwell since July 2023
19.8.23	Child A was taken to hospital with serious injuries. He was intubated and ventilated. The Father was arrested on a charge of Grievous Bodily Harm with Intent and taken into custody. Bail refused
21.8.23	Child A's ventilator was switched off and Child A passed away
31.8.23	The Father, being held on remand, was then arrested and charged with murder and child cruelty
10.7.24	Father convicted of murder

4. Key Practice Episodes During the Period Under Review

Date	Event
14.7.23-2.2.23	The Father attending over 60 supervised sessions with Child A in a community setting
6.2.23-18.5.23	The Father and Child A residing in a family residential assessment setting for 14 ½ weeks
18.5.23	Child A and the Father moving to a privately rented flat

5. Family Members and Carers' Contribution to the CSPR

5.1 It is essential that agencies, wherever possible, learn from families and their experience of services, and therefore involving family members and carers in a CSPR is an essential component, wherever possible.

5.2 Child A's Mother had no care of Child A, or contact with him, during the period under review. She was invited to contribute to the CSPR but did not engage.

5.3 We were unable to speak to Child A's paternal Grandmother because she had passed away.

5.4 The Foster Carers who cared for Child A from May 2022 to February 2023 were invited to contribute to this CSPR but were unable to.

5.5 The Father contributed to the CSPR. His perspective is fundamental to the CSPR, and his voice is important, but the CSPR is also mindful that Child A suffered and died at the hands of his father. His own contribution to the CSPR is therefore included as an appendix, rather than being front and centre of the report, which is what would happen if the primary carer of the subject child of the CSPR was not the person responsible for their death.

5.6 Having had input in the review from frontline professionals working with the Father, and having interviewed the Father, the review team has also concluded that the Father did

have genuine relationships with professionals, until he started to become overwhelmed by the pressure of his responsibilities; caring for his son, running a home, with all that entails, meeting with different professionals, attending different groups and taking Child A to nursery. When these responsibilities began to exceed his capacity, from late July, he started withdrawing from services.

6. Review Questions and Key Lines of Enquiry

- How effective are parenting assessment processes?
- How realistic are professionals' expectations of an individual's ability to parent when they have never had any involvement with a child?
- Do services have a good enough understanding of the role of the extended family in safeguarding and protecting children
- Are Child in our Care/Child in Need processes sufficiently robust and do plans align effectively?
- Are there barriers to a family being honest with services?

7. Analysis of Practice

7.1 General Findings

7.1.1 There is no evidence indicating that sex, race, ethnicity, social and economic background or other characteristics affected the experiences of professionals involved. While it remains significantly less common for a father or single man to express an interest in caring for a child – compared to mothers, single women, or couples – no evidence suggests this influenced the decision-making process. The professionals working with the Father supported his efforts based on his interactions with his son, his willingness to learn effective parenting skills, and his engagement with services and available support. Observing Child A's positive development and the strengthening bond between father and child were key factors underpinning their conclusions and subsequent recommendations.

7.1.2 In terms of Child A and the Father, there is no evidence that intersectionality affected their lived experience. The Father misunderstood how high the threshold is for a child being removed from their parents' care, but that is true across all socio-economic groups because of misinformation from those who have had children removed from their care, and inaccurate media reporting of cases and the "reasons" given for what a child was removed.

7.1.3 The relevant statutory checks were done in relation to the Father. He was known to the police for a reprimand for assault when he was a child, an allegation of assault by a taxi driver, on which there was insufficient evidence to prosecute, and two allegations from the Mother of Child A, which were not pursued. The Father was not known to any other agency, including CSC during his childhood.

7.1.4 The CSPR has no comment to make on the actions of Cafcass in this case. In making their recommendation to the court, they followed their own procedures and found, as all the other agencies who assessed the Father and Child A did, that Child A should go and live with the Father in the community. The CSPR considers it entirely reasonable that that was their conclusion, along with all the other agencies.

7.1.5 There was some record keeping, in terms of omissions, that was not in line with expected practice standards across a number of agencies. This did not impact on the case, nor the outcome for Child A. Each individual agency has noted and addressed the learning in this area.

7.1.6 From when Child A and the Father went to live in the community Child A was seen with bruising on four occasions. On 20th May 2023 the FSW observed a small bruise on his forehead and questioned the Father about it. The Father's response was that Child A often bumped into things, and he was quite unsteady on his feet. This was observed by the FSW during the visit; Child A was seen to "tumble/overbalance" more than half a dozen times" during the visit.

7.1.7 On 26th May 2023 at the Home-Start toddler group Child A was seen to have a "small, faded bruise" on his head. The Father was asked how this had happened and, again, the Father said Child A was unsteady on his feet and, again, this was observed to be the case in the group.

7.1.8 On 31st May 2023 the FSW observed "bruises on Child A's forehead that appear to be fading" The Father was asked about these and said they were from the "multiple stumbles" Child A had had the week before.

7.1.9 On all of the occasions set out above, when a bruise was observed, practitioners followed expected practice by asking about the bruise. The conclusion of the CSPR is that practitioners' acceptance of the Father's explanation for the bruising on each occasion was reasonable. Child A was known to have developmental delay and the unsteadiness on his feet aligned with his development stage. Child A was also observed by professionals as being unsteady on his feet on numerous occasions and the bruises were on an exposed and prominent part of the body, which is a natural place for accidental bruising to occur.

7.1.10 The only time practitioners did not follow expected practice was when Child A was taken to hospital, having suffered a febrile convulsion, on 29th June 2023. It was noted that Child A had an "old, mild black bruise spot" on his forehead. The Father was not asked about this, which was the expected practice.

7.1.11 Finally, whilst safeguarding is everyone's responsibility, CSC was the lead agency in this case. Other agencies take their lead from CSC. The priority for CSC will always be the children considered most vulnerable and the children at greatest risk of significant harm. i.e. child protection. Statutory visiting requirements were met but there were no concerns about the Father's care of Child A before or after moving into the community. Child A sometimes appeared tired or had minor bruises, common for children with developmental

delays and at Child A's developmental stage but nothing more than that. This was not a child about whom there were concerns and therefore it is entirely reasonable that the professionals supporting the family, whilst meeting statutory requirements, did not see a need to increase the number of visits, and level of oversight of Child A and his father.

7.2 How effective are parenting assessment processes?

7.2.1 The 'family time' community assessment

7.2.2 As stated previously, this assessment took place over 60 sessions over a period of just under seven months. Of the 60 sessions, the Father only missed three of them. It was the same Family Time Worker for almost every session, and she observed a growing bond developing between Child A and the Father, and an increasing delight in Child A when he saw the Father. The Family Time Worker wrote of the calmness of the sessions, Child A loving the emotional warmth provided by the Father. The constant encouragement from the Father and Child A's responses; babbling away, baby sounds, smiles and laughter and Child A opening and closing his hand to say goodbye.

7.2.3 She wrote of Child A lifting his arms to the Father saying, "up up". Child A starting to form words and the Father had such pride in that. Child A laughing so much he got hiccups.

7.2.4 There were many examples of the Father learning from the Family Time Worker and following her guidance. The Father learning how to care for Child A, checking his nappy and changing it, moving any potential hazards, learning to feed Child A.

7.2.5 The Family Time Worker observed the growing love she could see developing between the two.

7.2.6 There was never a concern about the Father. He was committed and conscientious and evidenced his learning. He was attentive, gentle and caring and Child A blossomed from the relationship with the Father.

7.2.7 Analysis of practice and conclusion

7.2.8 This was a highly affective assessment that achieved everything an assessment of this kind should. It was a strength that there was one Family Time Worker for most of the sessions. It was good for Child A not to have lots of different people all the time and the Father built a relationship with her. He trusted her and learnt from her. The CSPR highlights this as good practice.

7.2.9 The community 'family time' assessment was highly effective. The CSPR has no recommendation to make for Blackpool to improve how these assessments are undertaken.

7.2.10 The Residential Assessment

7.2.11 It is the responsibility of the local authority who is placing a child and their parent/s

in a residential assessment to ensure the assessment covers everything that needs to be covered.

7.2.12 During the three-and-a-half months Child A and the Father were in the residential setting there were a few concerns about the Father, the majority of which were minor concerns often found in those new to parenting. There were one or two occasions when the Father was questioned about something and he snapped back and was rude and defensive, towards the end of their time in the setting. At times he could be very defensive and did take any challenge as criticism, despite constant reassurance. On one occasion the Father handled Child A roughly. All of this formed part of the assessment but, based on the evidence, the CSPR agrees with the providers of the residential assessment that the Father gave every indication he would be able to provide good enough parenting for his son, which is the standard by which the Family Court assesses an individual's ability to parent.

7.2.13 As part of the assessment the Father received counselling in the residential setting and also did a 12-week parenting and direct work programme, which included ICON. The ICON programme is a programme based on prevention of head trauma and provides help to parents who care for babies to cope with crying.[1]

7.2.14 The Father spoke to the reviewers about his frustration in the setting sometimes. He said it got to him; the constantly being watched, as well as the fear that one small mistake could lead to him losing his son.

7.2.15 Again, with the benefit of hindsight one could hypothesise these were the early signs of what was to come but one could equally surmise that the pressure of being constantly watched, questioned and judged was just too much, at times, particularly as time went on. For any individual that constant surveillance and judgement would be incredibly stressful, with a camera even in the bedroom, even though the camera faced Child A's cot and not the Father's bed. (To be clear, it is an Ofsted requirement for residential assessment settings to have cameras, which is why the setting had them). The Father was also living in a communal home, with lots of other people, and was learning how to care for a toddler. His living situation could not have been more different from how he had lived previously, in all his adult life.

7.2.16 Overall, Child A thrived in the Father's care in the residential setting, and the Father consistently demonstrated his commitment to his son, his desire to learn and his love for his son.

7.2.17 The residential setting challenged CSC on the speed at which they allowed the Father to take Child A out, unsupervised – for an hour a day from just over a week from moving into the setting and for four hours a day from just after three weeks Child A and the Father had been in the setting. It was right of the residential setting to challenge if they thought it too fast but, in this case, the review team has not found that to be a concern,

[1] https://iconcope.org/about/

given the positive progress that continued to be made until the end of July. There is lots of evidence that the Father was using the time to continue to meet Child A's needs; they spent lots of time in parks, in playgrounds, interacting with other children. The Father used the time to build the bond with his son. Nothing came to light, either at the time or in the subsequent criminal trial, that the Father used that unsupervised time in any other way.

7.2.18 The conclusion of the residential assessment was that Child A was seen to thrive in the Father's care.

"Child A is observed to have a lovely bond with the Father that continues to develop daily. The Father was proactive and happy to take staff advice on board and utilises this. The Father has created a lovely routine for Child A. Bath and bedtime are completed with confidence and are done so safely and lovingly".

"The Father continues to talk about Child A with love and pride and appears extremely proud of him. Child A has a clear, positive bond with the Father, it has been lovely to see the relationship build and it continues to do so. Whenever the Father comes into the room Child A squeals with excitement and raises his arms for his daddy to pick him up saying up, up".

"The Father's confidence has grown massively in his responses to Child A and it is evident from observations how proud he is of their relationship and the hard work he has put in to ensure he has a strong bond with Child A. Child A is a very happy and content little boy. The Father is in tune with Child A's needs. The developing bond is beautiful to see, and both are attuned to each other. The child's progress, in relation to his development, has been significant since arriving. It is important to recognise this is down to the Father's consistent care and hard work".

7.2.19 It was an extremely positive parenting assessment, but the setting did also recognise, and highlight, the vulnerability of the Father, and therefore Child A, when they moved into their own home in the community.

7.2.20 From the assessment:

"It is important to recognise the Father's support network is extremely limited and he will need support to establish himself back into the community"

"It is important the local authority considers additional support for the Father and Child A due to a limited support network".

"Child A and the Father have positive role models in the residential setting staff but that would not be long-term, and it is important that the Father continues to ensure he is consistent with his emotional responses to ensure Child A's current and developing sense of security is not affected".

7.2.21 Finally, in the assessment summary "Although this is an extremely positive assessment, it is important to recognise the Father's lack of family support and isolation.

The Father is a first-time father which, prior to the placement at the residential setting, has been untested. Although he has done a fantastic job in meeting Child A's daily needs, stimulating, playing, and ensuring his developmental needs are a priority, this may be difficult to maintain out in the community without an additional support package to ensure the outcome remains positive".

7.2.22 Analysis of practice and conclusion

7.2.23 The CSPR finds the residential assessment to be thorough and comprehensive, and the setting raised any concerns they did have with CSC contemporaneously. The assessment highlighted, very clearly, where it considered potential risks to be when Child A and the Father went to live in the community, on their own, and the vulnerability of the Father and therefore Child A, in those circumstances.

7.2.24 The CSPR has no specific recommendation to make to improve how the setting itself undertakes assessments, based on this case. The only note would be that the setting challenges CSC more robustly, and uses the multi-agency escalation policy, if necessary, if they do not agree with decisions made by CSC, and the view of the setting is CSC is moving things forward too quickly.

Recommendation One

In each relevant case, consideration should be given as to whether an "in-home" assessment would be more effective in assessing parents' ability to cope alone, rather than a residential assessment

Additional comments

A residential assessment has its place, with some families, but could never begin to replicate the stresses and challenges of parenting in the community; with reduced support and oversight, and parents being responsible for everything. A residential assessment can only assess a parent's ability to parent, with full support and limited other responsibilities and is a starting point for the assessment of whether a parent is able to care for their child in the community.

An "in-home" assessment, with initial support slowly being reduced, to test parents' ability to cope alone in the community, would give a much truer reflection of the ability to parent.

7.2.25 The Move to Independent Living

7.2.26 The local authority parenting assessment prepared for the court in December 2022 acknowledged that should the Father have Child A in his care "he will need a much better develop support structure around him". It also said the local authority will "continue to support him (the Father) and the PGM and other family members have also indicated they would support him to achieve and sustain the changes required".

7.2.27 The local authority took several steps ahead of the move by the Father and Child A to independent living, to try to mitigate risk, including holding a Family Group Conference on 28th April 2023.

7.2.28 The purpose of the Family Group Conference was to develop a Family Plan "to identify a wraparound support network for the Father and Child A when they move into the community". The Conference was attended by a number of family members, including the PGM.

7.2.29 As part of the plan the following was agreed:

- All the family members offered to look after Child A, at short notice, if the Father ever needed some time to himself
- The family agreed which family members the Father should turn to should he require parenting advice
- One family member offered to help "toddler-proof" the home
- Several family members were identified and listed as being able to help the Father with day-to-day parenting tasks
- Several family members offered to help the Father with the move
- The availability of specific family members was listed in the Family Plan and under the PGM it said she could visit any time
- Several family members said they could support the Father with taking Child A to any medical appointments
- Several family members said they would be willing to be assessed as contingent carers, if the Father was unable to care for Child A, due to illness, for example

7.2.30 It was agreed that the PGM would attend the Family Plan review at a meeting approximately four weeks after the FGC, which she did.

7.2.31 When the Father moved into his home with Child A the ongoing assessment was about how Child A was doing, how the Father was coping: how clean and tidy he kept the home, which he did and was food in the fridge for Child A, which there was. Child A seemed very happy with the Father and continued to respond very positively to him, as he had in the previous two settings, with huge smiles.

7.2.32 The Father was told about places he could go with his son; play groups, parks etc. He was given assistance with sorting out council tax and amenity bills.

7.2.33 Analysis of practice and conclusion

7.2.34 The focus on the 'family time' community assessment and then the residential assessment was on the Father's ability to parent Child A; to feed him, keep him clean, stimulate him, keep him safe and show him love and warmth, which is what those assessments should have been.

7.2.35 The focus of the assessment when the Father and Child A moved to independent

living was on how the Father was coping in the community, and how Child A was developing/thriving which, again, is what the assessment should have been. The issue was the Father's lack of honesty with professionals, in terms of how he was coping, which is covered in the next section of the report.

7.2.36 The recommendations on this stage of the assessment process will also be covered in the next section of the report.

7.3 How realistic are professionals' expectations of an individual's ability to parent, when they have never had any involvement with a child?

7.3.1 It is important to highlight that women and girls have babies every single day and go home, sometimes alone, and care for them perfectly well. There are also estimated to be two million single parent households in the UK, 11% of which are single fathers[2]. The majority of those parents will care for their children perfectly well too.

7.3.2 It is a common finding from CSPRs that family history has not been sufficiently taken into account. Context is always relevant, and in this case, this was a man who had lived almost entirely off grid until he was 30. A man who had never rented or owned his own home and had therefore never run a home. A man who had never had a bank account, never sought benefits and had never been registered with a GP as an adult.

7.3.3 The transition from that lifestyle to living with your child for the first time but in a residential unit, where you are surrounded by people who offer help, support and constant encouragement would be considerable. However, in that environment the evening meal was provided by the setting, and everyone would eat together, swapping stories, supporting each other and commiserating with each other about the things that were testing that day. The Father spoke of enjoying that camaraderie and support at the end of each day.

7.3.4 Then, as a first-time parent the Father went from that environment to living completely alone, with all that 24/7 support from the staff, and from the other residents gone. That is a momentously different living situation.

7.3.5 When Father and Child A moved into the flat on 18th May 2023, they moved there together. That was the right way to do it for Child A but for the Father he had no time to learn how to be an adult running a home before he was fully responsible for a child.

7.3.6 The Home Placement Agreement developed by CSC was put in place for the day the move happened. The agreement referenced a number of professionals including the housing officer, the health visitor and a tenancy support worker. The Agreement, written by SW1 stated "this means I can ensure there are a number of professionals that see you and your daddy on a regular basis once you move home with your daddy". It goes on to

[2] https://www.gingerbread.org.uk/our-work/single-parents-facts-and-figures/

say" there are also family members who have agreed to be part of your support plan, including your grandmother, uncle and aunt. Professionals and family members will need to visit you at home on a regular basis to see that you're okay and ask your daddy if he needs help or support with anything". The Home Placement Agreement was not shared with the other agencies involved, which would be expected practice.

7.3.7 As part of the Agreement the Father had to agree to a number of points, including assessments and "visits, both announced and unannounced, which would happen as a minimum once a fortnight but will be more frequent". The agreement goes on to say these visits could be during office hours and out of hours. The visits would be from SW2, the FSW but also duty social workers on other days. The Father also had to agree to keep in touch with the SW2 and attend all meetings arranged by the local authority and Child A would attend all meetings with professionals, including health checks for children in care. Child A was under the Child Development Centre at the time and also needed to visit a specialist dentist.

7.3.8 The agreement also set out that it was the Father's responsibility to make contact with the carers of child A's siblings and ensure he had contact with his siblings at least once a week.

7.3.9 The Father had to agree to "always be contactable and having a working mobile and keeping all services aware of the number were to change".

7.3.10 Over the next few weeks the Father had to set up gas and electricity payments, register himself and Child A with a GP, register for council tax, and do all the other things new homeowners have to do, none of which he had ever done in his life. He did have the support of the FSW but that was a weekly visit. He was doing all of this while caring for a two-year-old and he did not have a fridge or a freezer until 31st May. He told the FSW that he was going to his Mother's house to feed Child A up until that time. He said it was good because it meant Child A spent lots of time with his Grandmother. It also meant the Father had the constant support and company of his Mother, who lived just around the corner.

7.3.11 Many parents face similar challenges and do not harm their children. The point here is that, in this case, these normal life challenges clearly exceeded the Father's capacity, which he hid from professionals. The Father gave no indication of finding things hard, for reasons set out in 7.3.18, other than a defensiveness when challenged on matters.

7.3.12 From the beginning of July, the PGM's health was deteriorating to the point that she had a stroke on 13th August 2023, when she was hospitalised. She remained in hospital until after Child A's death. She had been a significant support to the Father in the initial stages of Child A living with the Father and when she became unwell and was unable to offer that support, that impacted on the Father and his ability to care for and provide for his son.

7.3.13 Agencies have responsibilities to fulfill their agency's duties, which the professionals involved with Child A and his father were doing. The Father told the CSPR he felt overwhelmed by his new life. In his words, he was "inundated" with telephone calls and

visits from professionals, and he was expected to take Child A to various health appointments and also to nursery and also to the toddler group and he knew he was still being constantly assessed. He was also told that some of the visits from CSC would be unannounced and some might be outside of office hours.

The Father told the review the pressure was enormous.

7.3.14 This is what that looked like:

Date	Event
18.5.23	Father and Child A move to own home. Visit by the SW. PGM there
19.5.23	Call from SW1. The Father telephoned the Dad Matter worker, for a chat
20.5.23	Planned visit from FSW
23.5.23	Call from Dads Matter worker
24.5.23	Planned visit from FSW, who recommended a range of groups the Father could take Child A to and also asked the Father about the dental appointment needed for Child A. Forms completed to register with GP. The father said he still had to register accounts with gas and electricity companies. Call from Dads Matter worker
25.5.23	CIOC Review at the family home. PGM there. Dad's Matter worker telephoned the Father about delivery of the white goods they had sourced for him
26.5.23	The Father took Child A to toddler group. Call from Dads Matter worker
30.5.23	Call from FSW that the Father did not answer or respond to. Call from FGC coordinator to confirm all is going well and their involvement would end. Call from health visitor, no response.
31.5.23	Call from FSW that the Father did not answer or respond to, An unannounced visit from FSW. The Father had set up the gas and electricity. FSW asked about setting up the nursery, which the Father had done. They also discussed council tax
1.6.23	The Father registered himself and Child A with GP
5.6.23	Call from Dads Matter worker. The Father took Child A to pre-visit at the nursery
7.6.23	The Father took Child A to nursery
8.6.23	Planned visit from FSW. PGM there too. Call from Dads Matter worker
9.6.23	Planned visit by SW1. The Father took Child A to toddler group
12.6.23	The Father took Child A to nursery
13.6.23	Planned visit from FSW. PGM there too
14.6.23	Planned visit by SW1
15.6.23	Text from Dads Matter worker confirming the Father would take Child A to the toddler group that morning. The Father said they would attend but did not.

16.6.23	The Father failed to take Child A to nursery. He said Child A had a chest infection. Call from Dads Matter worker, because they had not attended toddler group the previous day
19.6.23	The Father failed to take Child A to nursery and did not respond to a call from the nursery
20.6.23	Call from FSW to arrange visit
22.6.23	Planned visit from FSW. The FSW talked about the Father taking Child A to playgroup and going to a dads group and Child A was still under the Child Development Centre for developmental delay and there was going to be a referral to the nursery nurse, who would then complete the two-year visit. All benefit and council tax forms completed. The Father sent letter about physiotherapy appointment on 10.7 Planned visit by health visitor. PGM there too.
23.6.23	The Father failed to take Child A to nursery. When contacted by them, he said Child A still had a chest infection
26.6.23	The Father took Child A to nursery
27.6.23	Text exchange with Dads Matter worker about how things were, and the next toddler group
28.6.23	Planned visit by SW1
29.6.23	Planned visit from FSW. Child A looked tired. Father said he had forgotten and was on his way out. FSW provided him with a list of community activities, and three different family hubs, for parents and children to do over the summer. Child A was later taken to hospital with fever and fitting. PGM was also in attendance. Discharged with no identified safeguarding concerns
30.6.23	The Father failed to take Child A to nursery. Call from nursery. No response. Call from Dads Matter worker because the Father failed to take Child A to the toddler group the previous day. The Father said they had had a very busy day. He did not mention the seizure
3.7.23	Call from FSW to arrange next visit. The Father took Child A to nursery
6.7.23	Planned visit from FSW. Noted Child A looked tired
7.7.23	The Father failed to take Child A to nursery. Call from nursery. No response.
10.7.23	The Father failed to take Child A to nursery. Call from nursery. No response. Nursery informed CSC Child A had only been taken twice since 12.6
11.7.23	Planned visit by Cafcass Guardian. Text from FSW
12.7.23	Text from FSW
13.7.23	Call from FSW
14.7.23	Final court hearing. Planned visit from FSW. The Father failed to take Child A to nursery. Call from nursery. No response. This was the last day of term for the nursery.
17.7.23	The Father failed to take Child A to physiotherapy appointment. Letter sent. SW1 informed

24.7.23	Call from FSW that the Father did not answer or respond to
25.7.23	Call from FSW to arrange final visit. The Father did not answer or respond to
26.7.23	Call from FSW that the Father did not answer or respond to. Also on that day, from the criminal trial, the Father sent a text to a friend saying “everyone is doing my f***ing nut in and I’ve got f****ing social and everyone else f***ing coming round”
28.7.23	FSW made unannounced visit. Child A seen, briefly, in his buggy as the Father said they were on their way out. Separately, SW1 made unannounced visit, as unable to reach the Father by telephone. Child A not seen by SW1. The father said he was asleep.
30.7.23	The Father was contacted via text message by the Dads Matter worker, trying to arrange a meet up
31.7.23	The Father texted again by the Dads Matter worker, trying to arrange meet up
1.8.23	The Father not at home when Dads Matter worker attempted a home visit, having not heard from the Father
3.8.23	Planned visit by SW1 and the SW2 together. Child A was not seen, the Father said he was with PGM
7.8.23	Child A discharged from physiotherapy/occupational therapy service due to not being brought to an occupational therapy appointment. Letter sent to the Father. The service informed CSC
8.8.23	The SW telephoned the Father to ask why the Father had not taken Child A to the occupational therapy appointment. The SW2 also telephoned the Father to confirm the next arranged visit on 10.8. The Father said it was not a good week; there had been a loss in the family. SW2 said she was on leave the next week and would telephone on her return
13.8.23	PGM had a stroke and was hospitalised
14.8.23	Call from the Dads Matter worker. The Father said, “all going well”. He did not mention PGM’s stroke the previous day
15.8.23	Unannounced visit by Dads Matter worker. No response
17.8.23	Unannounced visit by Dads Matter worker. No response

7.3.15 The Father was also expected to arrange for Child A to see his half-siblings every week, as set out in the Home Placement Agreement. He had to do that with their carers. This was noted as being quite challenging, by the residential setting, when Father and Child A were there. “He made numerous attempts to organise contact in the community with Child A's previous carers and half-siblings however this has not gone ahead due to the Foster Carers commitments". The Foster Carers were, understandably, very busy with their own schedule but this was another weekly task the Father was expected to undertake and so something else he could “fail”.

7.3.16 In the Father’s contribution to the CSPR he spoke of the constant pressure of being assessed and the feeling that he was being watched at all times. It had started from the first supervised session with Child A, in the community and, for him, there was no end in sight of being assessed. He spoke of the stress of being continually assessed. Following the

Child in our Care review on 25th May the IRO had asked SW2 about the child and family assessment which needed to be completed, so there was more assessing.

7.3.17 After the first day, and the initial excitement of having his own place, the Father described how overwhelming it was; being responsible for everything and caring for Child A by himself. He had had very little experience with children before child A came into his life. He said that when he could start to see that he could manage, it was alright. He said he did things as he had done them in the residential setting. He said he had to keep all the training he had had in his head in order to keep things running at home.

7.3.18 The reviewers asked the Father if he ever wavered; did he ever talk to professionals when he was struggling? He said he did have thoughts, especially about being a single parent, and his Mother was not healthy; the support from his family was not as strong as he would have liked it to be, because of his Mother's ill health and his other family members were, understandably, busy with their own lives. The Father said he did not think he could tell professionals how he was feeling. He said he was scared to have those conversations because he thought it would put doubt in their minds. He remembered being told that being a parent is the hardest thing, but he would respond "I feel I've got this". The Father said he felt that he needed to find a way to look after his son; Child A's Mother had let him down and he did not want Child A to grow up thinking his father had let him down too.

7.3.19 The Father spoke of the pressure and said that was the only thing he would change when he and Child A were living alone together. He said "I felt too much pressure off everyone; it was too overwhelming to cope with. I was being told to go to different groups. I felt too obligated. I wanted a relaxing time after being in the residential setting. The last thing I needed was more pressure. I understand it was good for my son's mental growth, but that was what nursery was for. With nursery, shopping, bills, everything was building. I could not take it anymore".

7.3.20 When asked where the pressure was coming from the Father said that the pressure was not "verbalised pressure. Maybe I felt this emotionally and I put myself under this pressure. I wanted 1:1 time with my son with nobody around. After the residential setting, I wanted to breathe and relax. I felt like 'let me relax a little bit'. I needed a bit of time to find my own feet. Some people might be able to do that as a single parent. I had little support from my family. I wish I had told someone. In my head, I was screaming out that I was struggling. This isn't what I wished for my son. I wanted him to have a different life".

7.3.21 The Father described choosing the nursery that he did, which was a half-hour walk away from their flat. He said he chose that nursery because it was in a better area than where they lived and he wanted a better life for his son. "I wanted him to have a good life and education and not get in touch with bad people like I had – that was my plan". He said that sometimes it was "too tiring to get to nursery. It was like a catch 22 – I wanted better for him, but it was too far from the flat".

7.3.22 Analysis and Conclusion

7.3.23 Agencies working in safeguarding and child protection have to fulfil their duties. The only way to assess a parent's ability to care for their child is to see the parent and the child. Looking at the schedule above, with the benefit of hindsight, one could say the schedule the Father was expected to adhere to was an impossible ask, for someone with his history.

7.3.24 From the timetable above one can see the Father started being dishonest with professionals and disengaging from the middle of July, which was around the time his Mother became ill. The Final Hearing happened then too, although the Father did not mention that as being significant.

7.3.25 The Father told the CSPR he was overwhelmed by the expectations. It was also a vicious cycle. He missed things and then was then repeatedly contacted by professionals, who were individually, and quite rightly, following up, which then caused the Father more stress.

7.3.26 Responsibility lay with the Father to share how he was feeling, but there is learning for services too.

Recommendation Two

Plans and assessment frameworks should have built into them consideration as to exactly what the expectations of parents are and whether those expectations are realistic and achievable

Additional comments

All parents struggle. Parenting for any parent is hugely challenging at times. Even if there are two parents, in a loving and supportive relationship, where responsibilities are shared, there are no worries about money, and the family is surrounded with love and support. Parental struggles are entirely natural.

In this case there was a parent who always said everything was fine and that was taken at face value because Child A was seen to be thriving.

7.4 Do services have a good enough understanding of the role of the extended family in safeguarding and protecting children?

7.4.1 As stated previously, context is important. In February 2023 as part of its children's social care implementation strategy, *Stable Homes Built on Love*[3], the government of the

[3] https://www.gov.uk/government/consultations/childrens-social-care-stable-homes-built-on-love

time announced the Families First for Children Pathfinder Programme[4]. One of the four key elements of the programme was "greater use of family networks, involving the wider family in decision-making at an earlier stage throughout the system". The importance of the wider family network in strengthening families, was highlighted. It was becoming well-recognised that if services worked 'with' families rather than doing things 'to' them and brought in wider family networks, better outcomes for children could be achieved.
7.4.2 In this case, it had been recognised by professionals that the Father having a support network would be an important factor when he moved to his own accommodation with Child A. It was addressed in the Family Group Conference of 28.4.23, having been highlighted in the residential assessment.

7.4.3 The Family Group Conference identified a number of family members who would assist and support the Father in his care of Child A. The professionals saw it as a real strength that the Father would be very well supported by his Mother, and other family members.

7.4.4 The Home Placement Agreement, put in place when the Father moved into his own flat with Child A, also referenced the Family Group Conference, and the importance of support from family members to the Father and his care of Child A.

7.4.5 What came to light following the death of Child A, which frontline professionals supporting Child A and the Father did not know, was that the PGM, who was the only family member in a position to offer the Father a high level of support, which she had done from the beginning, became seriously unwell in July, had a stroke on 13th August and was hospitalised, six days before Child A was admitted to hospital, where he died two days later. The PGM did not leave hospital until after the death of Child A. She had, therefore, been unable to offer the Father support from sometime in July. The other family members identified as being able to assist the Father would also have been deeply affected by the serious illness and subsequent stroke of the PGM, a beloved family member. They would have been dealing with their own trauma and issues, and therefore less likely to be in a position to support the Father.

7.4.6 It was for CSC, as the lead agency, to understand family involvement and assess the strengths and effectiveness of that involvement. A conundrum for the CSPR was how CSC could have known about the PGM's illness and subsequent hospitalisation and stroke, having not been told by the Father. This will be addressed in the final Key Line of Enquiry.

7.5 Are Child in our Care/Child in Need processes sufficiently robust and do plans align effectively?

[4] https://www.gov.uk/government/publications/families-first-for-children-ffc-pathfinder-programme/families-first-for-children-ffc-pathfinder-programme-and-family-networks-pilot-fnp

7.5.1 Child in our Care

7.5.2 There are statutory requirements in relation to children in the care of the local authority and reviews have to happen within a certain timeframe; 20 working days of the child going into care, then within three months and then every six months. All reviews for Child A were held within the statutory framework.

7.5.3 Child A was a Looked After Child, a "Child in Our Care", at the time he moved with the Father to their home in the community, on 18th May 2023. The local authority had shared parental responsibility and there was an Interim Care Order in place.

7.5.4 During the time Child A lived with the Father in the community as a CIOC there was one CIOC review, in line with statutory requirements, which took place in the family home. It is important to be clear that CIOC reviews can be a series of meetings, rather than having everyone around the table at the same time. Having said that, a fundamental expectation of CIOC reviews is having contributions from the key agencies. CSC were involved in the review. The health visitor had been invited to attend the review but was unable to. The view of the Cafcass worker was sought but, primarily in respect of Child A's siblings. The views of the nursery or the Dads Matters worker were not sought. This is not in line with expected practice standards.

7.5.5 At a supervision session on 21st June 2023 the IRO agreed with their supervisor that she would "provide oversight and monitoring" in between the statutory reviews to ensure agencies remained child focused.

7.5.6 Prior to Child A and the Father moving to their own accommodation CSC had developed and put in place the Home Placement agreement, as referenced earlier in the report. The details of the Agreement have been shared previously in the report.

7.5.7 Family Plan

7.5.8 As stated above there was a comprehensive Family Plan, put in place at a Family Group Conference held on 28th April 2023, which was then reviewed a month later.

7.5.9 Child in Need

7.5.10 From 14th July 2023 Child A was no longer a child in the care of the local authority. The court ordered a Child Arrangement Order, alongside a Supervision Order with the local authority to support Child A and the Father through a Child in Need plan.

7.5.11 *Working Together to Safeguard Children,* the statutory guidance for all agencies working with children sets out the requirement of children in need processes. The Guidance at the time was the 2018 Guidance. The 2023 guidance only came into force in December 2023, after the death of Child A.

7.5.12 *Working Together to Safeguard Children 2018* states that CSC is the lead agency in

CIN and sets out the following requirements:

"A multi-agency child in need plan should be developed which sets out which organisations and agencies will provide which services to the child and family. The plan should set clear measurable outcomes for the child and expectations for the parents. The plan should reflect the positive aspects of the family situation as well as the weaknesses".

7.5.13 Statutory guidance does not specify timescales for reviews of the CIN plan.

7.5.14 CSC did not inform partner agencies, specifically the health visitor, the nursery, or the Dads Matter support worker that the final hearing had happened on 14th July and what Child A's new legal status was or what the change of arrangements were.

7.5.15 SW1 drafted a CIN plan without consultation with other agencies, which is not in line with expected practice standards. There is no statutory timeframe for when the first CIN meeting should be held. On 28th July 2023 a meeting took place in the home between the Father and the SW. While the CIN plan was mentioned the discussion primarily focused on the potential for Child A to have contact with his Mother. There is no evidence SW1 addressed with the Father why Child A was not attending nursery, enquired about sources of family support, or raised additional matters that would typically be incorporated in a CIN plan. The first CIN meeting was scheduled for the week beginning 21st August 2023.

7.5.16 At SW2's supervision session on 7th August there was reference to Child A not being taken to his physiotherapy appointment but no mention of him not being taken to nursery.

7.5.17 The Father started to withdraw and to be dishonest with professionals from the middle of July 2023. On 28th July the FSW attempted a home visit, but the Father said he and Child A were out, the paternal Grandmother was seen. SW1 also visited that day, separately. The Father said Child A was asleep and he was not seen. On 3rd August the SW and the newly allocated social worker (SW2) attempted to see Child A but were told by the Father that Child A was out with his paternal Grandmother, which is highly unlikely because she was very unwell at this point, and on 8th August SW2 contacted the Father to discuss why he had not taken Child A to his physiotherapy appointment and made an appointment to see Child A on 10th August. The Father then contacted the SW2 and asked for that visit to be rearranged because he said there had been a death in the family.

7.5.18 Analysis of practice and conclusion

7.5.19 It is important to be clear that CSC has ultimate responsibility for ensuring there is an effective plan in place, and for oversight of that plan, when they are involved.

7.5.20 The work of the Local Authority should have been more joined up and lacked co-ordination. There was a general lack of robust and effective multi-agency working.

7.5.21 It is also important to be clear that all agencies working with children have responsibilities and a part to play in ensuring there is good multi-agency working. It is not solely the responsibility of CSC. Partner agencies have a duty to escalate concerns about

expected practice not taking place.

7.5.22 The interim care plan, which is dated 10 May 2023 for the court hearing 10 July 2023 says that when the Father and Child A went to live together the Father would be subject to "ongoing holistic assessment during this time". It also said, "the local authority will have responsibility to ensure the child's health needs are met alongside the Father, that all planned appointments are attended and Child A's health needs prioritised". The interim care plan was written by SW1. The final care plan repeated what was in the interim care plan.

7.5.23 The Home Placement Agreement, although naming a number of agencies, made no mention of agencies coming together and there was no framework or timetable for multi-agency reviews of how things were progressing for Child A and the father. The Home Placement Agreement also mentioned the support offered by a number of family members but did not refer, specifically, to the comprehensive Family Plan drawn up at the Family Group Conference.

7.5.24 Therefore, for CSC, there was a final care plan outlining "ongoing holistic assessment", a Family Plan, a draft CIN plan and the CIOC plan but there was not a single, unified plan managed by one staff member; all of the different plans should have been integrated into the overarching CIN plan. There was also a planned and expected handover from SW1 in the Court Team to SW2 in the long-term team, the Strengthening Families Team. The IRO expressed a desire to contribute to and oversee the CIN plan, as well as to chair the CIN meeting. SW1 did not convene a CIN meeting or gather input from others prior to drafting the plan.

7.5.25 Multiple agencies were involved, each operating independently. There was no coordination or oversight by CSC to integrate the work of all agencies or consolidate the strength and concerns identified by each agency, which would have strengthened the plan for the family.

7.5.26 It was the FSW who had the most contact with Child A and the Father from 18th May to 28th July, the date of her last visit. SW1 could have delegated authority to the FSW to liaise closely with the Dads Matter support worker, the nursery and the health visitor.

7.5.27 The allocated social worker should have contacted the Dads Matters support worker when they knew of their involvement and involved them in multi-agency meetings and in the support plan, through the FSW. That way CSC would have known when the Dads Matters support worker was finding it hard to get hold of the Father, and when Child A was not taken to the toddler group.

7.5.28 In terms of Dads Matter, the Father told the support worker on 16th January 2023 that he first knew he was going to be a father when his ex-girlfriend told him she was five months pregnant with his child. He said the child had been taken into care and he was seeing his child, Child A, with the Foster Carers and the Foster Carers liked him. The Father told the support worker he "wanted to go for custody of his son and the process was already in progress". The Father self-referred to the Dads Matter programme. The referral

was accepted by a senior coordinator.

7.5.29 As time went on the Father then told the Dads Matter support worker, he and Child A were being assessed in a residential unit, and they were in touch throughout that time. The Father then told the Dads Matter support worker when he moved into the community with Child A and also that the assessments were all going very well. Home-Start BFW, as the provider of the Dads Matter programme should have made contact with CSC when they knew they were first involved and Dad was going for custody of his child and discussed each of their roles, and built a relationship, rather than making an assumption that even though CSC was involved, they could not have particular concerns, otherwise they would have contacted Home-Start. The Home-Start toddler group did not know CSC was involved with Child A. Had Dads Matters had been in contact with CSC from the start it would have been clear that CSC was still involved, then Dad Matters (Home-Start) would have informed CSC that there had been difficulties in the latter weeks establishing contact with the Father.

7.5.30 It was Home-Start who provided the Father with a brand-new washing machine and fridge freezer when he moved into his flat, which was extremely helpful. The Father was terribly pleased with them and very grateful.

7.5.31 There should have been routine communication between CSC and the health visitor through care planning, CIOC reviews and CIN meetings. The recorded communication between CSC and the health visitor is limited. The health visitor was invited to the CIOC reviews but was only able to attend one. They did contribute to the reviews and received a copy of the reviews.

7.5.32 There is also no evidence that CSC was in communication with the nursery, although they were funding the placement, and they were made aware by the nursery that Child A was rarely taken, this was done in an email, to which CSC did not respond. This is not in line with expected standards. It was good practice that the nursery informed CSC about the poor attendance. All that the nursery had been told by CSC was that the Father was a protective factor and was doing everything he should be doing and they, therefore, had no particular concerns.

7.5.33 The day of the first CIOC review in the Father's home, when the IRO arrived the PGM was there. Standard procedure is that at CIOC reviews those with parental responsibility/care of the children are asked if they would like other family members involved. The Father asked if it would be alright for the PGM to stay for the review. The IRO agreed. The FGC of 28th April had established the PGM was going to have a pivotal support role and both the residential assessment, and the Home Placement Agreement had recognised the importance of the Father receiving family support, if he was to succeed in caring for his son. The subsequent CIOC My Plan also reflects the IRO was aware of the Family Plan. The Father should have been asked for his permission for the PGM to be invited to this first CIOC review, in the community, and she should have been invited to the CIOC review, rather than it just being a coincidence that she was there.

7.5.34 The IRO in this case highlighted the areas they considered important to SW1 but had

no power to enforce those recommendations. They spoke to their line manager, in supervision on 21st June about providing monitoring and oversight, it being standard practice in Blackpool for the IRO to track progress until the first CIN review and then, in the case of a Supervision Order, agree what monitoring they will have of the 12-month supervision order.

7.5.35 From 14th July, the Local Authority no longer had shared parental responsibility because there was a Child Arrangement Order, alongside a Supervision Order.

7.5.36 A Supervision Order requires the local authority to advise, assist and befriend a child[5]. This is done through regular meetings. In this case Child A was to be supported through a Child in Need plan, with CSC as the lead agency. As stated earlier, the statutory guidance at the time did not set out a timeframe for when the first Child in Need meeting happens or how frequently Child in Need plans had to be reviewed, although it did set out the requirement for them to be multi-agency.

7.5.37 As stated earlier, there is no record on the CSC file that a multi-agency CIN meeting was held and the social workers did not engage with the Dads Matters worker, who was supporting the Father, or with the nursery, which is not in line with expected standards. There was a draft CIN plan, but it was devised solely by CSC, with no input from other agencies which, again, is not in line with expected standards. There should have been a robust multi-agency CIN plan in place that took into account the Home Placement Agreement, the Family Plan and the CIOC Plan.

7.5.38 It should be emphasised that there were no particular concerns about Child A, or the Father. All professionals have to prioritise their work. The priority will always be where there are concerns a child has or is likely to suffer significant harm. There were no such concerns about Child A and, more than that, he was seen to be thriving, and the Father gave no indication he was struggling. Therefore, for the frontline professionals supporting the family the CSPR is of the view that it is very understandable that there were no concerns of abuse, when the Father became less and less engaged. It was also only about three weeks from when the Father started to disengage to when he murdered Child A.

7.5.39 The physiotherapy service contacted CSC when the Father failed to take Child A to an appointment, which is good practice. In this example the FSW did follow this up which, again, is good practice, and another appointment was made, an example of effective multi-agency working.

7.5.40 Having had the benefit of time to analyse what happened in this case, the CSPR has been able to clearly demonstrate how the Father started to withdraw. If there had been a robust Child in Need plan in place this should have been noticed by the agencies, who should then have questioned the Father's reasons for not being able to meet, or for the professionals to see Child A, or why he was not taking Child A to nursery or to toddler

[5] https://childlawadvice.org.uk/information-pages/supervision-orders/

group. To ask who the family member was who had died, to see Child A when the Father said he was asleep. Because there was no robust Child in Need plan all of this was missed.

7.5.41 Finally, as stated elsewhere, it is the view of the CSPR that the situation became too much for the Father to a large degree because of his Mother's poor health, her inability to support him as she had so willingly and well before she became ill and the effect on the Father of being so worried about his Mother's poor health when he was so dependent on her, both in terms of his own emotional needs but also the practical support she offered him now, as a father. The question is, how could CSC have learnt of her illness and subsequent stroke, other than from the Father? This is addressed in the recommendations.

Recommendation Three

The lead agency should ensure that all plans are coordinated and align effectively into a single, comprehensive, master plan.

Additional comments

In this case there were five different plans: the final care plan, the Home Placement Agreement, the Family Plan, the draft CIN plan and the CIOC plan. They ran alongside each other but there was no master plan incorporating all the other plans. In this case, it should have been the CIN plan that did that.

This is a common issue both locally and nationally.

Recommendation Four

When a child is placed at home with a Supervision Order supported by a CIN plan, there should be a multi-agency CIN meeting, with input from all key agencies, including community-based services, prior to the child returning/being placed at home.

Additional comments

It can be an issue in Blackpool that the local authority does not place equal importance on the views of third-sector organisations in safeguarding and child protection work. This is also a common finding, nationally, from child safeguarding practice reviews.

The meeting should be organised at the point where CSC knows they are going to make this recommendation to the court, and it is likely the court will agree. The meeting must have happened prior to the child being returned/placed at home.

Recommendation Five

When specific family members are going to play an integral part in Family/Child in Need/Child Protection/CIOC plans they should be invited to attend all relevant meetings, and those family members should be given contact details of key professionals.

Additional comments

Good relationships between professionals and families are key to good practice. Where families trust professionals, and know who to go to, they are more likely to share concerns.

In this case only Family Plan, CIOC and Child in Need plan applied but this recommendation is equally relevant when a child is the subject of a child protection plan.

In this case, had this occurred it would likely have been revealed that the PGM became unwell in July and was consequently unable to provide the essential support identified by professionals as a key component of the plan. Additionally, the responsibilities of other family members would have been clarified.

Although knowing the PGM was seriously ill might not have prevented Child A's death, it may have influenced the support plan to consider additional support for the Father and Child A.

Recommendation Six

Agencies must have inbuilt into their systems the importance of robust and effective multi-agency working, whilst maintaining constant professional curiosity.

Additional comments

To fully understand a child's lived experience, effective communication between professionals is required. CSPRs often note the lack of a coordinated approach among professionals, as observed in this case.

Having said that, as stated elsewhere, agencies met within statutory time frames and there were no concerns about Child A, who was thriving, and there were no concerns about Father.

It is also important to consider how professionals maintain curiosity in their assessments when a child appears to be doing well and there are no apparent concerns about parental care. As noted previously, maintaining realistic expectations is essential. It is improbably for someone to undertake responsibilities similar to those of the Father without encountering any difficulties.

However, as previously stated, agencies met statutory deadlines and there were no concerns regarding Child A, who was thriving, or the Father.

7.6 Are there barriers to a family being honest with services?

7.6.1 A common finding from Child Safeguarding Practice Reviews is that families have not

been honest with professionals. There can be many reasons for this but the one that families report so often, and the Father talked about in this case, is the fear of having your child removed from your care. The Munro Review of Child Protection[6] references this fear but as the Review points out "relatively few children are removed from their birth family".

7.6.2 Professionals who work with families, such as those in CSC and social workers, are sometimes seen by parents as possessing significant authority, including the ability to remove children from parental care. However, the threshold for such intervention is set very high. In practice, only the police and the family courts have the legal authority to remove children from their parents' care. CSC does not have this power, without involving the police or the courts.

7.6.3 There are nearly 84,000 children in care in England, out of 12.7 million children[7]. Misinformation about why children are taken into care often starts with local rumours among families or friends, leading to persistent myths about the ease of removal. These misconceptions - fueled further by media coverage - contribute to the widespread but incorrect beliefs that CSC can easily remove children from their parents.

7.6.4 It is clear that at some point the Father stopped being truthful with professionals. For example, we cannot confirm if Child A ever had a chest infection, as claimed for absences from nursery on 16th and 23 June 2023. Although advised to take Child A to the doctor and toddler group, the Father did not follow through. He repeatedly failed to take Child A to nursery in June and July 2023 and ignored calls from nursery staff and support workers. On 30th June, he omitted mentioning Child A's hospital visit with a seizure to a support worker. The Father also missed several communications from professionals between 14th and 31 July 2023.

7.6.5 During a social work visit on 3rd August 2023 the Father claimed Child A was with the PGM but as she had been seriously ill since July this is unlikely. The actual whereabouts of Child A that day remain unknown. On 14th August 2023, when contacted by the Dads Matter worker, the Father reported all was well and did not disclose his Mother's stroke the previous day.

7.6.6 The Father told the lead reviewer during the prison visit that he was too frightened to say he was struggling because he thought Child A would be taken away from him. He said that at one point he almost told SW1, because they had such a good relationship, but then he could not because of what he perceived the risk to be. He said he felt he would not get a second chance, if he did something "a little bit wrong".

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[6] https://assets.publishing.service.gov.uk/media/5a7b455ee5274a34770ea939/Munro-Review.pdf

[7] https://www.gov.uk/government/statistics/childrens-social-care-in-england-2025/main-findings-childrens-social-care-in-england-2025

7.6.7 The Father said he does remember professionals saying be honest with them, but he felt he could not because he thought he would lose his son, if he told professionals how he was feeling.

7.6.8 The reviewers asked the Father what professionals could say to parents so they feel they can be honest and say when they are struggling. The Father said that professionals had been praising him. He said it was an amazing feeling; that he was doing so well looking after his son. He said Child A did well and put weight on when they were in the residential setting. He said it felt like he was "doing what other single dads couldn't do. Couples struggle, doing it on your own is twice as hard". The reviewers asked the Father whether there was any point where he felt he could say how he was feeling and how he was struggling? He said there was one time when he was going to tell SW1 "but my fear got too much. I do wish I had told him. If I could turn back time".

7.6.9 Analysis of practice and conclusion

7.6.10 It has long been recognised that good relationships between professionals and families are vital to safeguarding children. This is particularly true of CSC, the lead agency in child protection. Building strong, positive relationships with families is crucial for effective child protection work. Social workers are trained in the importance of building those relationships, being transparent with families, respectful, empathetic and to recognise the importance of working in collaboration with families; to foster trust and encourage family engagement in the process.

7.6.11 While these considerations are important, it should be noted that in some cases families do provide accurate information to social workers, or other professionals, leading to the conclusion that the risks to the child are significant. When another professional believes a child is experiencing or may experience significant harm, they have a responsibility to notify CSC. If the threshold for removal is met, CSC is responsible for seeking the child's removal from the home, either through legal proceedings or with the consent of the parents.

7.6.12 That was the issue here; the Father remembers professionals telling him to be honest, but he was still fearful that if he was, his son would be taken away from him.

7.6.13 In summary; professionals say to families 'be honest with us. That is the best way for us to work together and the best way we can support you', but sometimes the family is and the child is then removed from their care. It is the duty of the local authority to seek to protect children in cases where the parents/carers are deemed unable to do so.

7.6.14 What is generally not understood by the public, nor by the media, is the extremely high threshold for removing a child from their parents/carers' care, in the UK. The CSPR cannot say, definitively, that Child A would not have been removed from the Father's care, if the Father had been honest with professionals or with family members, about how much he was struggling because no one, but the Father, knows how those struggles manifested themselves, until Child A was admitted to hospital on 19 August 2023.

7.6.15 It is well-recognised that children, generally, do best when they grow up in their own family. In this case, there were no other family members who were in a position to care for Child A. If the Father had not been suitable, the plan would have been for adoption. In view of how successful the initial 60 'family time' sessions had been, and how successful the residential assessment had been, the CSPR is confident that the agencies would have done everything they could to support the Father, so that Child A could grow up with the Father.

7.6.16 Finally, there was no suggestion, and no evidence, that the Father wanted Child A to live with him so he would have access to housing, or access to state benefits, for example, which can be a concern when someone comes forward saying they want to care for a child they have had nothing to do with. As stated elsewhere, the Father was seen as genuine by the frontline professionals and based on the evidence, the CSPR agrees with that assessment.

Recommendation Seven

All agencies working with children should ensure that their staff understand the importance of clear, honest communication with parents about expectations and emphasise that struggling and seeking help is not failure.

Additional comments

Parents should be told that the starting point for professionals is that, generally, children are best cared for within their families and that support will be offered to them to ensure they can safely achieve this. Agencies must explicitly state what constitutes unsafe care and offers support to keep children safely within their families. The ICON approach could serve as a foundation for this work, and the Partnership should seek to ensure that all agencies are equipped with the messages.

8. Summary

8.1 Certain aspects of professional and agency practice were found not to meet expected standards, as identified in this report. While continuous learning is necessary for all agencies, it is important to note that child A's death was not attributable to professional practice. Two comprehensive assessments were conducted to evaluate the Father's capacity to care for Child A: a 60-session community assessment and a three-and-a-half-month residential assessment. Throughout ten months of thorough evaluation, Child A was observed to be thriving in his father's care, with no significant concerns. All agencies involved agreed that it was in Child A's best interests to reside with his father, a view ultimately endorsed by the court. The Child Safeguarding Practice Review supports this decision, based on the information available at the time and without hindsight.

8.2 The CSPR has concluded that the central issue in this case was the Father losing the support of the PGM, as well as experiencing his Mother's illness and his fears regarding the possibility of his son being removed from his care. Despite positive relationships with several professionals, whom he told the CSPR he found supportive, he said he did not

disclose his concerns due to these fears. It was these factors that the Father said rendered him unable to tell anyone how much he was struggling, until it was too late, most importantly and tragically for Child A, but also too late for the Father, who will now spend a minimum of 22 years in prison for the murder of his son.

Appendix One - The Father's contribution to the CSPR

The Lead Reviewer and Head of Service for Safeguarding at Blackpool Council met the Father as part of the CSPR.

The Father said he felt very well supported by all the practitioners and they were all kind and helpful. He said that all the positive things that he did with his son and all the interactions that were noted as being positive were genuine and he really, really wanted to do a good job and care for his son.

The Father was 30 when he and Child A went to live together. The Father had never had his own home. He said he moved out of his childhood home when he was 18 but, in his words, that "did not last long", and he moved home again. In his adult life he then either stayed with friends or slept in the back of tattoo shops where he worked, for the next 12 years. He had never registered with a GP practice, as an adult, until Child A came into his life and he was advised to, he had never received benefits or had a bank account. He had never, in his life, had any level of responsibility other than having enough money to feed, clothe and care for himself. He had never had any of the responsibilities of adulthood, other than those very basic ones. He described himself as "being in a bit of a rut".

At age 30 the Father went from that life to having 60 sessions with Child A in the community, supervised by CSC, and he was supported by the supervisor. He then had three-and-a-half months in a residential assessment setting, where initially he was helped with everything. Even as the setting became more hands-off, which is the process if there are no concerns about the individual's ability to care for the child, they were still there, and he was fully supported, in those moments when he needed that. He was taught all the basic needs of a child, including a trip to the supermarket and a discussion about budgeting for food and cooking for Child A. He was allowed increasing time alone with Child A outside of the setting, because of his progress, but would always return every day. He was surrounded by individuals, both staff and other residents, who all helped each other.

The Father spoke about the times he was allowed to take his son out unsupervised, when they were in the residential setting. He would take his son on outings; to play areas, to parks, or just to walk around the town. He described showing the staff photographs of what they had done when they got back. The Father said the staff always took an interest in what he had done. He did not feel he had to show the staff the photographs to prove anything but "I liked showing them what we have done".

The Father went from that to completely living on his own. In his words "I had all that support, it was different living on my own", by which he meant as a single parent of a small child. He did find the flat himself, but he said he was given the motivation to do that by his social worker at the residential unit, and she had been very helpful in making that happen. He had not done that alone.

The Father spoke very highly of all the professionals supporting him. He described the worker who supervised the community sessions as being "amazing. She felt like a second mum to me". He described the SW as being "a nice man" and they got on really well from

the start. He said he understood the IRO was a higher manager as she checked the plans and what CSC was doing. The FSW as being a real support, the Dads Matters worker as being helpful and good; he would tell the Father how proud and happy he was of and for him. “He was a big part of the support”.

He said he felt well-supported by the professionals around him but at the same time he spoke of the pressure of being constantly watched – from when the first community assessment happened on 14.7.22, for those 60 sessions, and then for the three and a half months in the residential settings. He spoke of the cameras everywhere, of the observations of him. He said they were watched 24 hours a day; there was CCTV in the hallways, the stairs, in the bedroom he and Child A shared, although that was directed at Child A’s cot, not the Father’s bed. The Father said that a couple of weeks after he moved into the residential setting cameras were installed in the living room as well.

The Father said that when they were in the residential setting sometimes, he wanted to leave. He said it felt a bit frustrating and that “even if I did a little bit wrong, I felt that I wouldn’t get a second chance”.

The father said it was exciting moving into his own home, with Child A. He said it felt like a massive weight of his shoulders, up until that time he had been spending all day out and about looking for flats, sometimes four or five viewings in a day. He described when he got the keys, he also got a sofa, “My Mum came round, and we had a family fishy tea – like a home-warming celebration” before moving in officially.

The Father also said it was overwhelming at first, moving into his own flat and caring for Child A by himself. He said that when he could start to see that he could manage, it was alright. He said he did things as he had done them in the residential setting. He said he had to keep all the training he had had in his head in order to keep things running at home.

The Father said that he had very little previous experience of children. He said he had been around friends’ children and his cousin, when they were very young, but that was all.

The interviewers asked the father if he ever wavered; did he ever talk to professionals when he was struggling? He said he did have thoughts, especially about being a single parent, and his Mother was not healthy; the support from his family was not as strong as he would have liked it to be. The Father said he did not think he could tell professionals how he was feeling. He said he was scared to have those conversations because he thought it would put doubt in their minds. He remembered being told that being a parent is the hardest thing, but he would respond “I feel I’ve got this”. The Father said he felt that he needed to find a way to look after his son; his Mother had let him down and he did not want Child A to grow up thinking his father had let him down too.

The Father spoke of the pressure and that was the only thing he would change, when he and Child A were living alone together. He said “I felt too much pressure off everyone; it was too overwhelming to cope with. I was being told to go to different groups. I felt too obligated. I wanted a relaxing time after being in the residential setting. The last thing I needed was more pressure. I understand it was good for my son’s mental growth, but that

was what nursery was for. With nursery, shopping, bills, everything was building. I could not take it anymore".

The Father went on to say that the pressure was not "verbalised" pressure. Maybe I felt this emotionally and I put myself under this pressure. I wanted 1:1 time with my son with nobody around. After the residential setting, I wanted to breathe and relax. I felt like 'let me relax a little bit'. I needed a bit of time to find my own feet. Some people might be able to do that as a single parent. I had little support from my family. I wish I had told someone. In my head, I was screaming out that I was struggling. This isn't what I wished for my son. I wanted him to have a different life".

The Father described choosing the nursery that he did, which was a half-hour walk away from their flat. He said he chose that nursery because it was in a better area than where they lived and he wanted a better life for his son. "I wanted him to have a good life and education and not get in touch with bad people like I had – that was my plan". He said that sometimes it was "too tiring to get to nursery. It was like a catch 22 – I wanted better for him, but it was too far from the flat". The Father told the reviewers that it was a half-hour walk from the flat and Child A was only having a two-hour session there, so it was two hours of walking for a two-hour session. In fact, the sessions were not two hours, Child A was funded for two sessions a week, but a session could be up to four-and-a-half hours. Nursery records show that on the days the Father did take Child A Child A was there for the full four-and-a-half hours.

The Father said his Mother was always a hugely significant part in his life, but because she was suffering with her health, she could not be a massive help. I didn't want to feel I was taking advantage of her. She was not able to offer regular support as had been the plan.

The Father said he really loved his son. He said "I feel like I have let everyone down, everyone who tried to help me. They all did all they could to help me". He then named all the professionals who supported him so that he feels he has let down. He said "I don't want them to feel that I threw all the support they gave me and my son in their face. I want them to know it wasn't a façade. I really tried to do my best for my son. I wanted him to have a good life. I don't want this and what has happened to affect them in their future. Will you please tell them all that I wish I could turn the clock back, I really do. I wish that I had told someone that I was struggling. Will you tell them I am sorry"

Appendix Two - Terms of Reference

Aims and Purpose

- To establish what lessons are to be learned in this case, in relation to Child A and, critically, an analysis of any systemic or underlying reasons why actions were taken or not in this case.
- To examine how professionals and organisations work individually and together to safeguard children
- To identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.
- To bring about changes that will lead to an improved practice system for protecting children:
- The overall purpose of the review is to provide a summary of learning, and the identification of good practice continuously improve safeguarding and promoting the welfare of children in Blackpool:
- To reflect on any specific issues in relation to practice in Blackpool

Principles of the Review

- Objective, independent & evidence-based
- Guided by humanity, compassion and empathy with the child's voice at the heart of the process
- Asking questions to prevent future harm, culture focus on learning lessons and not blaming individuals or organisations.
- Balancing good strength practice and the required developing improvement practice
- Respecting equality and diversity
- Openness and transparency whilst safeguarding confidential information where possible

Membership of the Review Team

As set out in Appendix Three

Scope of the Review

Time period under review and the rationale

As set out in 3.1

Review Questions and Key Lines of Enquiry

As set out in 6.

Involvement of Family Members and Carers in the Review

- All attempts will be made to engage with Child A's Mother and father, as well as Child A's Foster Carer, with whom he lived until he moved to live with his father.

- The independent lead reviewer will attempt to meet with each of these individuals, along with a member of the review team.

- We will identify the timescale and process and ensure that the family and carer are able to respond to this review without undue pressure.

Methodology

This LCSPR will focus its key lines of enquiry around the specific questions outlined above.

A review ream will work in close collaboration with the Lead Reviewer to advise and support the review process through the following steps. The review team will be made up of strategic leads from each of the agencies involved.

Step One - First Review Team Meeting

The lead Reviewer will facilitate the first review team meeting. The purpose of which is to:

- Define the roles and responsibilities of review team members
- Agree the final Terms of Reference, in particular the themes and key lines of enquiry for the LCSPR, from analysis of the key events identified in the interagency chronology
- Consider whether any additional information is required
- Discuss the Practitioner Reflective Learning Workshop, both the format and who should attend
- The logistics of meetings with family members, including who will attend with JN
- Any particular sensitivities and confirm the timescale of the review
- Agree dates and times of all future meetings and events.

Step Two - Meetings with Family Members and Foster Carer

To be done by the lead reviewer and one review team member at each.

Step Three - First Draft of the Report

Lead reviewer to write first draft of the report. The first draft is then circulated to the review team to review.

Step Four - Second Review Team Meeting

The purpose of the second review team meeting is to:

Go through the first draft of the report and plan the Practitioner Reflective Learning Workshop.

Step Five - Second Draft of the Report

Lead reviewer makes amendments to the report, as agreed at the second review team meeting. Second draft then sent to the review team for review.

Step Six - Reflective Learning Workshop

A half-day Reflective Learning Workshop with the review team and the frontline professionals to go through the draft report for comment.

Step Seven - Third Draft of the Report

Lead reviewer makes amendments to the report, as agreed by the review team. Third draft then sent to the review team for final comments.

Step Eight - Final Report

Lead reviewer makes final amendments and submits final report to BSCP.

Governance and Accountability

The aim of MASA is to complete the LCSPR by the end of September 2025. This is with the caveat that it is being undertaking over the summer holiday period, which may cause delay.

On finalisation of the report the lead reviewer will be available to provide a summary of learning to the relevant strategic meetings of MASA.

Publication & Media Strategy

MASA will convene a meeting with the Partnership and agencies involved in this case to agree the publication and media strategy arrangements.

No later than seven working days prior to publication, a copy of the full report will be submitted to the Child Safeguarding Practice Review Panel and the Secretary of State setting out the publication strategy.

The report will be formally published on the MASA website and a copy submitted to the NSPCC National Repository.

Dissemination of Learning

See Blackpool Quality and Learning Improvement Framework

- All learning will be recorded on a learning action plan from the outset of the CSPR and overseen by the MASA effectiveness group

- Learning will be disseminated through the MASA Workforce Development Group and Pan Lancashire CSPR group

- The reviewer will be invited to deliver a presentation of key learning and recommendations at a MASA Board following sign off by DSP's
- A learning brief will be developed for practitioners and included in the joint partnership newsletter to ensure timely and consistent communication and sharing good practice

- Training materials will be updated to ensure learning is shared directly with frontline practitioners

- The full report and learning brief will be shared on the joint partnership website

- A learning impact record will be shared with partners through agency SPOCS, feedback will be gained at 6 and 12 months post publication

Confidentiality

All information discussed is strictly confidential and must not be disclosed to third parties without the agreement of the Partnership and lead reviewer. No material that states or discusses activity relating to specific agencies can be disclosed without the prior consent of those agencies.

All agency representatives are personally responsible for the safe transfer and safe keeping of all documentation that they possess in relation to this LCSPR and for the secure retention and disposal of that information in a confidential manner.

Disclosure

The police are required to ensure that there is fair disclosure of material that may be relevant to any investigation, and which does not form part of any prosecution case. Any material gathered in this review process could be subject to disclosure to the defence if it is considered to undermine the prosecution case or assist the case for the accused, even after criminal proceedings have concluded.

The police representative on the review team will alert the lead reviewer to any matters that require disclosure during the course of the review. The lead reviewer, police and Crown Prosecution Service are required to consider the confidentiality of material at all times and to balance that with the interests of justice.

Appendix Three - Methodology and Limitations

This review has been undertaken using systems methodology. I, as the lead reviewer, have worked closely with a review team – a team made up of senior managers from each of the agencies supporting Child A and the Father. Although the report is published in my name it is the work of the review team as a whole. There has also been input from the frontline professionals who supported Child A and his family, who are still working in Blackpool, or who are still in practice and happy to provide their input, the Father and Child A's Foster Carers.

Review Team	Organisation
Joanna Nicolas	Independent lead reviewer
Assistant Director of Operations	Blackpool LA Children Services
Review Investigator	Lancashire Police
Head of Safeguarding Children and Children in Care	Lancashire and South Cumbria ICB
Assistant Director	CAFCASS
Head of Safeguarding Children	Blackpool Teaching Hospital
Early Years' Service Manager (Representing the Nursery)	Blackpool Local Authority
Director of Residential Placement	Residential Parenting Assessment Unit
Director of Safeguarding	Blackpool Teaching Hospital
Strategic Safeguarding Lead	Home-Start

The smooth running of the review was enabled by the support of the MASA Business Unit.

Appendix Four - About the Author

I have worked in child protection/safeguarding for 30 years, the last seventeen of those as an independent safeguarding consultant, case review author and trainer.

I am an accredited systems lead reviewer having undertaken the Social Care Institute of Excellence's Learning Together systems methodology training in 2011. I have been leading systems reviews since then.

For more information, please see my website https://joannanicolas.co.uk