MANCHESTER SAFEGUARDING CHILDREN BOARD

Manchester Safeguarding Children Board

A Serious Case Review

'B1'

The Overview Report

September 2014

This report has been commissioned and prepared on behalf of Manchester Safeguarding Children Board and is available for publication on the 11th February 2016

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1 Introduction and context of the review

1. In early August 2013 the regional ambulance service were contacted by a 26 year old mother requesting an ambulance for her ten day old child (B1) who was not conscious or breathing at the family home in Manchester. The call was logged at 07.48 and by 07.49 a rapid response vehicle (RRV) was allocated along with a fully crewed ambulance. At 07.50 a further crewed ambulance that was already mobile had arrived at the family home at 07.53 along with the RRV. The original ambulance crew was stood down.

2. On arrival the paramedics found B1 in a bedroom on a bed with the 29 year old father lying beside the child. Mother informed the paramedics that father had lain on top of B1. The paramedics found B1 with no signs of life although initiated their basic life support treatment protocol with B1[1]. The ambulance left the property with B1 and mother for the local hospital arriving at 08.03 where B1's death was confirmed.

3. The police were notified of the incident through the emergency operations centre (EOC) at 08.00. The two older siblings (Sibling 1 and Sibling 2) were made the subject of police powers of protection (PPOP). A strategy meeting took place later the same day to plan statutory enquiries and assessment and to agree arrangements for the continuing protection of the surviving siblings.

4. Sibling 1 was aged ten at the time of the death and Sibling 2 was aged six. The two siblings had been the subject of a child protection plan from January 2009 until September 2010. They had also been looked after with the agreement of their parents from June 2010 until November 2010 when they were placed with their maternal grandmother. The involvement of children's social care services was then closed in April 2011.

5. There had been further involvement following referrals in January and June 2012 after a repeat of domestic abuse and the two older children were again subject of a child protection plan because of emotional abuse from March 2013. B1 was also the subject of a child protection plan following birth and therefore all children were identified as being at risk of significant harm.

6. The reasons for statutory involvement were centred on the domestic abuse and the use of alcohol and the neglect of the children. Father was convicted of neglect in early 2015 following the death of B1.

[1] The protocol covers continuous chest compression and ventilation, use of bag-valve mask to deliver oxygen, and insertion of a tube into the airway. An electro cardiogram applied to establish heart rhythm showed no activity. The paramedic continued their efforts throughout the journey to the hospital.

1.1 Rationale for conducting a serious case review

7. Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires a Local Safeguarding Children Board (LSCB) to undertake a review of a serious case in accordance with the procedures that are set out in chapter four of *Working Together to Safeguard Children (2013*).

8. The LSCB should always undertake a serious case review when a child dies or has been seriously harmed and abuse or neglect is either known or is suspected and there is cause for concern as to the way the authority, the Board or other relevant persons have worked together.

9. The reason for undertaking this review is that B1 may have died as a result of neglectful parental care. The death was reported to the Manchester Safeguarding Children Board (MSCB) and was reviewed by the serious case review sub-group on the 17th September 2013 who recommended to the independent chair of the MSCB that the circumstances of B1's death met the criteria for a mandatory serious case review.

10. The review was commissioned by Ian Rush, the independent chair of the MSCB on the 17th September 2013.

11. The commissioning meeting for the serious case review was on the 11th October 2013 and confirmed the scope and methodology for the serious case review.

12. The purpose of the review is to establish what lessons are learned from the case for improving safeguarding services, to improve inter-agency working and better safeguard and promote the welfare of children in Manchester.

1.2 The methodology of the serious case review

13. A serious case review team was convened of senior and specialist agency representatives to oversee the collation and analysis of information and outcomes of the review. The review was co-ordinated and managed by two independent lead reviewers with appropriate experience and training. Further information is provided in section 1.6.

14. The review team that oversaw the serious case review decided to build on the learning that had been developed from previous serious case reviews in the city; one of those had been wholly conducted using the SCIE (Social Care Institute for Excellence) framework and other serious case reviews had used the framework to present the findings from the review.

15. This review uses a systems based approach to analysing information and presenting the findings in the final chapter using recommended best practice in identifying improvement and learning.

16. Work began on compiling a multi-agency chronology in December 2013. From the collated chronology the initial meeting of the review team identified the initial key lines of enquiry.

17. The review team also identified information for individual agencies to provide to the review. This included almost 100 documents and reports from services working with the family in regard to assessments (DASH and children's social care services statutory) and multi-agency meetings (strategy meetings, child protection conferences and core groups) and child protection plans and working agreements. There were reports from professionals to the child protection conferences and midwifery records. The review also had copies of the domestic violence prevention notice (DVPN) and the domestic violence prevention order (DVPO).

18. The review team identified the services and individual practitioners that would provide information and participate in the review. A briefing was held in early January 2014 which was followed by a programme of individual conversations with seventeen practitioners which were facilitated by members of the review team and lead reviewers.

19. The review team used the information from the conversations and other evidence to identify the following as key practice episodes for particular learning in this serious case review:

    a) The incident of domestic abuse in June 2012 and referral to the police public protection and investigation unit and children's social care services;
    b) Use of the domestic violence prevention notice (DVPN) and domestic abuse prevention order (DVPO);
    c) Core assessment in March 2013;
    d) Core assessment in June 2012;
    e) Reassessment of father's level of risk by the probation service in August 2012;
    f) Pre-birth assessment and child protection conference in May 2013;
    g) The hospital discharge planning meeting in July 2013 after B1's birth.

20. The findings in the final chapter of this report use an adaptation of the framework developed by SCIE to present the key learning within the context of the local arrangements.

1.3 The scope of the serious case review

21. The period under review is from the 10th June 2012 (date of an incident of domestic abuse which initiated a multi agency intervention leading to the second episodes of the older siblings being subject of a child protection plan up to the date of the strategy meeting in mid August 2013.

22. All agency chronologies included detailed information about when the children were seen or observations were made about them.

23. The following agencies have provided information and contributed to the serious case review in accordance with *Working Together to Safeguard Children (2013)*, Chapter 4 and the associated LSCB guidance and relevant learning and improvement frameworks.

    - Health services in Greater Manchester that include:

        - Central Manchester Foundation NHS Trust (CMFT) (acute, maternity and community services)
        - Pennine Acute Hospitals NHS Trust (provided midwifery services during the pregnancies);
        - Manchester NHS general practitioner services under the clinical commissioning group;
        - North West Ambulance Service.

    - Manchester Education Services (primary education for Sibling 1 and Sibling 2)
    - Manchester Community Alcohol Team (Manchester City Council and Manchester Mental Health and Social Care NHS Trust)
    - Greater Manchester Police (GMP) (in respect of responding to incidents of domestic abuse and investigation of the death of B1)
    - Manchester Children and Families Services providing children's social care services in respect of statutory assessments, management of the child protection plan and arrangements for the two older children to be looked after (LAC) by their grandmother
    - City South Housing Trust
    - Greater Manchester Probation Service Trust
    - NSPCC (did not provide any services to the family).

24. Information sought from the family is described in section 1.7.

1.4 Particular issues identified by the serious case review team for further investigation by the key lines of enquiry:

25. In addition to analysing individual and organisational practice the review considered:

    a) The quality of the assessment of risk to B1 including; the adequacy of the child protection plan, the functioning of the core groups, the oversight and challenge of the child protection case conferences;

    b) The recognition and assessment of neglect;

    c) Were Public Law Outline arrangements ever considered in this case?

    d) The extent to which domestic abuse and alcohol abuse and the associated impact on parents were recognised and assessed;

e) Was there evidence of a resistant family or disguised compliance. Failure to recognise the risks associated with their behaviour and no willingness to change;

f) Voice of the child, were the children spoken / listened to? Were their views, wishes and feelings taken into consideration?

g) Race, ethnicity, culture and economic circumstances. Mother and Father were of different ethnic origin. What impact did this have on the family circumstances? Were there any tensions? What impact did this have on the children/subject?

1.5 Membership of the case review team and access to expert advice

26. The case review team that oversaw this review comprised the following people and organisations from Manchester:

Position	Organisation
Head of Safeguarding and Improvement Unit	Children and Families Directorate (children's social care) MCC
Locality Manager	Children and Families Directorate (children's social care) MCC
Detective Sergeant	Greater Manchester Police
Designated Doctor	Manchester Clinical Commissioning Group
Deputy Designated Nurse	Manchester Clinical Commissioning Group
Named Nurse	Central Manchester Foundation NHS Trust (CMFT)
Acting Operations Manager	Greater Manchester Probation Trust
Head of Service	Community Alcohol Team
Director of Resources	City South Housing Trust
Education Case Manager	Education and Skills Directorate MCC
Team Manager	NSPCC
Business and Performance Manager	MSCB
Business Support Officer	MSCB

27. The independent lead reviewers attended every meeting of the review team and case group meetings. One of the reviewers took lead responsibility for facilitating meetings and overseeing documentation and liaison in regard to family contact. The other lead reviewer took principle responsibility for drafting the report. Both of the independent reviewers participated in conversations and meetings with case group members and collating evidence and information.

28. The review team had access to legal advice from a solicitor in the council's legal service. The team also had access to other specialist advice if it had been required.

29. Written minutes of the review team meeting discussions and decisions were recorded by a member of the MSCB business unit.

1.6 Independent lead reviewers

30. Valerie Charles works as an independent consultant and is registered with the Health and Care Professions Council (HCPC). Valerie has been qualified since 1991 and has a professional social work qualification and MA. She has extensive experience of working in children's services in both the local authority and voluntary sector. She was a senior manager for NSPCC from 2006 to 2012. Valerie has worked in different roles within local safeguarding children boards, including chairing serious case reviews and has experience in systems methodology case reviews. Valerie has undertaken training for independent reviewers.

31. Peter Maddocks has over thirty-five years experience of social care services the majority of which has been concerned with services for children and families. He is the author of the report. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the HCPC. He undertakes work as an independent consultant and trainer and has led or contributed to several service reviews and statutory inspections in relation to safeguarding children. He has undertaken independent agency reviews and has provided independent overview reports to several LSCBs in England and Wales as well as work on domestic homicide reviews. He has undertaken work as an overview author on two previous serious case reviews in Manchester. Apart from this, he has not worked for any of the services contributing to this serious case review. He has also participated in training for overview authors and independent reviewers including the application of systems learning.

1.7 Parental and family contribution to the serious case review

32. In view of the separate investigation by the police as well as the coroner's enquiry the serious case review team had to ensure that all contact with the family was the subject of appropriate consultation and advice. The review team used the national guidance agreed between chief police officers, the Crown Prosecution Service and the Directors of Children's Services in England[2].

33. The parents were made aware of the serious case review when it was commissioned, in a letter sent to them on the 7th February 2014. At the time of the review being conducted there was an ongoing investigation by the police. Both parents were summoned in June 2014 to appear in court. Father was charged with offences

[2] A Guide for the Police and the Crown Prosecution Service and Local Safeguarding Children Boards to assist with liaison and the exchange of information when there are simultaneous chapter 8 serious case reviews and criminal proceedings; April 2011

relating to child neglect and was convicted in early 2015. He was sentenced to eight months in prison suspended for two years.

34. In view of the legal proceedings it was not possible to seek any direct evidence or information from either parent until after the criminal proceedings had been completed.

35. Mother took up the offer of a meeting with the independent reviewers after father's conviction. Mother acknowledged that at the time of the events examined by the review she had been unable to see the impact of domestic abuse and alcohol use on the children. She acknowledged that she had been unwilling accept the concerns of professionals.

36. Since the review was completed mother has undertaken courses that have helped her see the impact of such behaviour on children. She says that this would make her behave differently now. She says that she could now see things from the child's perspective and would be more open to the concerns and advice of professionals.

37. Mother found some professionals more helpful than others. She could not identify anything specific that could have helped at the time although was keen that the review helped learning.

1.8 Time scale for completing the serious case review

38. The case review team met on five occasions between December 2013 and April 2014. The review findings were presented to the MSCB in August 2014.

1.9 Status and ownership of the overview report

39. The overview report is the property of the Manchester Safeguarding Children Board (MSCB) as the commissioning board for the serious case review.

40. Since June 2010, all overview reports provided to LSCBs in England are expected to be published in full. This overview report provides the detailed account of the key events and the analysis of professional involvement and decision making in relation to B1 and family.

41. An executive summary is not required by the revised national guidance set out in *Working Together to safeguard Children 2013.* The MSCB will determine how and what further information is provided to the family at the conclusion of the review and following the submission of the overview report to the Department for Education.

1.10 Cultural, ethnic, linguistic and religious identity of the family

42. Child B1's mother is Black British and father is Asian British. Mother's first and only language is English. Father spoke Urdu and English. There is no recorded physical or

learning disability. There is no information about any religious or cultural affiliation over and above the fact that father was celebrating the Islamic festival of Eid the evening before Child B1 died. Father has been long term unemployed. Mother has worked in a series of casual or short term jobs although very limited detail is provided in any assessment or reports. The family were in receipt of housing and other benefits and rented a two bedroom property.

43. The father was living with his parents while the children stayed with their mother in the family home. Although the parents had daily contact father was not supposed to be staying overnight because of concerns about his use of alcohol and the potential for domestic abuse.

44. B1 was living in an area of Manchester that is amongst the ten per cent of the most deprived areas in England.

45. The area has a higher concentration of people from a Black or ethnic minority background compared to the city's overall population profile. The area has higher levels of children living in poverty, with ill health and also experiencing crime. The area has a higher concentration of adults who have no educational qualifications.

46. The north west of England has a higher rate of teenage pregnancies; there are also higher concentrations of families living in social housing and a lower proportion of children are living in two parent households.

47. There are 115,910 children and young people aged 0-19 years living in Manchester according to the 2009 mid-year population estimate. This accounts for 24 per cent of the city's total population of 483,830. Manchester has been growing at over 1 per cent a year since 2001, twice the average rate of growth in England and Wales. The number of children aged five to 14 years has decreased during this period, but there has been an increase of over 20 per cent in the number of children aged under five.

48. The 2007 Index of Multiple Deprivation ranked Manchester as the fourth most deprived local authority area in England. In 2009, 77 per cent of pupils lived in one of the 20 per cent most deprived areas in England. The area in which Child B1 lived is one of the 10 per cent most deprived areas in England. In 2010, 37 per cent of primary school pupils and 34 per cent of secondary school pupils were eligible for free school meals, significantly more than nationally. In the 2001 census, 31 per cent of children and young people aged 0 to 19 years were from minority ethnic groups compared with 26 per cent for the total population. According to the January 2010 school census, 35 per cent of primary school pupils and 30 per cent of secondary school pupils spoke English as an additional language, well above other areas of the country. Over 170 languages are spoken across schools in Manchester.

49. In Greater Manchester, domestic abuse accounts for six per cent of calls to the police for assistance. Of these calls, 16 per cent were from repeat victims. Greater Manchester recorded 905 assaults with intent to cause serious harm, of these 154 were domestic abuse related. This is 17 per cent of all assaults with intent to cause

serious harm recorded for the 12 months to end of August 2013. The force also recorded 12,953 assaults with injury, of these 4,478 were domestic abuse related. This is 35 per cent of all assaults with injury recorded for the 12 months to end of August 2013[3].

2 Summary of agency contact and involvement

Historical context

50. This summary of professional contact with B1 provides an account of the most significant events and decisions from the different services involved with B1 during the timeframe established for the review. It does not give an account of every contact with an individual professional or service.

51. Mother and father first met when they were teenagers. The family have been known to several services over many years. Both parents have longstanding problematic use of alcohol that certainly for father began in adolescence and this has been a significant factor in the aggravation of domestic abuse, antisocial behaviour and neglect of the children.

52. Mother had been permanently excluded from school. She first came to the notice of the police for a robbery as a 12 year old. She has been arrested 26 times between 1996 and 2012. The father also had a disrupted education. He first came to the notice of the police as a 15 year old in relation to robbery. He has had numerous contacts with the police since then; on two occasions it was in relation to driving offences. He has a record of verbal and physical violence including arguments and assaults on at least 15 occasions to mother and assaults on at least two males. He was convicted and sentenced to 30 months imprisonment in March 2010 following an assault on a neighbour with a hammer in 2009.

53. There was an incident of domestic abuse as early as 2002 and a year before the first child was born in 2003. The parents separated very briefly in May 2004 when mother told the father to leave the home due to his drinking, constant arguing and lack of support in parenting the children. There were further reports of domestic abuse in June 2004 that involved a new partner that mother had. Both adults refused to give statements.

54. The parents were reconciled during 2004. There was further domestic abuse involving both parents. There were five incidents of domestic abuse involving a police response between the birth of the first child in August 2003 and the birth of the second child in March 2007. In October 2008 father was cautioned for two common assaults on mother and Sibling 2 during an incident of domestic abuse. The subsequent referral to children's social care services led to the first initial child

[3] Source: HMIC data collection. Crime figures are taken from police-recorded crime submitted to the Home Office.

protection conference. There were 15 recorded incidents of domestic abuse between August 2002 and June 2012.

55. Children's social care services have known the family since December 2003 due to the recurring concerns about domestic abuse, both parent's alcohol abuse and the lack of their insight into the impact of these factors on their children.

56. There is a history of poor maternal and paternal engagement with health services. There were attendances at the hospital emergency service for the older siblings; there were eight for Sibling 2 between April 2007 and September 2011. There were missed appointments with primary health workers such as health visitors and delays in completing routine health assessments. Both older children had a history of delayed immunisations and missed dental appointments; this resulted in severe dental caries (tooth decay) for one of the older siblings and the extraction of nine teeth. Sibling 1 had delayed development of speech and language.

57. The older siblings were made the subject of child protection plan under the category of neglect between 16th January 2009 and the 22nd September 2010. Mother was referred three times to the community alcohol team (CAT) between May and October 2009 and again on two more occasions in 2010 but did not attend any appointments. She acknowledged drinking heavily but asserted that it was 'only at weekends' and when the children were with their maternal grandmother. The involvement of CAT ended in January 2010 when it was apparent that mother was unwilling to engage with any of the advice and support being offered[4].

58. The children subsequently became looked after children under section 20 of the Children Act 1989 and were placed with their maternal grandmother between 14th June 2010 and again on the 17th November 2010 after their mother had reportedly gone to the shops and the police used their powers of protection; when they were returned to mother's care the father was still in prison. During the time that the children were looked after it appears that mother had daily and extensive contact and remained effectively in control of contact and interaction with the various professionals. The case was closed in April 2011.

59. Children's social care services received further referrals in January and June 2012 owing to further incidents of domestic abuse and the two older children again became subject of child protection plans on the 7th March 2013 under the category of emotional abuse.

60. The family had significant levels of debt including being in arrears with the rent. The landlord had secured a Possession Order but had not initiated any eviction proceedings.

[4] Outside the time frame for the SCR she was referred again in October and November 2013 and did not engage, and then a social worker referred again in January 2014. On that referral it states that mother denies that she has a problem with alcohol although her presentation suggests otherwise.

Incident of domestic abuse and response by services

61. On the 10th June 2012 in the late afternoon the police were summoned by mother who had been assaulted by father. The police arrived and mother began to shout and scream about father hitting her in the face and that he had also broken her jaw the previous month. She said that she was fed up with him and wanted to be rid of him. Mother was intoxicated.

62. The officers interviewed the parents separately. Mother had been out all night and had returned to the house with three men. There had been an argument between mother and father and during the argument father had punched mother to the side of the face; there was no mark visible to the officers. Mother slapped father in the face while the officers were still present. Both parents were arrested in relation to the respective assaults although it was subsequently decided that neither would be prosecuted on the basis that it would not be in the public interest.

63. The officer completed a DASH (domestic abuse, stalking and harassment) assessment that graded the circumstances as reflecting medium risk.[5] A referral was made to children's social care services and a strategy meeting on the 27th June 2012 took place between the police and children's social care services. The meeting acknowledged that there had been a core assessment completed in March 2012 following previous incidents of domestic abuse which had concluded that there were no concerns in regard to the children and that mother was able to safeguard them. The children were reported to be up to date with immunisations and the school did not have concerns. The case had been closed to children's social care services. The police understood that a further core assessment would be completed by children's social care services; in the event an initial assessment was completed on the 27th June 2012.

64. The initial assessment was completed outside timescale and concluded that the pattern of domestic abuse had been ongoing for several years and that further assessments were required to ensure that the children were not at risk. The assessment notes that mother did not want to allow social workers into the house to speak to the children alone. The assessment also noted that mother showed no insight or understanding about the negative impact on the children. The initial assessment recommended that a core assessment would be completed.

Report of domestic abuse in August 2012 and use of the domestic violence prevention notice (DVPO)

[5] ACPO (association of chief police officers) council accredited the DASH (Domestic Abuse, Stalking and Honour Based Violence) to be implemented across all police services in the UK from March 2009. The DASH is a risk identification, assessment and management framework and means that most police services and a large number of partner agencies across the UK are using a common checklist for identifying and assessing risk, with the intention to save lives.

65. Mother made a 999 call to the police to report father having punched her to the face and was refusing to leave the property. Police officers went to the house and arrested father. Mother told the arresting officers that she did not wish to make an allegation of assault or to make a statement. Father was subsequently interviewed under caution during which he declined to make any comment. The CPS advised that due to insufficient evidence they would not authorise a prosecution. The incident was the seventh since the beginning of the year and the police constable made report to the public protection investigation unit recommending that further action and support was required because there were two children in the household. The sergeant in public protection investigation unit initially allocated the case for follow up referral to the MARAC and to seek a strategy meeting. It was subsequently reassessed before going to MARAC and graded as medium risk and therefore not for MARAC.

66. Father was issued with a domestic violence prevention notice (DVPN) and the domestic violence prevention order (DVPO) issued by the magistrates[6]. This was delivered to the paternal grandparents' home on the 9th August 2012 where father was living although he was not in. The DVPO was left with his father. The order prohibited father from going to the family home or to assault, harass or molest mother. The order was for 28 days.

67. A police referral was made to children's social care services on the 16th August 2012 to inform them about the further domestic abuse and the issuing of the DVPN and DVPO and requesting a strategy meeting given the concern that father would be allowed back into the family home. Coincidentally father's prison licence came to an end on the 19th August 2012 and bringing the involvement and supervision of father by a probation officer to an end[7].

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[6] A DVPN was initially piloted in three police areas from June 2011 and is the 'go order' issued to a perpetrator and is the initial notice issued by the police to provide emergency protection to an individual believed to be the victim of domestic violence. This notice, which must be authorised by a police superintendent, contains prohibitions that effectively bar the suspected perpetrator from returning to the victim's home or otherwise contacting the victim. A DVPO (domestic violence prevention order) is issued by a magistrate upon the application through notice of the police and lasts for 28 days.

[7] Prisoners who qualify for parole are released from prison 'on licence'. This means that although they are not serving their sentence in prison they are still required to adhere to certain conditions whilst serving the remaining part of their sentence in the community. Time spent 'on licence' in the community is supervised by the probation service. There are six standard conditions for prisoners serving determinate sentences (a custodial sentence with a fixed length). The prisoner should: behave appropriately and not commit further offences or undertake any activity that may undermine their attempts to resettle in the community; maintain contact with their supervising probation officer and do what is asked of them; allow their supervising probation officer to visit them at home if they need to; live at an address approved by their probation officer and keep them informed of any changes of address (even if only for one night); only do work, paid or unpaid, that has been approved by their probation officer and keep them notified of any changes in employment; not travel outside of the United Kingdom. If the conditions are breached the prisoner is sent back to prison to complete their original sentence.

68. In the event, a strategy meeting did not take place; a joint home visit to mother by a detective constable from the public protection investigation unit and the social worker on the 29th August 2012 explained that unless the domestic abuse was resolved it might be necessary to refer the children back to a child protection conference with a view to making them subject of a child protection plan. Mother did not want this to happen and said that she was now prepared to take counselling and mediation (which in any event would not have been an appropriate strategy and response to domestic abuse). She also made it clear that she did not agree with the DVPN.

Completion of core assessment October 2012 and multi agency meeting discuss domestic abuse

69. The core assessment had been agreed following the incident of domestic abuse in June 2012 and was therefore significantly outside the national and local timescales for completing a statutory assessment. The assessment concluded that 'case planning should occur' and that the children would be spoken to alone at school to ascertain their wishes and feelings. The assessment also recommended counselling for both of the parents.

70. On the 16th November 2012 a multi agency meeting at the school chaired by the social worker and attended by the mother, head teacher and school nurse discussed the incidents of domestic abuse. Sibling 1's school attendance was just over 90 per cent whilst Sibling 2 had managed almost 97 per cent attendance. Both children had been discharged from the dental clinic at the local health centre after two appointments had been missed.

Further domestic abuse in late 2012 and evidence of significant debts

71. In November and December 2012 the police followed up two 999 phone calls that were abandoned by the caller. On the 9th December there was third call that was also abandoned and again the police followed up with a visit to the home. On this occasion the police found mother upset that the police were in the house. Both parents were unwilling to speak with the police officers who had noticed several letters thrown around the kitchen floor and that indicated that the family owed several thousand pounds to various companies. Father agreed to leave the property.

Confirmation of third pregnancy, evidence of neglect and further domestic abuse and second use of the DVPN

72. On the 17th December 2012 mother made the first contact with the midwifery service at the local health centre in regard to her pregnancy with B1. She did not attend the antenatal booking appointment made with the community midwives for the 24th December 2012.

73. Mother attended for the ante natal booking appointment on the 7th January 2013. The booking confirmed details about the parents including the fact that they both

smoked and were willing to accept specialist support regarding this. Information about substance misuse was only recorded in relation to mother who reported that she did not misuse alcohol or drugs. There is confirmation that routine enquiries were made about domestic abuse and that no disclosure was made. She was booked for midwifery led care during the pregnancy[8].

74. On the 9th January 2013 five year old Sibling 2 had nine teeth removed due to dental cavities at the hospital paediatric dental service. The GP was routinely notified by letter.

75. On the 12th January 2013 mother contacted the police in the early afternoon to report that father had assaulted her. Mother stated that she was too busy to make a statement but would do so at a later time. Father was arrested but declined to answer any questions.

76. A multi agency child in need (CIN) meeting on the 15th January 2013 was chaired by the social worker at the school. The meeting was advised that mother was pregnant and that there had been further incidents of domestic abuse. No minutes were recorded and no CIN plan was agreed. A further meeting was scheduled for the 5th March 2013. There is no record of the midwifery or health visiting service being alerted to the CIN meeting or invited to participate.

Section 47 enquiries and initial child protection conference

77. On the 23rd January 2013 father was issued with a second DVPN after both parents had declined to co-operate with the police in regard to the domestic abuse incidents. A referral was made to children's social care services on the 1st February 2013.

78. A strategy meeting was held three weeks later on the 22nd February 2013. The meeting agreed that the police and children's social care services would complete enquiries. On the 25th February 2013 the decision was taken to convene an initial child protection conference which took place on the 7th March 2013.

79. The initial child protection conference discussed the pattern of domestic abuse, the dental cavities and use of alcohol by both parents. The initial child protection conference agreed that both children would be subject of a child protection plan under the category of emotional abuse, that a core assessment would be completed and that the school nurse would coordinate a health assessment of both children.

80. The first core group meeting on the 21st March 2013 was told that the family were on the verge of eviction due to the rent arrears; this appears to have been an assumption rather than based on fact as the landlord service has never initiated any

[8] The booking form asks for details about the birth father in regard to their name and date of birth and a box for proposed contact with the baby although the space to provide information is minimal and in this case was completed with just 'father'. Although the form recorded information about smoking for both parents the subsequent questions about substance use focussed completely on the mother.

eviction procedure. The social worker had produced a 'working agreement' that was challenged by mother in relation to the proposed restrictions on her contact with father. Father was to be referred to alcohol services.

81. The second core group meeting on the 25th April 2013 was attended by mother but not by father. The landlord had organised involvement from the FIP service. The social worker had made a referral to women's aid; counselling at Relate was also discussed. The social worker advised the group that the case would be allocated to a different social worker (SW3). The case was transferred later that day.

82. The first review child protection conference on the 8th May 2013 was told that mother would separate from father because she wanted to put her children first. However father wanted to return to the family by the time that B1 was born. He claimed that he was no longer drinking alcohol. The core assessment remained unfinished and a pre-birth assessment was required for B1 within the following five weeks. The children remained subject to the child protection plan. The chair of the child protection conference advised that the 'working agreement' needed to included a 'firm agreement that father will self refer to the community alcohol team' and that failure to adhere to the child protection plan should result in 'legal consultation'.

Initial child protection conference and post birth contact

83. On the 3rd July 2013 the initial child protection conference in regard to the unborn B1 agreed that the baby would be subject of a child protection plan because of the risk of emotional neglect. The child protection plan was opposed by mother. B1 was born at the end of July 2013 at 38 weeks gestation but with a low birth weight of 2.19kgs.

84. A discharge planning meeting at the hospital was told that father was not living at the home address but stayed overnight a couple of nights a week. The postnatal discharge planner was completed confirming that there had been a discussion about reducing the risk of cot death with the parents and that written information had been provided[9]. The planner recorded that mother stated that she was not a smoker which was contradictory to the information recorded at the booking of the pregnancy.

85. The first visit by the midwifery service was done without knowledge of the child protection plan. B1 was making good weight gain.

86. Less than a week after being discharged from hospital B1 died.

[9] The post natal discharge planner is a discrete document that is a list of actions to be completed prior to discharge from hospital and includes a section on 'discharge information discussed' such as post natal exercise, contraception and reducing the risk of cot death.

3 Appraisal of professional practice in this case

87. B1's parents and siblings were well known to agencies and there had been a high level of involvement for over ten years. During this time there had been persistent concerns about domestic abuse and consumption of alcohol. Father was convicted in 2009 following an assault on a neighbour. Although the parents separated for a few weeks in 2004 and again during father's imprisonment between March 2010 and May 2011, they have continued their relationship ever since they were teenagers.

88. The family lived in a small and settled community. Although they had rent arrears and there had been reports of anti-social behaviour the family had not been regarded as particularly problematic by the landlord service relative to other tenancies. The senior manager in the landlord service had not been made aware of them until the serious case review signifying that they were not a family that were attracting a high level of concern from a housing and community perspective. If any safeguarding issues arising from B1's birth had been clearly identified then the housing officer could have requested the Director to consider waiving the rent arrears control that blocked the application from being progressed; this would have restarted the application process and moved the family up the re-housing application list. This was not done.

89. Mother was in employment intermittently; this disrupted housing benefit which contributed to some of the difficulties in rent arrears although the family were known to have significant levels of debt although the extent and nature of debt was never established by any service. The children regularly attended school where they participated well and received good support and education at an outstanding school (as judged by Ofsted).

90. Although there had been child protection plan's in place for the two older siblings for several months between January 2009 and September 2010 and again from March 2012, there had been a collective inability to recognise and respond to the parent's attitude, behaviour and lifestyle that was detrimental to the children's emotional health and well being.

91. The parents have a long history of minimising concerns about their children's emotional well being and were unwilling to engage with any professional unless it was on their terms or to postpone any threatened action to have the children removed from their care.

92. The parents made little effort to disguise their ambivalent or hostile attitude to professionals raising concerns about the children and mother in particular proved to be very effective in hijacking the conduct of some important meetings such as the child protection conferences or reviews when she felt threatened and was not prepared to acknowledge or accept inconvenient or uncomfortable evidence about how the behaviour of both parents would damage their children.

93. Several of the professionals talked about how emotional and challenging some of the meetings had been and commented on how the minutes did not reflect that dimension of the interaction.

94. Mother consistently refused to allow professionals to speak to the children on their own or at school; both of the older siblings were very guarded in their interaction with teaching and support staff for example. She did not participate in core groups and nor did father.

95. Mother was reluctant to allow any service into the house including the family intervention project (FIP) that had been organised through the landlord service when they knew about the child protection plan from March 2012. Mother was especially opposed to children's social care services and saw any other service as a route for information to be fed back. Mother was very concerned to not give any reasons for the children to be removed from her care. The reluctance to engage contributed to a 'softly softly' strategy being used to try to gain confidence and trust and undermined a more assertive approach that some professionals including one of the child protection conference chairs felt should have been pursued.

96. The FIP worker made a total of 29 visits to the home of which only 15 were successful in getting access to the house; five visits were cancelled by mother at short notice. The FIP worker had the most success in getting access to the house. There was never an explicit rejection of the contact; more usually if an excuse was given it was because there was a clinic appointment or a need to go to a job interview. Ironically, the FIP worker was never given a copy of the child protection plan or the working agreements although did attend meetings and was in contact with the social workers.

97. Mother's repertoire of strategies for dealing with professionals ranged from being warm and friendly (at least initially until challenged such as with the midwife), ingratiation (such as baking cakes for school), being argumentative through to outright confrontation and attempted intimidation and could adapt her behaviour to the circumstances of particular situations. Some professionals understood the behaviour for what it was although crucially this was not the case for everybody and especially for people coming new to the case and giving mother in particular the benefit of new starts.

98. The initial booking for the pregnancy with B1 with the community midwife involved a routine discussion of history. Mother denied any domestic abuse, drinking alcohol and said that she did not have a social worker involved with the family. She was already 15 weeks late when making the initial booking; the late booking represented neglect of both mother's and her baby's health. She had already missed the first screening that is routine during early pregnancy.

99. The use of alcohol and incidents of domestic abuse were often linked. This does not mean that alcohol was the cause of the domestic abuse but it certainly exacerbated the verbal and physical violence and on at least one occasion was a significant contributor to one of the children being struck during an incident. The assault for

which father was convicted and sentenced to 30 months imprisonment also took place after he had consumed several alcoholic drinks (vodka and cokes).

100. The parents' lifestyle around alcohol and some use of cannabis had implications in terms of how much of the family's limited income was used to fund this as well as the behaviour that resulted from it. The family have very significant levels of debt and have considerable rent arrears. Although much of the drinking appeared to take place in the home there were times when mother was out all night and on one occasion returned with unknown men to the house.

101. The police were summoned frequently to deal with incidents of domestic abuse. Almost on every occasion both parents declined to make statements. Mother refused to participate in the DASH assessment. Although the police had latterly used new legal powers to manage the risk of domestic abuse through for example issuing a DVPN and following this up with a DVPO this only addressed short term action and there was insufficiently co-ordinated and concerted follow up action by other services. Collectively, there was insufficient attention to the underlying reasons for the domestic abuse or to the cumulative impact on the children.

102. The DVPO was not served in person on father but to his father who agreed to make sure his son received it. The procedures do not require the notice or order to be served in person but merely delivered to their address.

103. Although the sergeant in the public protection investigation unit had issued instructions that a strategy meeting was required because of the frequency of incidents and concerns about the impact on the children the instruction was not followed through. Instead the home visit by the social worker and a police officer said that a child protection conference would be required if there was a repeat of the incidents. Not only does this miss an opportunity to explore what has been happening in this household by sharing information across agencies and checking what further action was required, it also provided an incentive to the parents to not involve any agency in future incidents.

104. It was in February 2013 when a strategy meeting was held leading to a child protection conference and was after further incidents of domestic abuse. The trigger in February was the realisation that mother was five months pregnant. It was the March child protection conference when mother was dismissive of the history of domestic abuse and its impact on the children in spite of the chair of the child protection conference being very assertive and clear about the extent of the history and the implications for children's emotional and physical safety.

105. Although alcohol misuse has been a longstanding concern, neither of the parents has been known to the local specialist alcohol service. Although advice had been given to seek help neither of the parents has done this through a self referral.

106. Whilst father was in prison he had participated in a number of programmes such as healthy relationships and alcohol awareness[10] although information about this was not shared with the probation officer and the post programme report was not reviewed in the community and indicates a lack of continuity in the offender management for father. He was not motivated to do any further work upon release, reflected in his non engagement with any community alcohol treatment. The programmes in prison were not designed to provide the level of therapeutic or intensity of intervention to address the extent of alcohol dependency, violent behaviour or the domestic abuse. Additionally, the index offence for which he had been convicted would not have met the threshold for entry on to a structured and intensive programme such as IDVA. The child protection conference in March 2012 was led (not by probation) to believe that the domestic abuse work in prison had been part of an IDAP programme which was not the case[11].

107. Upon father's release from prison on licence in May 2011 he was assessed by the probation service as being a low risk source of serious harm; that assessment was based on looking narrowly at the crime for which he had been convicted and making a judgement about whether it for example was life threatening, had caused serious physical injury or psychological harm. He had been convicted of striking an adult male on the head with a hammer. The case was subsequently transferred to another probation officer who became aware of the domestic abuse and along with other factors such as the substance misuse reassessed the level of risk to be medium (to the family and to the public) when the licence was completed in August 2012. This reflected a more holistic approach to understanding the nature of risk and wanted to alert any subsequent offender managers to the history to father's use of violence to gain control and his excessive use of alcohol that was an aggravating factor. Significantly, the probation officer was not included as a member of the core group.

108. As part of the prison release and planning father had been assessed for suitability to participate in a thinking skills programme which is a cognitive behavioural therapy. He was assessed as functioning at a higher level than the thresholds set for the programme and he therefore only had access to work preparation. His problematic and violent behaviours were therefore not subject to any concerted intervention.

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[10] The alcohol awareness programme is not accredited and therefore there is limited evidence about efficacy. The healthy relationships is accredited by psychologists. The group work was not reviewed by the probation officer.

[11] IDAP (integrated domestic abuse programme) is a nationally-accredited community-based group work programme in the UK designed to reduce re-offending by adult male domestic violence offenders. It is based on the domestic abuse project developed in Duluth, Minnesota, USA, which led to a comprehensive overhaul of the criminal justice agencies' response to these cases and the development of an integrated community approach. For it to be effective, it requires good communication and co-operation between services that consistently focus on the safety of women and children who have been subjected to the domestic abuse and that the perpetrator acknowledges and takes responsibility for their behaviour through the programme. The programme is not suitable for men who have mental health or severe substance misuse problems that undermine their capacity to achieve the learning outcomes of the programme. In this case father, as well as mother, had chronic and long term dependency on alcohol.

109. There had been evidence of neglect over many years and this was the focus for the involvement of services. Mother neglected her own health during the pregnancies and there have been many missed appointments for routine health check ups for herself and for the children. The dental cavities that contributed to one of the children having nine teeth extracted is evidence of neglect over an extended period of time. The significance of this did not appear to be understood by the core group or by the dental practitioners.

110. Although some professionals had longstanding concerns about the children and have had a clear insight about the extent to which neither parent has been prepared to acknowledge concerns, this was not explicitly discussed.

111. There have been frequent changes and reallocations of social workers that had led to inconsistency in knowledge and developing a strategy for the case. Very little was known about the individual history of either parents or of the family. Assessments have not been adequate, all have been delayed and none have contained information about direct views wishes and feelings of the children or collated information from other services.

112. The pre-birth assessment for B1 in May 2013 was late, contains inconsistent spelling of children's names, and is very superficial in summarising information or providing analysis. There is high reliance on the parents' assertions that for example they have stopped drinking and that mother would report father to the police if he drank alcohol. The assessment asserts that mother had prepared for the pregnancy but provides no evidence over and above that a pram had been purchased; there is no reference to any other preparation and significantly given the circumstances of B1's death, there is no reference to proposed sleeping arrangements or whether a cot had been acquired.

113. There is no information either from the older siblings in terms of their views wishes and feelings about the pregnancy and general circumstances and no information from other professionals. This reflected the fact that mother obstructed professionals from having opportunity to talk with the children on their own as well as key professionals such as social workers not being sufficiently assertive and focussed on pursuing such contact especially as part of statutory enquiries, assessment and child protection plan.

114. Issues such as overcrowding after B1 was born are mentioned in the assessment but there is no indication of any discussion with the landlord service.

115. The team manager realised that the assessment was inadequate but because of the extent of other workload personally and across the team felt that that it was better for an inadequate assessment to go forward rather than risk further delay.

116. Mother's pregnancy with B1 was the subject of multi agency pre-birth risk identification and B1 was subject of a child protection plan from birth. Paradoxically, professionals such as the head teacher and the school nurse were initially invited to

attend but this was rescinded. It is believed that this was because the chair who was allocated the child protection conference was on leave when the allocation took place and support staff mistakenly believed that the child protection conference should only involve people who would be involved with B1 rather than the siblings. The consequence was that two professionals who had extensive and historical knowledge and understanding about the family's circumstances were not able to contribute information and assist with analysis about risk. Other professionals such as the probation officer who had such a good understanding about father's risk was also not involved in discussion involving B1.

117. Although B1 was therefore regarded as at risk of harm from neglect it is clear that the full extent of risk was not sufficiently understood. For example the fact that mother had continued to smoke and to use alcohol through the pregnancy and B1's low birth weight were factors associated with sudden infant death syndrome (SIDS). This is in spite of the well developed local strategies that have reduced the incidence of SIDS in the city.

118. There was confusion in regard to arrangements for co-ordinating multi agency contact with B1. The birth was three weeks earlier than expected and the hospital midwife had to be very assertive about convening a discharge planning meeting after the birth and before B1 and mother returned home. The pre-birth assessment had been subject of delay and had already reduced the amount of time to assess and plan a multi-agency child protection plan.

119. The child protection conference in March 2012 was told that there were no education or health concerns that would indicate neglect; this was in spite of one of the children having very severe dental cavities that had contributed to the extraction of nine teeth.

120. The two older children appear to be very resilient in spite of their exposure to abuse and neglect. They have a close bond with each other and are sociable and bright and participate well at an excellent school. The apparent absence of neglect in regard to the children's physical appearance and presentation may have led some professionals to think the risk from the parents' behaviour was less severe. The older siblings also appear to have a good relationship with members of the extended family such as grandmother and an aunt.

121. B1 was made the subject of a child protection plan in the category of emotional abuse prior to birth at a conference held on the 3rd July 2013. All children were still subject of plans at the time of B1's death. The pre-birth assessment that had been completed provided an incomplete evaluation of historical abuse of the older siblings and probably contributed to an overly optimistic assessment of risk.

122. The assessment did not take enough account of the known history and did not take account of the risk factors at birth in regard to the dangers of sudden infant death. The pre-birth child protection conference only received a verbal update from a social

worker who was taking responsibility for the case from the social worker who had undertaken the assessment.

123. The property was overcrowded with the arrival of B1. It had been assumed that because of the rent arrears there would be no prospect of the family being offered an alternative and larger home. In fact the landlord had a policy of considering housing need that involved a senior manager considering individual family circumstances and making a decision as to whether to approve a transfer while there were rent arrears. This was not done in this case.

124. The work of the core groups was underpinned by a series of working agreements that were in addition to the outline child protection plan agreed at the child protection conference. Significant parts of the working agreements were disregarded by the parents. For example the requirement for the parents to live in separate households was ignored and by the time that the birth of B1 was imminent the mother was determined to have the father in the family home in order to provide support. This was not known about by several members of the core group who were involved or in contact with the older siblings.

125. The agreements had no provision for dealing with non compliance and there were no consequences when important aspects of an agreement were simply ignored. Some professionals such as the social worker and chairs of conference felt isolated in trying to tackle the parents' attitudes and behaviour. Other professionals felt not enough was being done and that there was not enough of an assertive grip on case management.

126. The duty system of allocating the independent chairs for child protection conferences contributed to a change in the chair between the child protection conference that decided to make the older siblings subject of a child protection plan and the pre-birth initial child protection conference that made the decision in regard to B1. The chair of the earlier child protection conference in respect of the older siblings had a long term involvement in the historical child protection conference and had used this historical knowledge to be assertive in his approach with mother's minimisation of concerns in particular. He knew of the domestic abuse and its significance along with the substance abuse. He was sceptical about mother's efforts to divert attention. The next chair did not have that level of knowledge and had limited time to read them self into the case prior to the child protection conference. As a consequence there was less opportunity to challenge and manage the attitude and behaviour of mother in particular.

127. There was further loss of historical oversight when the decision was taken to exclude professionals such as the head teacher and school nurse from the B1 child protection conference on the basis that they had no direct contact or input in respect of B1. The head teacher had been originally invited but was then removed from the list of professionals to participate.

128. The workload of all the services had varying implications for how aspects of the case were managed. There was significant reorganisation of children's social care services that coincided with an increase in referrals and allocation of complex work. There were three social workers allocated at different times between March and September 2013. The team manager at the time of B1's pre-birth child protection conference was managing a team that was responsible for 92 statutory assessments. It was against this background that an inadequate assessment was allowed through to the pre-birth conference to avoid further delay.

129. The child protection conference chairs also had a busy workload that reflected increases in the numbers of children subject of a CPC; there are currently over 900 children subject of a child protection plan in Manchester. The police have also made changes to their work practice in respect of attending CPC. One of the sergeant positions in the public protection investigation unit was vacant between December 2012 and July 2013. The public protection investigation unit can be dealing with as many as 140 incidents of varying urgency. The school nursing service has been re-configured resulting in school nurses working with larger clusters of schools.

130. The person with the longest and most consistent contact with the family was the head teacher who had a good understanding about the circumstances and issues in the family. The head teacher had tried to get more consistent and intensive involvement from other services in response to issues such as domestic abuse; more than once there was a delay of several weeks and moments of opportunity had passed such as when mother had bruising to the face. The head teacher no longer has parent support advisors and this has implications for the personal capacity of the head teacher and work with vulnerable families.

131. The heavy workloads of several professionals led to some corners being cut in respect of assessment, quality assurance and follow up on the implementation of plans and agreements. There is little capacity for professionals to talk with each other and to develop clearer strategies for managing uncooperative and resistant parents. Reports to child protection conferences are frequently delivered on the day of a child protection conference. Discussions about the release of parents from prison and returning to families are often postponed until after the release rather than before to plan any assessment or support.

132. The probation officer was the only professional to report having a more manageable workload at the time that had allowed more extensive contact with the family and other professionals and provided capacity to do a more extensive final assessment; that workload has since increased.

133. For the professionals who had the longest contact with the family there was a general consensus that father had very little motivation to work or to engage with professionals and that mother was also dismissive of professional advice. People who had longer term contact with the family felt that some of the professionals who were either younger or had less contact or involvement with the parents were susceptible to mother's tactics and disruptive behaviour and her ability to create collusive

alliances that for example allowed father back into the household without enough monitoring of arrangements.

134. The frequent changes in social workers had a negative impact on the quality of co-ordination of multi agency work. Plans and agreements were not routinely circulated. A written record of discussions and decision of core groups was often left to individual professionals to make their own note.

3.1 In what way does the case provide a window into the local systems for safeguarding children?

135. The extent to which the quality of risk assessment and responding to the attitude and behaviour of two parents who were unwilling to acknowledge how it represented risk to the emotional well being of their children was insufficiently managed and co-ordinated is concerning. The parents remained in control of professional interaction and influenced decision making and were effective in preventing meaningful intervention. Personal and organisational capacity is a significant factor in how the case was managed.

136. Both of the parents were aware that their lifestyle and abusive relationship was a concern for professionals. Mother in particular was very concerned about children's social care services being able to remove the children from her care. This appeared to be a major factor in her minimisation of concerns either in multi agency meetings or dealing with the frequent call outs to the police. At no stage does anybody appear to have really explored the quality of attachment and emotional care that the older siblings have had over many years. The fact that both children are at the same school, have a close relationship with each other and are in a setting that provides outstanding education and pastoral support have been important sources of resilience for them. In other words, in spite of the neglect and emotional abuse at home they have managed to show remarkable ability to develop social relationships with peers and to make progress at school.

137. The case has revealed some good examples of assertive practice. This has included the clear challenge by one of the chairs of the child protection conference in March 2012 in regard to mother's history of minimising concerns about domestic abuse and the referral made by the police officer in June 2012 and recommendation that co-ordinated action was required to address the concerns about the children. There were other referrals from the police which in February 2012 led to the latest child protection plans being put in place. The use of the DVPN and DVPO was evidence of using new powers for a more proactive approach to domestic abuse. Unfortunately it did not translate into enough of a multi agency strategy or take enough account of mother's unwillingness to recognise the threat of the abuse for the children.

138. The level of obstruction and unwillingness to engage by the parents was never discussed and the response from key agencies such as children's social care services was not adequate. The response was too often inconsistent and lacked enough purpose. In large part this probably reflected the behaviour of individual

professionals feeling overwhelmed by their workloads and disruption in the lines of management and professional support.

4 Analysis of key themes from the case and description of findings for learning and improvement

139. Meaningful analysis of the complex human interactions and decision making processes that are involved in multiagency work with vulnerable children and troubled families needs to understand why things happen and the extent to which the local systems (people, work processes, organisational arrangements) help or hinder effective work locally within 'the tunnel'[12].

140. This chapter sets out the key findings designed to offer challenge and reflection for the MSCB and partners. The emphasis is not on the more traditional formulation of SMART recommendations that tend to call for ever more procedure or protocol.

141. The key findings are framed using a systems based typology developed by SCIE to identify some of the underlying patterns that appear to be significant for local practice in Manchester:

a) Cognitive influence and human bias in processing information and observation;
b) Family and professional contact and interaction;
c) Responses to significant incidents and information;
d) Tools and frameworks to support professional judgment and practice;
e) Management and agency to agency systems.

142. The remainder of this report aims to use this particular case to reflect on what this reveals about gaps or areas for further development in the local child protection system.

143. In providing the reflections and challenges to the MSCB there is an expectation that there will be a response to the key findings in regard to the following:

a) An indication as to whether the MSCB accepts the findings;
b) Information as to how the MSCB will take any particular findings forward;
c) Information about who is best placed to lead on any particular activity;
d) An indication of the timescales for responding to the findings;
e) Information about how and when it will be reported.

144. The MSCB will determine how this information is managed and communicated to relevant stakeholders. The formal response should form part of the publication of the serious case review.

[12] View in the Tunnel is explained by Dekker (2002) as reconstructing how different professionals saw the case as it unfolded; understanding other people's assessments and actions, the review team try to attain the perspective of the people who were there at the time, their decisions were based on what they saw on the inside of the tunnel; not on what happens to be known today through the benefit of hindsight.

4.1 Cognitive influence and human bias in processing information and observation

Understanding domestic abuse as coercion and control rather than anger management; identifying and responding to parents not engaging with professional's concerns about child welfare and safety; the influence of parental fear of statutory intervention and keeping possession of their children.

145. Evan Stark[13] describes how domestic violence has to be understood more clearly as coercion in order to understand the impact on the adult victims (and their children) and to understand why these relationships so often endure for many years as it has in this case.

146. Being able to place information and observation of incidents and behaviour within good enough historical knowledge rather than treating events as individual or isolated is fundamental along with a good understanding about coercion, control the nature of abusive relationships.

147. The probation officer appeared to be the only professional to have a clear understanding about father's use of violence to resolve conflict and to regain control and the risk it represented particularly given the habitual use of alcohol and the associated loss of inhibition.

148. Individual police officers were concerned about the frequency of the call outs to deal with incidents of domestic abuse although much of their effort to assess risk was undermined by the lack of co-operation from either adult.

149. In general the response from professionals was to see the domestic abuse as being poor behaviour that was insensitive to the needs of the children and that it required threats of action to make the parents change their behaviour. This reveals a misunderstanding about the nature of abusive relationships.

150. The domestic abuse was a longstanding and recurring concern for all the services. It provoked some of the clearest examples of where both parents were unwilling to engage with the concerns about the impact on and risk to the children's emotional, psychological and physical well being.

151. There is no record of any discussion in single or multi agency settings about the extent and significance of the parents' lack of engagement. Parents may present in a number of ways on a continuum from hostility, threats and violence through to superficial and ineffective engagement. Behaviours may include ambivalence, avoidance, confrontation, refusal and violence.

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[13] Coercive Control: How men entrap women in personal life Evan Stark: Oxford University Press 2007

152. Unless resistance and non engagement is recognised there will be a danger that effective intervention is compromised and control remains with the parent. It can influence how practitioners respond; they can become hesitant, be concerned about confrontation and focus on the parent's agenda or concerns rather than on the child. Reference is made to adopting a softly softly approach in an effort to secure mother's confidence. This is not a criticism of any individual practice; the point is that the absence of engagement was never discussed openly and therefore no agreed strategy and plan was put in place.

153. Any persistent displays of avoidant, hostile or resistant behaviour should be taken very seriously. Research shows that this behaviour can be a factor for fatal child abuse and neglect (Chance & Scannapieco, 2002)[14].

154. Although some professionals expressed very clear feelings that neither of the parents was engaging or taking concerns seriously there was little or no discussion about this. The only example of recorded effort to deal with resistance was in the child protection conference in March 2012 when the chair clearly made a concerted effort to confront the lack of engagement with the concerns. However this was not followed up and chairing transferred to another chair for the child protection conference in relation to the unborn B1.

155. A key finding from a review of evidence on what works in protecting children living with highly resistant families was the need for authoritative child protection practice. Families' lack of engagement or hostility hampered practitioners' decision-making capabilities and follow-through with assessments and plans ... practitioners became overly optimistic, focusing too much on small improvements made by families rather than keeping families' full histories in mind[15].

Issues for the MSCB to consider in regard to learning and improvement

1. Is the MSCB satisfied that there is sufficient understanding about domestic abuse and the dangers of professionals adopting inappropriate strategies such as conciliation or mediation in their intervention?

4.2 Family and professional contact and interaction

The dangerous combination of busy and overloaded professionals combining with the manipulative and obstructive behaviour of adults resistant to services and professional contact; contact and interaction as the exercising of parental control over children and

[14] Chance, T., & Scannapieco, M. 2002. Ecological Correlates of Child Maltreatment: Similarities and Differences Between Child Fatality and Nonfatality Cases. *Child and Adolescent Social Work Journal*.

[15] Effective practice to protect children living in highly resistant families. London: Centre for Excellence and Outcomes in Children and Young People's Services. C4EO (2010)

challenging of professional authority; understanding manipulative and obstructive behaviour and having strategies in place to respond.

156. A consistent concern for mother was her fear that children's social care services would remove the children from her care. This was a dominant factor in her interaction with all of the services. This was a reason for not wanting to participate in the police DASH risk assessments or to make any statements in relation to domestic abuse. It was a significant factor in her efforts to minimise or silence information and reports about domestic abuse and substance abuse. The older siblings were clearly encouraged not to give any information to the staff at the school and mother controlled and influenced all of the professional contact with the children.

157. Some of the professionals had a very clear insight and perspective about the nature of the parents' interaction with professionals and that it was about control of information and managing the response of professionals. This involved a repertoire of different tactics and behaviour that have been described in earlier sections of the report. Some professionals felt that mother wanted to retain the contact with services for as long as she was able to extract the benefit that she wanted in regard to material support and assistance but this would always be on her terms. There was never any discussion between professionals about the interaction or motivation of the parents.

158. All of the people in contact with the family were managing complex and in some cases excessive workloads. Managers were also dealing with a large workload as well as having the additional challenges of working though a reconfiguration of services. In these circumstances there was little capacity for reflection.

159. Key roles such as the social worker were subject to changes and reallocation. Many of the professionals had no long term contact and involvement with the family and crucially those who did have long term involvement such as the head teacher were excluded from the child protection conference in regard to B1.

160. The combination of key professionals changing and the absence of any discussion between professionals meant that the effectiveness of meetings and discussion with the parents was not as effective as it could have been. The use of working agreements made little demand on the parents and were ignored when inconvenient for the parents; this included the use of alcohol and the requirement for father to not stay in the household for example.

161. There are a variety of reasons for families wanting to avoid a service, poorly engaging with a service, disengaging over time, or refusing a service. Families may also have different responses to different services or change over time in their response to services. Service fatigue is not uncommon, particularly in families with complex needs and the long term involvement of several different agencies or professionals.

162. Families who display evasive or resistant behaviour can be challenging to work with. Examples of such behaviour include:

a) avoiding home visits (often cancelling at the last minute) or not appearing to be home (curtains drawn and not responding to telephone calls or knocks on the door);

b) children failing to attend school or child care (which was not a significant factor for school attendance although mother did not use any other out of school provision);

c) parents not attending appointments, in particular prearranged meetings that involve the assessment of themselves or the children or are in denial about issues such as use of alcohol and domestic abuse;

d) repeated excuses why the worker cannot see the child or young person, for example "they are at their grandparents" or are "sleeping" or as in this case downright refusal at times.

163. Any persistent displays of avoidant, hostile or resistant behaviour should be taken very seriously because of the association with fatal child abuse and neglect.

164. Non-compliance and disguised compliance by parents were common features in cases reviewed by Ofsted in their national report on professional responses to neglect[16]. The report found that although some multi-agency groups adopted clear strategies to manage such behaviour, this was not evident in all cases. Where parents were not engaging with plans, and outcomes for children were not improving, professionals did not consistently challenge parents. This was reflected in this case.

Issues for the MSCB to consider in regard to learning and improvement

2. Is the MSCB satisfied that there is sufficient understanding and professional capacity in developing a sufficiently assertive and informed response to resistant families where there are concerns about the development or safety of children?

4.3 Responses to information and incidents

Delays in the follow up to incidents through a multi agency and co-ordinated response; recognition of indicators and evidence of neglect such as dental cavities in young children; ensuring that the serving of the DVPN lead to follow up by other services and require the presence and direct engagement of the perpetrator; the reliance in the booking of pregnancies on the mother providing relevant health and social history; understanding the significance of low birth weight and the combination with other risk factors.

[16] In the child's time: professional responses to neglect; Ofsted; March 2014

165. Delay in referrals and passing of information between services has an impact on subsequent enquiry, assessment and intervention especially when responding to resistant families. This occurred for example between the police and children's social care services. There were also delays in responding to the request from the police to convene a strategy meeting and follow up information. The head teacher saw facial bruising on mother's face and reported this to children's social care services in anticipation that enquiries and assessment would follow. This did not happen for several weeks by which time the opportunity for more focussed enquiry and intervention had passed.

166. The identification of neglect is seen increasingly to be important in work with vulnerable children. In a study completed in 2012[17] health visitors indicated that dental neglect is rarely an isolated issue that leads on its own to child protection referral however poor dental health in children is a marker of broader neglect.

167. Abused and neglected children have been found to have higher levels of tooth decay than the general population (Valencia-Rojas et al. 2008[18]) therefore when primary health care workers such as health visitors are aware of the presence of dental neglect it should alert them to the potential for broader neglect and subsequent child protection and particularly in families that are resistant to professional advice and factors such as domestic abuse and substance misuse are factors.

168. In this case there was evidence of potential neglect in relation to the dental cavities that resulted in one of the children having nine teeth extracted. The fact that this appeared to have been allowed to be minimised is concerning.

169. A local survey has emphasised that dentists are well placed to notice signs of child abuse and neglect, yet research shows that UK dentists are unprepared for a role in protecting children at risk and there is under reporting of concerns[19].

170. B1 had a birth weight of 2.19kgs. Low birth weight babies of 2.5kgs or less are subject of particular post natal observation and support. The local guidance in respect of SIDS identifies the cluster of factors that can increase the risk of death in an infant and there is a particular focus on safe sleeping practice for example. Although these risk factors are well understood in the health community it is not apparent that other key professionals including social workers have sufficient knowledge and understanding. Curiously, given the assertiveness from a health professional, this did not form part of an explicit discussion of the discharge planning

[17] Health Visitors' Role in Assessing Oral Health in Children: Investigating Dental Neglect Thresholds. Bradbury-Jones. C., Taylor, J., Innes. N., Evans, D. & Ballantyne, F. August 2012

[18] Prevalence of early childhood caries in a population of children with history of maltreatment. Journal of Public Health Dentistry, 68(2), 94-101. Valencia-Rojas, N., Lawrence, H.P., Goodman, D. (2008)

[19] Safeguarding children in dentistry: Do paediatric dentists neglect child dental neglect? J.C. Harris, C. Elcock, P. D. Sidebotham & R. R. Welbury British Dental Journal 2009:206, 465 - 470 (2009)

meeting following the birth of B1 and was not part of any of the working agreements or plans.

Issues for the MSCB to consider in regard to learning and improvement

3. How can the MSCB promote more co-ordinated and effective response to managing the behaviour and risk from perpetrators of domestic abuse in households with children when using measures such as the domestic violence prevention notices and orders?

4. Are the arrangements for pre birth assessment of risk to unborn children appropriate and fit for purpose?

4.4 Tools to support professional judgment and decision making

The limited use of tools or frameworks to assess to identify the extent of domestic abuse and coercion, of neglect, risk or substance misuse; the compilation of assessments rely heavily on repeated narrative and incomplete information about history or the perspectives of all relevant professionals; the procedures for using measures to prevent repeat domestic abuse are complex and bureaucratic.

171. Indicators of neglect are many and varied and each on their own are unlikely to provide definitive evidence and is why it is important for professionals to have recognisable frameworks within which to collate and analyse the significance of information and observation.

172. Neglect can be indicated by the physical appearance of a child other than the dental cavities. By all accounts there was nothing to indicate concern about either of the children. This may have been a reason for neglect being missed; unless the child looks neglected will they be regarded as neglected?

173. There may be indicators in the child's behaviour. There was nothing observed in the behaviour of these children to cause concern although the behaviour of the parents was a source of concern. Substance abuse is a significant factor in parents neglecting the emotional and physical needs of their children. It would have been advisable to have considered using tools such as the attachment style interview and graded care profiling that would have helped provide a more informed view about mother's parenting capacity, motivation and insight regarding her children's needs[20].

174. The team manager referred to the availability of local resources such as the Bruce Thornton Risk Assessment Model and recent work on improvements to risk assessment.

[20] There are other tools and frameworks that are available to professionals and some such as the attachment style interview require specific training.

175. The third group of indicators in regard to neglect is the behaviour of adults. It is this third category of indicators that have greatest relevance in this case. It was the behaviour of both parents and their inability to understand how it had an impact on the emotional well being of the children that was recognised as far as agreeing to make the children subject of a child protection plan on two different occasions although lost both momentum and focus in regard to subsequent plans and work.

176. The quality of the assessments in this case was poor. There was a summary of concerns but there was insufficient exploration of history, attitude and motivation and no inclusion of detail from the older siblings regarding their wishes and feelings; this was in part due to the severe limits that mother put on any professionals having contact with the children on their own. There was no use of recognisable frameworks or tools to help collate and analyse information although children's social care services have invested in some.

177. The assessments did not seek and therefore include information from other professionals some of whom had a long history of contact with the children and an insight about the circumstances of the children and the attitude of the parents.

178. The team manager had recognised at the time that the pre-birth assessment was inadequate but had felt unable to stop it going forward because of the consequences for delaying the pre-birth child protection conference and planning. The team manager was dealing with a backlog of other assessments and work at the time.

179. Priority has been given in children's services to achieving improved quality in statutory assessments of children since the unannounced statutory inspection of contact, referral and assessment services in August 2011 that found that some assessments had lacked 'rigour and offer insufficient analysis, resulting in a lack of clarity of children's needs and vulnerabilities on which to base the provision of services'. This had been an area for development at the previous inspection and was also reflected in this case.

180. Some caseloads were also found to be high and this was leading in certain instances to delays in information being recorded on the electronic recording system. Some staff reported during the inspection as well as during conversations for this review of working excessive hours in order to meet the deadlines required to safeguard children. Additional posts have been created to address this issue.

181. Police and partners in Manchester had welcomed the use of the domestic violence prevention notices and orders although the recent HMIC inspection had found their use was inconsistent across the force and found that some staff described the application process as being complex and bureaucratic. A full evaluation of both pilot schemes has been undertaken by the Home Office that reported some concern from officers that the system was too complex for many officers to use without further training and that the bureaucracy associated with DVPOs was still an issue. The

evaluation as well as inspections by HMIC emphasise the importance of the procedures being used in conjunction with other support services.[21]

Issues for the MSCB to consider in regard to learning and improvement

5. Does the MSCB have sufficient information about the availability and use of appropriate risk assessment tools and frameworks to support professional judgement and decision making with troubled families and vulnerable children?

6. Does the MSCB have sufficient information about the quality and outcome of assessments for vulnerable children and new born babies where there are concerns about parental behaviour and lifestyle?

4.5 Management and agency to agency systems

Excessive workload and reconfiguring of services has an impact on the capacity of individual professionals; the system of duty allocation of chairs for child protection conferences disrupts independent continuity and oversight; screening and identifying higher risk pregnancies.

182. This review has highlighted the extent to which the performance and decision making of professionals is adversely affected by the functioning of other systems and organisational arrangements around them.

183. At the time of the review there were just over 900 children subject of a child protection plan. Manchester has a high rate of children who require protection; almost double the average for England and much higher than the rate for the north west of England[22].

184. The government have acknowledged that there is a high turnover of social workers in the UK, a short working life (estimated as an average of just eight years in the UK), and perhaps in consequence a shortage of experienced social workers in England, which can result in newly qualified social workers dealing with complex cases too early in their career. A survey of local authorities in 2011 estimated a 9.1 per cent turnover rate for social workers in children's services (equivalent to 1 in 11 workers leaving per year). The vacancy rate for children's services social workers nationally was 6.1 per cent[23]. In this case there were three different social workers allocated to the case over a six month period between March and September 2012.

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[21] Evaluation of the Pilot of Domestic Violence Protection Orders Research Report 76 London Metropolitan University & Middlesex University: Liz Kelly, Joanna R. Adler, Miranda A. H. Horvath, Jo Lovett, Mark Coulson, David Kernohan and Mark Gray; November 2013; Home Office

[22] 80.6 children per 10,000 compared to an England average of 46.2 and a regional average of 53.1 in 2012/2013. (Characteristics of Children in Need 2012 to 2013 February 2014; DfE)

[23] Child protection, social work reform and intervention: research priorities and questions; March 2014; DfE.

185. The workload in other specialist units was also a factor in this case. For example the specialist police officers in the public protection investigation unit had implications for the speed and effectiveness of some risk assessment and communication in this case. The public protection investigation unit deal with child protection, vulnerable adults and domestic abuse. A large proportion of the work is child protection. There are three work streams, each work stream managed by a detective sergeant and are overseen by one inspector. Each team has approximately 22/23 constables. The volume of work becomes a particular problem if a team does not have a sergeant in post and have to cover the vacancy. One sergeant moved in December 2012 and the post was vacant without any back fill until July 2013.

186. There are a high number of incidents that have to be prioritised and risk assessed by officers on a daily basis. A log is created and the cases are 'triaged' each day; it is not always possible to triage an incident on the day or the following day, and it can take some time for some incidents to be triaged. The timescale for reviewing cases within public protection investigation unit varies, every morning there is a domestic abuse governance meeting noting the DA from the previous day. Incidents go in a queue which can be quite high (approximately 100 standard risk and 40 medium risk).

187. High workloads can also contribute to early departures from child protection work. The impact of these factors on practice and difficulties with retention is a concern in a number of developed countries, including Sweden, the USA and Australia. Research in this area indicated that interventions addressing organisational and administrative factors (rather than individual employee factors) produced stronger effects in preventing undesirable turnover.

188. The allocation of a chair to an initial child protection conference need to take sufficient account of previous contact or knowledge about a family. In this case, the initial child protection conference was allocated to another chair in order to meet timescales and a clash with previously scheduled commitments of the chair for the older siblings. In a case that had so much history and complexity, the allocation of B1 to a different chair was a significant loss of continuity.

189. National revisions to the midwifery self booking arrangements mean that pregnant women can go to midwifery services direct without reference to GP practices. The initial booking includes routine inquiries about social and other history from the parent(s) which inevitably relies heavily on the accuracy of the self reporting. In this case mother did not disclose any involvement from children's social care services, did not disclose the history of domestic abuse or the history of significant alcohol use.

Issues for the MSCB to consider in regard to learning and improvement

7. Does the MSCB have enough information about the workload of services working with the most vulnerable children?

4.6 Issues for national policy

190. The use of DVPN and DVPNs are a welcome addition to the measures available to manage domestic abuse. The use of such measures in situations where children are living in the same household need to take account of the framework of law and guidance for safeguarding children. The evidence from this single case and from national evaluations reinforces the values of ensuring that DVPN and DVPOs are used in conjunction with other services and are underpinned by sufficiently effective interagency planning and intervention.

Peter Maddocks MA, CQSW.
September 2014

APPENDIX A: Multi agency action plan

The finding identified by the serious case review	*Do MSCB accept the finding?*	*If MSCB accepts the finding how will it be taken forward?*	*Who is best placed to take this forward and in what timescale?*	*Timescale for responding to the finding and how will it be reported?*
1. Understanding domestic abuse as coercion and control rather than anger management; identifying and responding to parents not engaging with professional's concerns about child welfare and safety; the influence of parental fear of statutory intervention and keeping possession of their children. Issues for MSCB to consider: *1.1 Is MSCB satisfied that there is sufficient understanding about domestic abuse and the dangers of professionals adopting inappropriate strategies such as conciliation or mediation in their intervention?*	Yes	1.1 MSCB is not satisfied that there is sufficient understanding about domestic abuse and the dangers of professionals adopting inappropriate strategies such as conciliation or mediation in their intervention and will take this forward by establishing links with the Community Safety Partnership (CSP) in relation to the 'Delivering Differently' approach to domestic abuse. 1.1.1 A letter in the name of the MSCB Independent Chair will be sent to the Chair of CSP requesting assurances that the new approach takes account of the learning from this review and will strengthen arrangements to safeguard children. 1.1.2 The Safeguarding Children Practice Develop Group (currently known as SPIG) will monitor the new arrangements ensuring that the safeguarding of children is strengthened.	1.1.1. Letter to CSP Chair. MSCB Business Unit by end of September 2014. (Business Manager AMC) 1.1.2 Safeguarding Children Practice Development Group monitoring by end of January 2015.(Chair tbc)	1.1 By the end of January 2015 via a report from the relevant group to MSCB.

The finding identified by the serious case review	*Do MSCB accept the finding?*	*If MSCB accepts the finding how will it be taken forward?*	*Who is best placed to take this forward and in what timescale?*	*Timescale for responding to the finding and how will it be reported?*
2. The dangerous combination of busy and overloaded professionals combining with the manipulative and obstructive behaviour of adults resistant to services and professional contact; contact and interaction as the exercising of parental control over children and challenging of professional authority; understanding manipulative and obstructive behaviour and having strategies in place to respond. Issues for MSCB to consider: 2.1 *Is MSCB satisfied that there is sufficient understanding and professional capacity in developing a sufficiently assertive and informed response to resistant families where there are concerns about the development or safety of children?*	Yes	2.1 MSCB is not satisfied that there is sufficient understanding and professional capacity in developing a sufficiently assertive and informed response to resistant families where there are concerns about the development or safety of children and will take this forward by tasking the Learning and Development Sub-Group (Currently known as the Workforce Development Sub-Group) to challenge agencies about the support given to staff.	2.1 Learning & Development Sub-Group by the end of January 2015. (L&D SG Chair AMc tbc)	2.1 The Sub-Group will report to MSCB no later than the end of February 2015.
3. Delays in the follow up to incidents through a multi agency and co-ordinated response; recognition of indicators and evidence of neglect such as dental cavities;	Yes	3.1 MSCB will promote more co-ordinated and effective response to managing the behaviour and risk from perpetrators of domestic abuse in households with children when using measures	3.1 Superintendent South Manchester Division, GMP by the end of December	3.1 Report to MSCB by the end of December 2014.

The finding identified by the serious case review	*Do MSCB accept the finding?*	*If MSCB accepts the finding how will it be taken forward?*	*Who is best placed to take this forward and in what timescale?*	*Timescale for responding to the finding and how will it be reported?*
ensuring that the serving of the DVPN lead to follow up by other services and require the presence and direct engagement of the perpetrator; the reliance in the booking of pregnancies on the mother providing relevant health and social history; understanding the significance of low birth weight and the combination with other risk factors. Issues for MSCB to consider: *3.1 How can the MSCB promote more co-ordinated and effective response to managing the behaviour and risk from perpetrators of domestic abuse in households with children when using measures such as the domestic violence prevention notices and orders?* *3.2 Are the arrangements for pre birth assessment of risk to unborn children appropriate and fit for purpose?*		such as the domestic violence prevention notices (DVPN) and orders by tasking the Superintendent South Manchester Division, GMP to liaise with the Head of the Public Protection Division in order to develop a protocol for the integrated approach to the use of DVPN's and orders. 3.2 In order to ensure that pre birth assessments of risk to unborn children are appropriate and fit for purpose. MSCB will task Strategic Lead Children's, children's social care services to facilitate a review of pre birth assessments to include volume, quality, outcomes and tools used to complete them.	2014.(WC) 3.2 Strategic Lead Children's, children's social care services by the end of December 2014. (RP)	3.2 Report to MSCB by the end of December 2014.

The finding identified by the serious case review	*Do MSCB accept the finding?*	*If MSCB accepts the finding how will it be taken forward?*	*Who is best placed to take this forward and in what timescale?*	*Timescale for responding to the finding and how will it be reported?*
4. The limited use of tools or frameworks to assess to identify the extent of domestic abuse and coercion, of neglect, risk or substance misuse; the compilation of assessments rely heavily on repeated narrative and incomplete information about history or the perspectives of all relevant professionals; the procedures for using measures to prevent repeat domestic abuse are complex and bureaucratic. Issues for MSCB to consider: *4.1 Does the MSCB have sufficient information about the availability and use of appropriate risk assessment tools and frameworks to support professional judgement and decision making with troubled families and vulnerable children?* *4.2 Does the MSCB have sufficient information about the quality and outcome of assessments for vulnerable children and new born babies where there are concerns about parental behaviour and lifestyle?*	Yes	4.1 MSCB does not have sufficient information about the availability and use of appropriate risk assessment tools and frameworks to support professional judgement and decision making with troubled families and vulnerable children. Therefore through the Safeguarding Children Practice Development Sub-Group (currently known as SPIG) will call for evidence from GMP, Health and children's social care services of risk assessments in place that reflect good practice? 4.2 To ensure that MSCB have sufficient information about the quality and outcome of assessments for vulnerable children and new born babies where there are concerns about parental behaviour and lifestyle. The Quality Assurance and Performance Improvement Group will audit relevant assessments and report back with findings and recommendations.	Safeguarding Children Practice Development Sub-Group by the end of February 2015.(Chair tbc) 4.2 Quality Assurance & Performance Improvement Group by the end of March 2015.(SPIG Chair RW)	Report to MSCB by the end of February 2015. 4.2 Report to MSCB by the end of March 2015.

The finding identified by the serious case review	*Do MSCB accept the finding?*	*If MSCB accepts the finding how will it be taken forward?*	*Who is best placed to take this forward and in what timescale?*	*Timescale for responding to the finding and how will it be reported?*
5. Excessive workload and reconfiguring of services has an impact on the capacity of individual professionals; the system of duty allocation of chairs for child protection conferences disrupts independent continuity and oversight; screening and identifying higher risk pregnancies. Issues for MSCB to consider: *5.1 Does the MSCB have enough information about the workload of services working with the most vulnerable children?* *5.2 Does the MSCB have sufficient enough information about contract arrangements for termination or withdrawal of services by any provider to resistant families including children subject of a CIN or child protection plan?*	Yes	5.1 In order to be sighted on the workload of services working with the most vulnerable children the Quality Assurance & Performance Improvement Sub- Group will ensure that the appropriate information is within the Performance Management Framework currently under development and scrutinised by the associated quality assurance framework. 5.2 In order for MSCB to have sufficient information about contract arrangements for termination or withdrawal of services by any provider to resistant families including children subject of a CIN or child protection plan it will require the Safeguarding Children Practice Development Sub-Group (currently known as SPIG) to ask in what circumstances will services be withdrawn in relevant agencies and to seek assurances about what alternative measures will be taken as a result.	5.1 Quality Assurance & Performance Improvement Sub-Group by end of January 2015.(SPIG Chair RW) 5.2 Safeguarding Children Practice Development Sub-Group by end of January 2015. (Chair tbc)	5.1 Report to MSCB by end of January 2015. 5.2 Report to MSCB by end of January 2015.

APPENDIX B: Procedures and guidance relevant to this serious case review
Legislation

The Children Act 1989
Section 11 of the Children Act 2004 places a duty on the key people and bodies described in the Act[24] to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The application of this duty varies according to the nature of each agency and its particular functions. The Section 11 duty means that these key people and bodies must make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children and this includes any services that they contract out to others.

Section 17 imposes a duty upon local authorities to safeguard and promote the welfare of children in need.

Section 47 requires a local authority to make enquiries they consider necessary to decide whether they need to take action to safeguard a child or promote their welfare when they have reasonable cause to suspect that a child is suffering, or is likely to suffer significant harm. These enquiries should start within 48 hours. The local authority is required to consider whether legal action is required and this includes exercising any powers including those in section 11 of the Crime and Disorder Act 1998 (Child Safety Orders) or when a Baby Has contravened a ban imposed by a Curfew Notice within the meaning of chapter I of Part I of the Crime and Disorder Act 1998.

Section 46 provides the Police with Powers of Protection to take children into police protection where a constable has reasonable cause to believe that a child would otherwise be likely to suffer significant harm.

The Children Act 2004
Section 10 requires each local authority to make arrangements to promote co-operation between it, each of its relevant partners and such other persons or bodies, working with children in the authority's area, as the authority consider appropriate. The arrangements are to be

[24] Local Authorities, including District Councils, the Police, National Offender Management Service, NHS bodies, Youth Offending Teams, Governors/Directors of Prisons and Young Offenders Institution, Directors of Secure Training

made with a view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes. This section is the legislative basis for children's trusts arrangements.

Section 11 of the Children Act 2004 places a duty on the key people and bodies described in the Act[25] to make arrangements to ensure that their functions are discharged with regard to the need to safeguard and promote the welfare of children. The application of this duty varies according to the nature of each agency and its particular functions. The Section 11 duty means that these key people and bodies must make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children and this includes any services that they contract out to others.

Safeguarding Procedures

The local safeguarding children procedures

The procedures provide advice and guidance on the recognition and referral arrangements for children suffering abuse. This includes emotional abuse that involves causing children to feel frightened or in danger. The procedures also cover physical abuse of children. The procedures also describe abuse involving the neglect of children that includes failing to protect children from physical harm or danger or the failure to ensure access to appropriate medical care or treatment. This includes describing distinct action to be taken when professionals have concerns about a child, arrangements for making a referral, and the action to be taken. The procedures cover arrangements for the ACPC (now superseded by LSCB) to ensure there are effective arrangements that promote good interagency working and sharing of information and training. The procedures describe specific responsibilities for all agencies contributing to this serious case review.

Other local procedures relevant to this serious case review

National guidance

Working Together to Safeguard Children (2010) and (2013)

The national guidance to interagency working to protect children is set out in Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. The guidance includes safeguarding and promoting the welfare of children who

[25] Local Authorities, including District Councils, the Police, National Offender Management Service, NHS bodies, Youth Offending Teams, Governors/Directors of Prisons and Young Offenders Institution, Directors of Secure Training Centres.

may be particularly vulnerable. This guidance was extensively revised and republished in March 2013. The revised guidance placed greater responsibility on local areas to develop their own frameworks and standards. It abolished the national framework for assessment and instead no required local areas to have in place their own assessment arrangements.

Framework for the Assessment of Children in Need and their Families 2001

The guidance in respect of *the Framework for the Assessment of Children in Need and their Families* was issued under section 7 of the Local Authority Social Services Act 1970 and was therefore mandatory until it was abolished with the publication of *Working Together* in 2013. .

The framework set out the framework for ensuring a timely response and effective provision of services to children in need. It makes clear the importance of achieving improved outcomes for children through effective collaboration between practitioners and agencies. The framework set out clear timescales for key activities. This included making decisions on referrals within one working day, completing initial assessments within seven working days and core assessments within 35 working days. As part of an initial assessment children should have been seen and spoken with to ensure their feelings and wishes contributed to understanding about how they were affected. If concerns regarding significant harm were identified they had to be the subject of a strategy discussion to co-ordinate information and plan enquiries. Child protection procedures had to be followed.

Assessments should be centred on the child, be rooted in child development that requires children being assessed within the context of their environment and surroundings. It should be a continuing process and not a single or administrative event or task. They should involve other relevant professionals. The outcome of the assessment should have been a clear analysis of the needs of the child and their parents or carers capacity to meet their needs and keep them safe. The assessment should identify whether intervention was required to secure the well – being of the child. Such intervention should have been described in clear plans that included the services being provided, the people responsible for specific action and describe a process for review.

Common Assessment Framework (CAF)

The CAF is a key part of delivering direct services to children that are integrated and focused around the needs of children and young people. The CAF is a standardised approach to conducting assessments of children's additional needs and deciding how these should be met. It can be used by practitioners across children's services in England. The CAF remains in place.

The CAF promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development. Practitioners are then better placed to agree with children and families about appropriate modes of support. The CAF also aims to improve integrated working by promoting coordinated service provisions.

All areas were expected to implement the CAF, along with the lead professional role and information sharing, between April 2006 and March 2008.

Local guidance

Safe sleeping for infants 2009

This is guidance published by the Obstetric Clinical Effectiveness Group and Division of Medicine and Community Services Clinical Effectiveness Group in Manchester through the Central Manchester University Hospitals NHS Foundation Trust. This guidance outlines the core principles of safe sleeping which are implemented nationally. To ensure a consistent message is given to parents in Manchester this guidance was written following a period of collaborative working between Manchester and Pennine (Bury, Rochdale and Oldham) Trusts. In 2002 Manchester had the highest infant mortality rate in the country. Examination of the SUDI by Manchester's serious case review panel revealed some recurring features. A significant number of these deaths were associated with risk factors known to increase the risk of SUDI (sudden unexpected death of infants) and now more generally referred to as SID (sudden infant death). There is a plethora of evidence from long term studies of SUDI suggesting that some of the infant deaths associated with bed-sharing, co-sleeping and other risk factors could have been avoided. Parents/carers should be advised never to fall sleep with their baby:

- If they or their partner smoke or smoked in the ante natal period, even if they never smoke in bed or at home.
- If they or their partner have been drinking alcohol.
- If they or their partner take medication or drugs (prescribed or otherwise) which cause drowsiness.
- If they or their partner feel very tired.
- If their baby was low birth weight (less than 2.5kg).
- If their baby was premature (born before 37 weeks).