

**REPORT
REGARDING ISSUES OF
CONSENT
IN RELATION TO
BABY K**

Report of the Executive of
Nottingham City Safeguarding Children Board
23 February 2009

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1. Introduction

- 1.1 Removing a baby from its mother at birth is a very serious matter but the law recognises that this is sometimes necessary for the safety of the new born child. The legal framework within which Social Workers and Police Officers are empowered to act is contained in the Children Act 1989. Statutory guidance for professionals responsible for making such difficult and sensitive decisions about the protection of children is provided by the Department for Children, Schools and Families in Working Together to Safeguard Children 2006.
- 1.2 This Review was commissioned by the then Director of Children's Services for Nottingham from the Executive of Nottingham City Safeguarding Children Board for Nottingham City Council, and initiated on 21 February 2008 after extensive publicity of circumstances in January 2008 where the High Court found that Nottingham City Children's Services had removed a baby from its mother unlawfully.

2. Summary of Circumstances Leading to the Review

- 2.1 Baby K was born at 0211 hours on 30 January 2008 in the Maternity Unit of Nottingham City Hospital, 4 days before his expected date of delivery. His mother, X who was aged 18, had been known to many Nottingham agencies from age 14 and was in receipt of leaving care services.
- 2.2 At 0510 hours on 30 January 2008, 3 hours after he was born, baby K was removed from his mother by the Midwife and cared for on a separate ward of Nottingham City Hospital in accordance with a birth plan held by the hospital and following communication with a Nottingham City Children's Services out of hours Social Worker.
- 2.3 On 30 January 2008, Counsel representing X, at the hearing of an application to the High Court for Judicial Review in connection with her Leaving Care Pathway Assessment and Plan, applied for an immediate order that baby K should be reunited with X. It was contended that baby K's removal from his mother's care was unlawful and Counsel for Nottingham City Council conceded that there had been no lawful basis for removing the baby.
- 2.4 Mr Justice Munby ordered that, provided X remained at Nottingham City Hospital, she should be reunited with baby K unless there was a lawful basis for him being removed from her care. Consequent to the order of Mr Justice Munby, baby K was returned to his mother at 1230 hours that day, following a separation of 7 hours and 20 minutes.

- 2.5 Unusually, and owing to the nature of the proceedings within the context of which the application was heard, this order was made in open court.
- 2.6 At 1240 hours on 30 January 2008, Nottingham City Council applied for an Interim Care Order in respect of baby K and this was granted on 31 January until the following day, 1 February 2008, when a further hearing granted a second Interim Care Order for a longer period.
- 2.7 The judgement of Mr Justice Munby on 1 February 2008¹, his expansion of that judgement and award of damages to X on 18 February 2008² and the granting of the Interim Care Order were widely reported by the media in terms that were critical of the agencies involved but particularly of Nottingham City Council.
- 2.8 The Council's legal advisers and Children's Services, Nottingham University Hospitals Trust and Nottingham City Primary Care Trust immediately put into place measures to ensure that such an event would not happen again, pending the agreement of a new interagency procedure by the Nottingham City Safeguarding Children Board for managing situations where a newly born baby is anticipated to be in need of protection.

3. Terms of Reference

- 3.1 The Terms of Reference of the review were to consider:
- a factual chronology of the action that has been taken in each agency
 - whether the Nottingham City Safeguarding Children Board child protection procedures have been followed
 - whether the case suggests that there is an urgent need to review those procedures
 - whether any other action is needed now within any agency or for the Nottingham City Safeguarding Children Board
 - whether the analysis of the information and the consequent response by all agencies was appropriate
 - whether communication functions worked appropriately both for the Council and the Nottingham City Safeguarding Children Board.
- 3.2 The scope of the review was from the date of the Initial Child Protection Conference, 18 December 2007, to the date on which Mr Justice Munby made his full judgement, 18 February 2008 (inclusive), with discretion for agencies to include earlier events if considered pertinent.

¹ G (R on the application of) v Nottingham City Council [2008] EWHC 152 (Admin)

² R (G) v Nottingham City Council [2008] EWHC 400 (Admin)

4. Review Process

- 4.1 This report was compiled jointly by Mr. Chris Few, an Independent Consultant and a former Police Officer with responsibility for safeguarding children issues; and Mrs. Margaret McGlade, Independent Chair of the Nottingham City Safeguarding Children Board and a former Director of Social Services.
- 4.2 The Review was conducted using the Nottingham City Safeguarding Children Board (NCSCB) procedures for Serious Case Reviews although it should be noted that the circumstances which led to this Review did not meet the criteria for a Serious Case Review within the meaning of Working Together to Safeguard Children (2006), as Baby K was not harmed.
- 4.3 Individual Management Reports, supporting documents and correspondence dealing with specific issues were received from:
- Nottingham City Council Children's Services
 - Nottingham Health Community
 - Nottinghamshire Healthcare NHS Trust
 - Nottingham City Council Legal Services
 - CAFCASS
 - Connexions Nottinghamshire
 - Nottinghamshire Police
 - National Probation Service
 - Nottingham City Council Communication Team
 - Nottingham City Homes.
- 4.4 Other materials consulted during the Review included:
- Judgement of Mr Justice Munby 1.2.08.
Family Law Week: G (R on the application of) v Nottingham City Council [2008] EWHC 152 (Admin).
Available at: www.familylawweek.co.uk
 - Judgement of Mr Justice Munby 18.2.08.
Family Law Week: R(G) v Nottingham City Council [2008] EWHC 400 (Admin).
Available at: www.familylawweek.co.uk
- 4.5 The Reference Group for the Review, which met on five occasions between May 2008 and January 2009, was chaired by the Independent Chair of the Nottingham City Safeguarding Children Board and comprised representatives of the following agencies:
- Nottingham City Safeguarding Children Board
 - Nottinghamshire Healthcare NHS Trust
 - Nottingham City Primary Care Trust

- Nottingham University Hospitals NHS Trust
 - Nottingham City Council.
- 4.6 Because of staffing issues, the Nottingham City Council Children's Services representative was unable to attend the first three meetings of the reference group and instead Nottingham City Council Children's Services, Legal Services and Media Department were consulted and commented on drafts of this report. These staffing issues also led to delays in the review process in that further time was needed for the clarification and analysis of information.
- 4.7 The final drafts of the report were independently reviewed by Mr. David Spicer, Barrister and Legal Adviser to the Nottinghamshire County Safeguarding Children Board.
- 4.8 Throughout this report baby K's mother is referred to as X and his father as Y. The baby is referred to as baby K as this was the how the baby was referred to in the court proceedings and publicity surrounding the case.
- 4.9 In line with the legal obligation to protect the confidentiality of X, Y and baby K this report has been constructed in such a way as to focus on the actions of agencies and has only included such personal information as was placed in the public domain during the original hearings. The ethnicity of X and Y was known to agencies but was not found to be relevant to the events under review. Some references to the views of X during the period under review have been included where it has been necessary to explain how events unfolded.
- 4.10 The mother of baby K was invited to meet with the first named author of this report and to contribute to the Review but declined to do so.

Postscript

On 13 February 2009 Judge Michael Stokes QC, Recorder of Nottingham, lifted criminal reporting restrictions preventing the identification of the mother in this case, following her conviction on a charge of child cruelty in relation to baby K.

He said: "It is well documented that the social services department acted unlawfully in removing your child from you. "All they did that was inappropriate was that they took the child from you before they obtained a court order. "Your subsequent conduct clearly demonstrates beyond any doubt at all that the instinct and judgment of the social workers was entirely correct."³

With the exception of the addition of this postscript the report has not been altered in the light of this.

³<http://www.thisisnottingham.co.uk/news/Mother-threw-baby-social-worker/article-698105-detail/article.html>

5. Summary of Key Events

- 5.1 At the time of baby K's birth the parents were aged 18 and 19 years respectively. From the age of 14, X had had extensive contact with agencies in Nottingham, had been in the care of Nottingham City Council and at the time of baby K's birth was being provided with services under the Children (Leaving Care) Regulations 2001.
- 5.2 In June 2007, X was confirmed to be pregnant and on 6 August 2007 a Leaving Care Worker providing support to X raised concerns that she would be unable to care for her child once born. Consequent to this, Initial and Core Assessments were conducted by Nottingham City Children's Services.
- 5.3 On 18 December 2007, at a pre-birth Initial Child Protection Conference attended by X and her solicitor, unborn baby K was placed on the Nottingham City Child Protection Register under the category of Neglect and was made the subject of a Child Protection Plan. The conference recommended that an application for an Interim Care Order should be made, X should not be allowed to leave the hospital with the baby and an Emergency Protection Order should be sought if needed. The Social Worker advised the Conference that she would not have time to assess X's mother as a potential carer for the baby or undertake any other kinship care assessments prior to the baby's birth.
- 5.4 On 19 December 2007, a 'birth planning' meeting was held between the Social Worker for unborn baby K and 4 health professionals to plan how the recommendations of the Child Protection Conference should be implemented either in the community or in hospital at the point when X gave birth. The plan which was drawn up involved the baby being cared for on a separate ward soon after the birth.
- 5.5 These arrangements were subsequently explained to X but she was not asked if she agreed with them; nor was she asked to sign them and she was not given a written copy. The plan, which was described as a 'birth plan' was circulated to all the health service providers to which X might present in labour.
- 5.6 On 20 December 2007, a Legal Planning Meeting attended by the Social Worker, the Team Manager, the Service Manager and a Council Solicitor decided that the grounds for an application for an Interim Care Order were met and noted that an Emergency Protection Order should be sought if necessary. The 'birth plan' document itself was not available at this meeting but the discussion was based on the plan to separate the mother and baby, rather than a plan not to allow X to leave the hospital with the baby.

- 5.7 On 27 December 2007, the Social Worker assessed X's mother to be a suitable person to supervise X's contact with the baby whilst in hospital but did not pass this information on to anyone.
- 5.8 On 28 December 2007, a Child Protection Core Group meeting was held. The purpose of this meeting was to produce a detailed Child Protection Plan to implement the full recommendations of the Child Protection Conference, a significant part of which task had already been undertaken by the 'birth planning' meeting. The meeting did not review or alter the 'birth plan' but appended it to the Child Protection Plan drawn up in the meeting.
- 5.9 On 10 January 2008, Solicitors for X wrote to the Council's Legal Services advising that they would be making an application for a residential assessment of X's capacity to parent her child. This was acknowledged but not passed on to the unborn child's Social Worker.
- 5.10 On 16 January 2008, a Solicitor acting for X's mother wrote to the City Council's Legal Services asking that she be assessed for her suitability to be the carer for the unborn baby. This was also acknowledged but not passed on to the unborn child's Social Worker.
- 5.11 On the 17 January 2008, a review of X's Leaving Care Pathway Plan took place with X, her Leaving Care Worker, the Social Worker for her unborn child, both Team Managers and the Nurse Specialist.
- 5.12 On 18 January 2008, the Social Worker for unborn baby K submitted the reports and papers required for an application for an Interim Care Order to the City Council's Legal Services, completing drafts presented to the Legal Planning Meeting and further papers provided on 8 January 2008.
- 5.13 On 22 January 2008, the City Council's Legal Services received notification that an application by X for Judicial Review of her Leaving Care Pathway Plan would be listed for hearing in the week commencing 28 January, which was also the week when X was due to give birth. On 28 January 2008 the date for this hearing was confirmed as 30 January 2008.
- 5.14 At that time there was some indication that issues about the care of X's as yet unborn baby might be raised at the hearing.
- 5.15 In the week before the baby arrived, X is recorded in the Children's Services case file as having said to her Social Worker that she was becoming more attached to the baby and would like to try to parent it, but is also noted as saying she knows (Children's Services) wouldn't let her keep the baby anyway.

- 5.16 On 29 January 2008, the Social Worker met X and took her to Nottingham City Hospital in the early stages of labour, dropping her off there at her request.
- 5.17 At 0211 hours on 30 January 2008, baby K was born in the Maternity Unit at the hospital. Her mother accompanied X during the birth. This was the early hours of the day on which X's Leaving Care Pathway Plan had been listed for Judicial Review.
- 5.18 At 0500 hours, after her mother went home, ward staff consulted Nottingham City Council Emergency Duty Team who confirmed they should implement the birth plan, which meant placing baby K on a separate ward. X was asked by the midwife on duty if she realised that she needed to separate her from her baby and said 'Yes' and made no objection.⁴ She was not asked if she agreed. This was done at 0510 hours that day.
- 5.19 Hospital records note that later on the morning of 30 January 2008, X, her mother and her aunt were unhappy that they could not see the baby. X was seen in the foyer of the hospital by a health worker and was said to be distressed. Hospital staff informed Nottingham City Council Children's Services of the baby's birth and that X was distressed. Children's Services agreed to find someone to supervise X's access to the baby but this had not happened by the time it was overtaken by events.
- 5.20 The Social Worker for baby K learned of the birth whilst en route to court in Nottingham for another case, which also involved her Team Manager and the Council's Solicitor for the baby K case.
- 5.21 At 0930 hours, at the High Court in London, Council representatives were made aware that Counsel for X intended to raise X's separation from her baby during the Judicial Review hearing. A Team Manager in Nottingham Children's Services was advised of this at 0955 hours that morning.
- 5.22 At 1010 hours that day Nottingham City Council's representatives in London contacted the hospital to establish the facts of what had happened in Nottingham and confirmed that the baby had indeed been separated from his mother.
- 5.23 Consequent to the application by X's legal representatives, Mr Justice Munby ordered that, provided X remained at Nottingham City Hospital, she should be reunited with baby K unless there was a lawful basis for the baby being removed from her care.
- 5.24 At 1230 hours, baby K was returned to his mother.

⁴ Midwife's statement in court proceedings

- 5.25 At 1240 hours an application by Nottingham City Council for an Interim Care Order was lodged at Nottingham Family Proceedings Court, the representatives for X having given an undertaking that she would not seek to leave the hospital with the baby.
- 5.26 The Interim Care Order hearing began on 31 January 2008, when an order was granted and the hearing was adjourned overnight. On 1 February 2008 a further Interim Care Order in respect of baby K was granted for a longer period.
- 5.27 Following his discharge from hospital on the afternoon of 1 February 2008, baby K was placed by Nottingham City Council in a foster placement.
- 5.28 On 7 February 2008, an appeal by X against the Interim Care Order was dismissed by the High Court. Other aspects of the Order were varied to facilitate an assessment of the viability of a residential assessment of X's and potentially Y's parenting capacity under section 38(6) of the Children Act 1989.
- 5.29 The case came before Mr Justice Munby again on 18 February 2008. His judgement was handed down on 5 March 2008⁵:
- 5.30 On 12 March Mr Justice Munby, on the application of Nottingham City Council, discharged the order requiring a residential assessment. He also made a time limited order under section 34(4) of the Children Act 1989 permitting Nottingham City Council to refuse contact by X with baby K as a result of an incident during contact between X, the baby's father and K. He made public an anonymised summary of his judgment in both matters.⁶

6. Findings of the Review

- 6.1 Prior to the birth of baby K, the involvement of agencies with X was set against the background of a fluid and continually developing situation, involving frequent contact with and intervention by a range of professionals across a number of agencies. X had a troubled history and working with her in the context of her pregnancy was complex.
- 6.2 Over the period of her pregnancy, X's views on the future care of her child were inconsistent and varied between providing care herself, placing the child with her family and having the child placed for adoption. From X's expressed feelings and wishes about her pregnancy and the baby, professionals

⁵ R (G) v Nottingham City Council (No 2) [2008] EWHC 400 (Admin).

⁶ Re K [2008] EWHC 540 (Fam)

concluded that she did not want the baby and knew she could not look after it. Although it was acknowledged that X may change her views after the birth of her child this perspective underpinned both health and social work staff planning for the baby's birth.

6.3 Prior to the Initial Child Protection Conference agency actions could have been better coordinated but individual responses to events were generally appropriate.

6.4 There were two exceptions to this.

- 1) Firstly, there were no arrangements in place between Nottinghamshire Police and Nottingham City Council Children's Services for the referral of unborn children where domestic abuse had been reported to the police by one of their parents. An allegation by X that she had, while pregnant, been assaulted by Y which was reported to the Police on 29 October 2007 was not therefore referred to Children's Services.

While Nottingham City Council Children's Services were informed of this by X herself, the making of a referral would have increased the likelihood that the Police would have been engaged in the subsequent planning processes and that potential risks associated with Y would have been considered.

- 2) Secondly, social work practice in relation to the assessments undertaken prior to the Initial Child Protection Conference did not comply with procedures or prescribed timescales. The assessment process did not engage all relevant agencies and family members. As a result, the written assessments were insufficient and did not meet the requirements of the statutory guidance in the Department of Health framework for assessment.⁷

Had practice in this regard been better the nature and extent of the risks posed by X, in particular that of actively harming her child and others, may have been more fully identified in the Core Assessment and the report to the Initial Child Protection Conference.

6.5 A number of other process and practice issues also limited the effectiveness of the Conference.

6.6 Firstly, not all the relevant professionals, especially those from the Probation Service, the Police, the NHS Mental Health Trust and Connexions who had contact with X were invited to the Conference. It is not clear why this happened but it followed on from the earlier practice which did not engage them in the

⁷ Framework for Assessment of Children in Need and their Families DH (2000)

assessments. This may have been because the assessments were based on a decision to undertake a Child In Need assessment rather than one in the context of a Child Protection enquiry. This meant that not all relevant information was available to the Initial Child Protection Conference and not all relevant issues were effectively explored.

- 6.7 Secondly, the Initial Child Protection Conference was a difficult meeting to manage. As is usual in such meetings, X was present but the manner of her participation was challenging. It might have been more appropriate for part of the meeting to been held without X to ensure that all issues were fully discussed. This is provided for in both Working Together to Safeguard Children and Nottingham City Safeguarding Children Board procedures.⁸
- 6.8 Thirdly, the meeting should have ensured that recommendations of the Conference were linked to the identified risks. The Conference should also have ensured that where recommendations were dependent upon decisions to be taken at the Legal Planning Meeting, contingency arrangements were identified.
- 6.9 Despite these limitations, the Initial Child Protection Conference concluded that the baby was at risk of significant harm from neglect and that X should not be permitted to leave the hospital with the baby. The recommendations were appropriate on the basis of the information and assessment discussed.
- 6.10 There was agreement that an Interim Care Order should be obtained and an Emergency Protection Order applied for if this was needed to protect the baby. The minutes and recommendations did not record that the baby would be at risk whilst in hospital. This could therefore have provided an appropriate legal framework for the protection of the baby and should have been built into the detailed planning for the birth.
- 6.11 Better practice prior to and at the Initial Child Protection Conference might have led it to come to the view that the risks to the unborn baby were more of physical harm rather than of neglect. If it had done so it might have made more robust recommendations which could have included the supervision of the baby on the ward or the separation of the baby at birth or soon after, with consideration of the appropriate legal framework for this remitted to the subsequent Legal Planning Meeting.
- 6.12 A 'birth planning' meeting was held the following day at the City Hospital between the Social Worker and four health professionals. The Social Worker and one of the health professionals had been present at the Initial Child Protection

⁸ Working Together to Safeguard Children (2006) 5.86 and NCSCB Procedures 3.109.

Conference. Its purpose was to agree and circulate advice to the community midwifery services and hospitals where X might present about how to manage the birth and the mother and baby afterwards. This was an ad hoc meeting which is not provided for within Nottingham City Safeguarding Children Board procedures but the tasks of the meeting were specified in the recommendations of the Initial Child Protection Conference.

- 6.13 It had originally been intended that the 'birth plan' would be drawn up with X present after the Initial Child Protection Conference, but this did not happen as X did not co-operate. She was not present at the meeting when it took place on the following day.
- 6.14 The professionals at this meeting introduced information about risks which had not been included in the reports provided to the Initial Child Protection Conference or discussed there. These risks were that X could actively harm her child and could pose a risk to others. This potential was grounded in statements previously made by X. Other information considered was however inaccurate; in particular that X had a history of absconding from health care facilities. This was not the case, X only having told staff she would leave the hospital and get out of Nottingham.
- 6.15 It appears to have been in the context of this wider discussion of risks that the professionals present decided that the mother and baby should be separated soon after birth and cared for on separate wards. A factor in this appears to have been that professionals felt X and her baby could not be adequately supervised on the ward with normal staffing.
- 6.16 Preparing a detailed plan for protecting the baby at the point of birth should have formed part of the task of the Core Group, which first met on 28 December 2007, once legal advice had been obtained. The production of the information alert for hospitals and community midwives should have been undertaken there or immediately following that meeting. That the 'birth planning' meeting took place before the Core Group meeting appears to have been because of the imminence of the birth, the urgency of issuing the alert before the Christmas and New Year period and because some key professionals were due to go on leave.
- 6.17 The designation of the plan prepared at the meeting as a 'birth plan' was a confusion, as the term is more usually given to a plan for the birth itself prepared in accordance with NHS guidelines by health staff. This 'birth plan' did include some healthcare elements of a birth plan for an expectant mother but was effectively a plan for safeguarding X's child once born. Bringing these two functions into one plan may have contributed to a lack of clear ownership of the plan by any professional or agency and to the lack of legal focus.

- 6.18 The Review has identified that this was the critical point at which the events which led to Mr Justice Munby's ruling were set in train.
- 6.19 The Review has also found that those involved do not appear to have recognised that they had gone beyond the recommendations of the Initial Child Protection Conference in this 'birth plan' and hence did not realise that there was a need for further legal or managerial advice.
- 6.20 Nottingham City Safeguarding Children Board procedures provide for professionals who have concerns about the outcome of a Child Protection Conference, or have new information, to refer this to the Team Manager for the child who should discuss it with the Chair of the Initial Child Protection Conference⁹. However in this situation it would appear that none of the professionals present, some of whom are experienced in managing high risk cases, recognised that they had gone beyond the original decision of the Initial Child Protection Conference and that this had implications for the legal process which the new plan required.
- 6.21 The Legal Planning Meeting on the 20 December 2008, attended by a different Solicitor to the one with conduct of the case who had attended the Initial Child Protection Conference and a Children's Services Service Manager, as well as the Social Worker, and Team Manager, was an opportunity to ensure not just that the threshold for care proceedings was met but also that the plan for protecting baby K after his birth was legally sound.
- 6.22 The Review found that this meeting planned on the basis of the separation of the baby from his mother at birth rather than on basis of the recommendation of the Initial Child Protection Conference that X should not be permitted to leave the hospital with the baby. By this time the birth plan and the decision and recommendations from the Initial Child Protection Conference had been circulated, but these two documents were not available in the meeting. The meeting therefore relied upon verbal information from the Social Worker, who was the only person common to all three meetings, and those present did not know that the plan being described differed from the recommendations of the Initial Child Protection Conference.
- 6.23 The meeting discussed the plan to separate the mother and baby soon after the birth, on the understanding that X was in agreement with this, relying upon her consent as the legal basis for the proposed separation of the mother and child¹⁰. The potential for X's consent to be withdrawn or to be impacted upon by her mental health was recognised and the need for an Emergency Protection Order if this happened was discussed

⁹ Paragraphs 3-136 and 3-158 of NCSCB procedures.

¹⁰ Under Section 20 1989 Children Act

and recorded in contemporaneous notes. Later information based on recollection is that the meeting did discuss the option of engaging the assistance of the Police to exercise their protection powers¹¹, in response to an emergency situation identified by hospital staff, and also advised that the Children's Services Emergency Duty Team should be alerted, and noted that this had already been done. The meeting recorded that the criteria for care proceedings were met but did not produce a detailed contingency plan detailing whether the criteria for an Emergency Protection Order with or without notice were also met.

- 6.24 This meeting did not check for recorded evidence that X was in agreement with the plan at the time of the Legal Planning Meeting, but it is clear that those involved believed from the information discussed at the meeting that her agreement was not in any doubt. Responsibility for obtaining consent to children being accommodated by the local authority is normally dealt with by Team Managers and Social Workers.
- 6.25 The review was advised that it was not customary for either the Service Manager or the Council's legal advisers to quality assure the legal documentation in a legal planning meeting as that was not its purpose and that that task lay with the Solicitor having conduct of the case.
- 6.26 Whilst the question of consent was discussed at this meeting it does not appear that the question of whether consent given immediately after birth could be considered as valid consent, given X's vulnerability, was not discussed. In his judgement against the council Mr Justice Munby restated the legal position about valid consent in these circumstances and the reasons for it, saying 'Our law has long recognized that women in the aftermath of birth may not be as able to act wisely as at other times. It is, after all, compassionate regard for those realities which underlies statutory provisions as disparate as section 1 of the Infanticide Act 1938 and section 52(3) of the Adoption and Children Act 2002'¹²
- 6.27 It appears that testing the validity of consent to accommodation, taking into account the parent's capacity to consent at the time the consent was required was not routine in legal planning meetings at this time.
- 6.28 Thereafter there is no evidence of any further discussion about the matter of consent taking place between the Social Worker and the Solicitor having conduct of the case.
- 6.29 The Core Group on the 28 December 2007, should have developed a detailed Child Protection Plan to implement the

¹¹ Under Section 46 Children Act 1989

¹² R (G) v Nottingham City Council [2008] EWHC 400 (Admin) paragraph 52

recommendations and decisions of the Initial Child Protection Conference, bringing together the decisions of the 'birth planning' meeting, since it had already taken place, and the Legal Planning Meeting. It did not however do this. The composite document of the Child Protection Plan with the appended 'birth plan' which was agreed by the Core Group contained conflicting information, with the Child Protection Plan remaining explicitly focussed on a risk of neglect and making no reference to removing the baby soon after birth, which was the key feature of the 'birth plan'. This seriously undermined its value to professionals following the birth of baby K.

- 6.30 This meeting which took place between Christmas and the New Year, within the required timescale, was attended only by the Team Manager and the Social Worker. The absence of other professionals from this meeting seriously limited its ability to fulfil its purpose. The Team Manager and the Social Worker had been present in the Legal Planning Meeting which had discussed the 'birth plan' and there was no new input into this meeting which might have led the Team Manager or Social Worker to re-evaluate the plan and to recognise that it had changed and was in need of the addition of the legal process to be followed when the baby arrived.
- 6.31 The Chair of the Initial Child Protection Conference, who also had a responsibility for ensuring the quality of the Child Protection Plan, was not sent a copy as procedures require.¹³. This meant that a further opportunity to identify that the plan had changed was lost.
- 6.32 The outcome of this sequence of meetings was that the plan to remove the baby at birth, decided on in the 'birth planning' meeting, had become the intended course of action, although this had not been the intention of the Initial Child Protection Conference. This relied on X consenting to separation from her child once she gave birth, but the Child Protection Plan did not have a specific action to ensure that she was seen by a Social Worker or other authorised professional before the baby was removed. It had also not been considered that consent obtained in these circumstances might not be valid and therefore had not made a detailed plan for an Emergency Protection Order to be obtained or for Police Protection powers to be exercised prior to the baby's removal.
- 6.33 It is evident that with the exception of the 'birth planning' meeting, the decisions were made within the formal framework of the Nottingham City Safeguarding Children Board. It was also the case that Nottingham City Council had provided legal advice to the decision making process. The Review has therefore concluded that there was an appropriate decision making and accountability structure in place but that on this occasion it did not serve X, the front line professionals or

¹³ Paragraph 3.148 of NCSCB procedures.

Nottingham City Council well. This formal decision making framework should have been sufficient to identify and correct the mistake made at the 'birth planning' meeting but it did not do so.

- 6.34 The Solicitors, Children's Services professionals and community health professionals most involved were all properly qualified and experienced in working with difficult cases where legal process may be required. It is clear that it was always the intention to seek an Interim Care Order and the necessary paperwork was prepared in good time. The need for an Emergency Protection Order or police powers were also considered. The Review has therefore concluded that the error was not due to inexperience of the professionals involved or lack of knowledge of the overall legal framework within which child care professionals operate.
- 6.35 Between the Core Group meeting on the 28 December 2007 and the baby's birth on 30 January 2008, a number of failings in communication also contributed to events on the day that baby K was born.
- 6.36 Firstly, the Social Worker, agreed with X an amendment to the 'birth plan' which enabled X's mother to supervise X's access to the baby at the hospital. This was not communicated to any of the professionals involved so that on the morning after the baby's birth, when X's mother and aunt visited the hospital no one on the ward knew that this had been agreed. This may have triggered the contact with X's solicitor, who by coincidence was already in the High Court on X's behalf in relation to her Leaving Care Pathway Plan, but it did not cause the problem of the lack of a legal basis for the plan.
- 6.37 Secondly, information provided to the Nottingham Children's Services Emergency Duty Team did not specify the action to be taken by the out of hours Social Worker. That professional was therefore reliant upon plans which were available within the electronic case file.
- 6.38 The review received contradictory information as to whether it was customary for an alert to the Emergency Duty Team to specify the action that was required and whether in the absence of a specific alert, the Emergency Duty team would accept plans made by the Social Worker holding the case. In this case the plan was relying on X's consent and the need for this to be reviewed with her once the baby was born had already been overlooked in the planning meetings.
- 6.39 In the event, the out of hours Social Worker should have enquired into the basis for the proposed separation, and should have visited the hospital to speak with X. Reliance on X's consent to the baby's removal effectively meant the baby was being accommodated under Section 20 of the Children Act

1989 and this decision should have been overseen by a Social Worker.

- 6.40 Staff at the hospital relied on Nottingham City Council Children's Services to assure the legality of the actions they took in separating the baby from his mother and had not foreseen any need to have their own legal advice. This was custom and practice at the time. It was however inappropriate; all agencies and professionals are responsible for understanding the legal framework within which they practice and for working within that framework.
- 6.41 Not effectively progressing the assessments of Y and the wider family of baby K as potential carers could also have impacted upon events on the morning of his birth. Although later the assessments found that family members were either not suitable or not willing to care for baby K, the potential to have identified options which were acceptable to X should have been explored. This might have led to her providing informed and explicit consent to an arrangement which appropriately safeguarded her child.
- 6.42 Non compliance with relevant timescales prior to convening the Child Protection Conference and the lack of resources identified at the Conference itself, all contributed to these assessments not being completed prior to X's child being born. The lack of time to complete these assessments should have been challenged by the Chair of the Conference or the Core Group and addressed by Nottingham City Children's Services management.
- 6.43 The failure to assess Y as a potential carer for baby K was also part of a more general absence of engagement of him by the professionals in the assessment and care planning processes. This, together with a lack of consideration of him within the Core Assessment and failure to invite him to the Initial Child Protection Conference, without clear and valid reasons, was not in accordance with statutory guidance. The review was advised that there were considerable difficulties in contacting Y and that significant efforts had been made; however these were not recorded in the case file.
- 6.44 There were other missed opportunities for professionals to recognise that the reliance on X's consent and the associated plans were likely to be subject to legal challenge and to intervene to change them.
- 6.45 Firstly, correspondence received by Legal Services from X's legal representatives intimating the intention to seek a residential assessment placement, particularly in conjunction with the application for Judicial Review of X's Leaving Care Pathway Plan, provided indications that legal challenge was possible. The Solicitor in the case considered that these were matters would be addressed in the Interim Care Order

proceedings and therefore did not need to be dealt with until then. This meant that there was no discussion between Legal Services and the responsible Social Worker about the possible significance of this.

- 6.46 Secondly this case occurred in the context of X's legal representatives having, from November 2007 onwards, made a number of applications for Judicial Review of actions taken by Nottingham City Council. In addition to the proceedings in respect of X's Leaving Care Pathway at the time of baby K's birth those Solicitors were corresponding with Nottingham City Council on four other cases. In these circumstances it would have been appropriate for the Council's Legal Services and Nottingham City Children's Services to initiate a senior level scrutiny of those cases where Judicial Review was applied for to identify issues that could be challenged, make improvements if necessary and manage risks to the local authority. This could have provided an opportunity for the problem of the legal basis for birth plan to have been recognised, though it may not have done so.
- 6.47 Thirdly, indications of the changing feelings of X towards the baby, shared with the Social Worker in the days before she gave birth, might have alerted the social worker to an increasing likelihood that X would not want to give the baby up once it was born and that more definite arrangements for an Emergency Protection Order to support the 'birth plan' would be needed.
- 6.48 Fourthly, by 0930 hours on the morning of 30 January 2008, the professionals representing Nottingham City Council at the High Court were aware that the legal challenge would take place. These professionals were not directly involved in the management of the risk to baby K. They did however communicate this to a manager acting for the Children's Services Service Manager in Nottingham who could have intervened to have arrangements put in place at the hospital, prior to the application being made, which did not rely upon X's consent to separation from her child. The professionals at the High Court could also potentially have requested a delay in the application whilst those arrangements were made. There is however no indication that this was considered. This would not have affected the judgment that the separation was unlawful but may have reduced the level of criticism directed at agencies in Nottingham.
- 6.49 Of concern is that on the 30 January 2008, when the direction was passed to the hospital to reunite baby K with his mother, there was no discussion between Children's Services and the hospital as to whether any additional measures to safeguard him, beyond the routine attention of hospital staff, were needed. This was however consistent with the original recommendation of the Initial Child Protection Conference.

- 6.50 Once the removal of her child was challenged by X in the High Court there was nothing that any agency could have done to avoid the criticism of agencies in Nottingham within Mr Justice Munby's judgement, or the adverse media coverage. In relation to the hearing on 18 February 2008, however, that criticism may have been mitigated had the reliance on the implied consent of X been presented as an explanation for the actions of professionals rather than as a justification on behalf of Nottingham City Council.
- 6.51 That the legal challenge took place within an arena that was open to media and public scrutiny is considered incidental to the observations on the practice leading to that situation. It did however have obvious implications for the subsequent management of the case and for public perception of and confidence in the agencies involved.
- 6.52 Despite the weight of media attention the incident fell outside the criteria for implementing the critical incident procedures of both Nottingham City Council and Nottingham University Hospitals Trust, which are designed for serious incidents concerning public and patient safety rather than public confidence in agencies. Nevertheless those managing the situation would have benefited from this type of high level co-ordination within and between the agencies involved. The review found that Nottingham City Safeguarding Children Board did not have an inter-agency protocol or procedure in place for managing a situation of this nature.

7. Conclusions

- 7.1 Throughout the period covered by this Review the overall focus of the agencies and professionals involved with X's child was appropriately on safeguarding him and promoting his best interests.
- 7.2 By the time of the Initial Child Protection Conference on 18 December 2007, it was clear that X's child would be at risk of significant harm if left in his mother's care and this judgement was confirmed by the subsequent making of an Interim Care Order on 31 January 2008.
- 7.3 The Review has found that that the difficulties encountered in this case arose not from the overall intention of the agencies and professionals involved to implement alternative care arrangements for baby K, which would protect him from harm, but from the processes and practice applied to achieving this.
- 7.4 The Review has concluded that the reason why baby K was separated from his mother shortly after birth without either explicit consent or due legal process is that there was insufficient clarity and rigour in the approach by all professionals involved to the legal framework within which

intervention to protect baby K took place and in particular to the reliance on consent by X within the plans for that intervention.

- 7.5 The professionals involved believed that prior to the baby's birth X did not want or feel able to care for her child. There were many events which led them to this view but they were also aware that she could change her mind when the baby arrived. They did not however obtain explicit consent to her baby being removed from her care whilst an Interim Care Order was sought. They relied on the fact that she and her Solicitor were fully aware of the plan and that X had not objected when it was explained to her. Crucially they had not made specific arrangements to have her consent confirmed and documented once the baby was born nor had they considered whether consent given immediately after birth could be considered valid because of the vulnerability of this young woman in that situation.
- 7.6 Whilst such consent need not be in writing, it needs to be evidenced and to quote Mr Justice Munby "a prudent local authority would surely always wish to ensure that an alleged parental consent in such a case is properly recorded in writing and evidenced by the parent's signature"¹⁴.
- 7.7 The Review found that there was a critical point in the management of the case from which the key mistake originated. This was that a necessary but ad hoc meeting, outside the Nottingham City Safeguarding Children Board procedures, to agree advice for community midwives and hospitals about the arrangements for X to give birth and to protect her baby, went beyond its brief. It escalated the plan recommended by the Initial Child Protection Conference from one of X being able to care for her baby on the ward but not to leave the hospital with him, into one of removing her child at birth, with no unsupervised access. This change was not recognised by those involved as a significant departure from the decision of the Initial Child Protection Conference despite two experienced professionals, who had substantial contact with X during her pregnancy, being common to both meetings.
- 7.8 On the information available to the Review the plan to separate the baby at birth may have been appropriate, given the risks which had been identified. Its implementation was however always going to need a detailed plan involving an assessment of X's capacity to give consent, the obtaining of that consent prior to the removal of the baby, and a detailed contingency plan which specified whether the criteria for an Emergency Protection Order without notice, or alternatively an Emergency Protection Order with notice were met, along with appropriate supervision arrangements for the period until an order was obtained. The birth plan was the only documentation sent to the hospital and midwifery staff and it did not contain any of this

¹⁴ R(G) v Nottingham City Council [2008] EWHC 400 (Admin).paragraph 53
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essential framework. This was therefore always likely to lead Children's Services and hospital staff into acting outside the law unless followed up with instructions about the appropriate legal process.

- 7.9 The Review has also identified that the weakness of the plan in relation to the issue of valid consent was not addressed by any of the professionals involved .
- 7.10 Further, the notice of the impending judicial review of X's Leaving Care Pathway Plan did not prompt any additional review of the Child Protection Plan by a more senior manager.
- 7.11 The significance of the issue of consent was also not recognised by any of the health professionals involved or their managers in connection with either the planning processes or the action taken following the birth of baby K. In this connection it is acknowledged that there was not an appropriate framework within either the Nottingham University Hospitals NHS Trust or Nottingham Primary Care Trust to ensure that professionals took responsibility for practicing within the law in this kind of situation and supported them in doing so. Whilst Mr. Justice Munby acknowledged the difficulties faced by those health professions who were on the ward in the middle of the night the Review considers that in such a fundamental matter of human rights they too need to be sufficiently aware of the law to exercise their responsibility to act within it.
- 7.12 The Review has concluded that a confused process between the Initial Child Protection Conference and the birth planning meeting, partly caused by the difficulties in managing the Initial Child Protection Conference and pressures of timing, led the key professionals to slip without realising it into making a plan which, if implemented without putting in place the appropriate legal processes, would be unlawful. This was effectively an error of individual and collective professional judgement.
- 7.13 Further, the managers and legal advisors operating within the Nottingham City Council accountability framework should have been able to prevent the front line practitioners from implementing this plan without an appropriate legal framework, but did not do so.
- 7.14 The Review has not found a single simple explanation for this.
- 7.15 It has concluded that a collection of factors were at work:
- a) a necessary focus on the need to protect the baby;
 - b) the difficulty of doing so in an orderly manner in the context of the volatility of the mother;
 - c) the professionals' belief that she did not want to keep or feel able to care for the baby;

- d) a lack of continuity in the attendance at the four key meetings and poor attendance at the Child Protection Core Group which may well have affected the ability of the professionals to recognise that the plan had changed unintentionally;
- e) a lack of clarity in professional decision making about consent, including:
- a belief that because X had not objected to the plan she therefore agreed with it;
 - a belief that it was preferable to work on the basis of consent or lack of objection as an expression of working in partnership with X and in keeping with the 'no order' principle of the 1989 Children Act¹⁵, without recognising the limitations of that approach in relation to valid consent;
 - an absence of focus on the need to make an assessment of the validity of consent where this is the basis for children being accommodated by the local authority; either when consent is given in circumstances where the parent knows that if they do not give consent the authority intends to seek a legal order, or as in this case where consent is sought at or soon after childbirth where the validity of consent needs special consideration;
 - a lack of recognition of the difference in legal requirements applicable to a plan for X not leaving the hospital with the baby, where intervention would be underpinned by a legal power if the mother attempted to leave with the baby, and a plan for the baby to be removed at birth where the definite intention to intervene required either valid consent or the application of legal powers;
 - a lack of clarity amongst some professionals that caring for the baby in another ward without the mother's consent with only supervised access by the mother constituted removing the baby under the Children Act 1989;
- f) the lack of an explicit process by either the council's legal services or children's services managers to assure themselves that arrangements for obtaining consent following the birth were in place and that such consent would be considered valid;
- g) a lack of clarity in the processes around the Emergency Duty Team;
- h) a reliance by frontline health professionals and managers within the two NHS Trusts on Nottingham City Children's

¹⁵ Section 1(5) of the Children Act 1989

Services to assure the lawfulness of health professionals' actions in an agreed interagency plan, together with a lack of awareness by those staff of the applicable legal framework;

- i) work pressure in Children's Services may well have contributed to some of the procedural and communications weaknesses in the case; but this was not the cause of the mistake in relation to the issue of consent.

7.16 The commitment of the professionals involved to ensure a safe outcome for the baby whilst continuing to work with and alongside his mother has not been in doubt.

7.17 Finally, the Review has concluded that even had the shortcomings of the plan to safeguard baby K been recognised; and arrangements put in place for obtaining, following his birth, explicit consent to his removal from his mother, or for exercising the legal provisions of the Children Act 1989, the professionals involved would still have been operating in an uncertain interface between the law and effective child protection practice. The validity of any consent given in such circumstances by such a troubled young woman would have been potentially questionable and only legal powers intended for use in emergency situations, and without opportunities for their basis to be tested by the courts, would have been available as alternatives during the period that X was separated from her child.

8. Lessons for the Future

8.1 The key learning from this case is:

- all professionals need to take personal responsibility for understanding and operating within the law. Managers and legal advisors should provide effective oversight in this regard;
- there is a need for a clear process pathway, which is compliant with Statutory Guidance and relevant legislation, for professionals managing concerns for unborn children;
- compliance with Working Together to Safeguard Children (2006) and Nottingham City Safeguarding Children Board procedures should have high priority for individual workers at all times, as these represent best practice and provide a framework to support good and lawful decision making;
- factors which hinder adherence to these procedures, such as workload pressures need to be given priority by management, as lack of resources is not a valid reason for not complying with the law in safeguarding children;

- all professionals should exercise their responsibility to fully engage with inter-agency meetings and to clearly share all relevant information. They should be supported in overcoming any barriers to doing so by the chairs of such meetings and their managers;
- working in partnership with parents to safeguard children should not be taken to mean relying on consent to actions which fundamentally affect parents' human rights without detailed consideration of the legal framework governing such decisions and absolute clarity that consent has been freely and validly given and is well evidenced.
- where a parent is willing to consent to their child being looked after by the Local Authority after birth the capacity of the parent to consent to this will need to form part of the assessment. Given the known vulnerability of mothers at the time of giving birth and soon after reliance on consent to the child's reception into care or its separation from the parent will rarely be appropriate, albeit that there are circumstances in which it may be so.¹⁶ Therefore where the removal of a baby at or soon after birth and prior to leaving hospital is considered necessary for the protection of the child this will usually need to be supported by a legal order;
- cases where there is a likelihood of an application for judicial review would benefit from scrutiny by senior managers so that any weaknesses in the provision of services or the management of the case can be remedied.

9. Recommendations

1. That Nottingham City Safeguarding Children Board develop processes for managing concerns for unborn children which are compliant with Statutory Guidance and relevant legislation.
2. That Nottingham City Safeguarding Children Board produce practice guidance for managers and practitioners specifically addressing the issue of valid consent in powers of professionals to intervene to safeguard children in planned and unplanned situations, and ensure that this is included in relevant training provided by partner agencies and in the Board's training strategy.
3. That Nottingham City Safeguarding Children Board and its partner agencies develop a multi agency 'critical incident' procedure including a media protocol for managing responses to incidents which have a serious and widespread impact on the safeguarding of children in Nottingham or affect public confidence in safeguarding children arrangements. Partner agencies should ensure that their internal critical incident policies and procedures are consistent with the arrangements developed.

¹⁶ Ref R (G) v Nottingham City Council [2008] EWHC 400 (Admin) Paragraph 58

4. That partner agencies of Nottingham City Safeguarding Children Board ensure that robust frameworks are in place and operated in a manner which effectively holds managers and staff accountable for the standards of their own practice; and for holding any staff they manage accountable for their practice. These should include explicit requirements and quality standards for professional supervision.
5. That Nottingham City Safeguarding Children Board ensure that the terms of reference for Child Protection Conference Chairs provide for robust management and oversight of Child Protection Conferences and associated child protection planning processes.
6. That partner agencies of Nottingham City Safeguarding Children Board require staff to explicitly record the reasons for fathers not being fully engaged in assessment and care planning processes relating to their children and the rationale for any decisions taken which would constrain such engagement.
7. That partner agencies of Nottingham City Safeguarding Children Board ensure that effective processes are in place for identifying and responding to potential risks to unborn children in connection with domestic violence incidents.
8. That the Nottingham City Council Director for Children's Services considers raising with the Department for Children, Schools and Families the potential for the law to be amended to enable the evidence that an unborn child, the time of whose arrival is unpredictable, will be at risk of significant harm and will require protection to be tested by a court in advance of the child's birth and appropriate directions to be made. This could offer a reasonable alternative to the current processes which have to be undertaken frequently out of hours in emotionally and practically difficult circumstances when the baby's arrives and offer better respect for the Human Rights of the parent and those of the baby.

Chris Few
Margaret McGlade
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