MANCHESTER SAFEGUARDING CHILDREN BOARD

CHILD D1

SERIOUS CASE REVIEW

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

INDEPENDENT LEAD REVIEWER: Clare Hyde MBE

June 2015

CONTENTS

CONTENTS

INTRODUCTION

1.1 This Serious Case Review was conducted under the statutory guidance of Working Together to Safeguard Children 2013 which states that a Serious Case Review should take place after a child has died "where abuse or neglect is known or suspected."

1.2 The subject of this case is Child D1; an eight month old baby and the circumstances are that on the evening of Saturday 5th July 2014 Child D1's mother and father (MD1 and FD1) were socialising with friends at MD1's home in Manchester. FD1 does not reside at the address only staying there several nights per week. FD1 left at 11pm that night to stay at his mother's house leaving MD1 and two neighbours drinking wine. It would appear that MD1 and the neighbours consumed three bottles of wine between them until the neighbours left between 2am and 3am the following morning.

1.3 At this time MD1 took Child D1 from the cot bed and took the baby into her own bed in another room. She woke about 1:30pm the next day, 6th July 2014, and found Child D1 lying lifeless. The child was lay on the back, on the floor, under a plastic bin liner containing clothes.

1.4 A joint forensic and paediatric post mortem examination subsequently took place and the initial findings are unascertained. There was no information at that stage to suggest that Child D1's death was as the result of a deliberate act. The physical appearance of Child D1 was that the child was a healthy baby with no signs of neglect. An inquest was opened by the Coroner on 18th July 2014.

1.5 Prior to the birth of Child D1, Child D1 was subject of a Pre-Birth Assessment in view of a number of risk factors that indicated that the child might be exposed to levels of significant harm from the parent's circumstances and lifestyle. The factors included; FD1's cannabis usage and engagement in criminal activities, MD1's anger management issues and in light of neither parent having experienced consistent and stable parenting themselves. MD1 had been in the care of the Local Authority and at the time of these circumstances was known to the Care Leavers Service by virtue of her care experience.

1.6 This culminated in an Initial Child Protection Conference on the 9th September 2013 when pre-birth Child D1 was made subject of a Child Protection Plan in the category of neglect, later changed to emotional abuse. Parallel to the child protection process the Local Authority in November 2013 applied for an Interim Care Order. At the first hearing the Local Authority agreed an Interim Supervision Order. These proceedings concluded in April 2014 when Child D1 was made subject of a Supervision Order for 12 months.

1.7 At a Review Child Protection Case Conference held in December 2013, a unanimous decision was reached that Child D1 should no longer be subject of a Child Protection Plan after information had been received indicating that mother (MD1) was making good progress in meeting the child's needs with all professionals commending mother on her progress as a mother. Similar positive information was apparent within the care proceedings where a psychological assessment concluded that MD1 had demonstrated a significant positive attitude and responsibility as a parent and in accepting responsibility for her anti-social behaviour as a younger teenager. This information informed decision making and the position was fully supported by Child D1's Guardian who noted strong and positive attachment between Child D1 and mother. Following the Review Conference in December 2013, Child D1 was subject to Child in Need Case Planning during which mother was described as meeting all expectations placed upon her. Child D1 was still subject of Case Planning procedures at the time of death and was subject of a Supervision Order as referred to above.

1.8 The Manchester Safeguarding Children Board (MSCB) was notified of this incident on 15th July 2014 via receipt of a referral to the Serious Case Review Sub Group (SCRSG) and the case was reviewed by that group on the 15th August 2014 and 29th August 2014.

1.9 On the 29th August 2014 further information was received from GMP that traces of cocaine and cannabis were found in clippings of Child D1's hair and a blood sample was obtained from MD1.

1.10 On the 29th August 2014 members of the SCRSG were unanimous in their view that criteria for SCR were met for the following reasons:

1. Neglect of Child D1 is suspected; and

2. The child has died.

1.11 The definition of neglect as outlined Working Together 2013 namely, appendix A Glossary, page 86 includes, "Once a child is born neglect may involve a parent or carer failing to protect a child from physical and emotional harm or danger and/or ensure adequate supervision."

1.12 A recommendation was made to the Independent Chair of the MSCB who ratified the recommendation on the 3rd September 2014.

1.13 Working Together 2013 is clear that Serious Case Reviews are a part of the Learning and Improvement Framework that all Local Safeguarding Children Boards must have in place to identify learning from cases in order that local and national practice to safeguard children can continuously improve.

1.14 The purpose of a Serious Case Review is to conduct "a rigorous, objective analysis of what happened and why, so that important lessons can be learnt and services improved to reduce the risk of future harm to children.'' To facilitate this Manchester Safeguarding Children Board (MSCB) Serious Case Review Sub Group (SCR SG) developed key lines of enquiry for the review.

1.15 Reviews therefore must seek to:

identify precisely who did what and the underlying reasons that led individuals and organisations to act as they did;

understand practice from the point of view of the individuals and organisations involved at the time rather than using hindsight;

be transparent about the way information is collected and analysed; and

to make use of relevant research and case evidence to inform the findings.

1.16 The Serious Case Review covers the period from March 2012 which is the date of a Multi-Agency Meeting held at the children's home where MD1 was living to July 2014 which is the day that Child D1's body was released by the Coroner.

METHODOLOGY

2.1 The government has indicated that it supports changes recommended by Professor Eileen Munro that Serious Case Reviews should be conducted using systems based learning methodology and it was agreed that important learning could be gained by conducting a 'whole system' Serious Case Review in order to conceptualise how services routinely operate and to identify what is working well or where there are problematic areas.

2.2 The MSCB Serious Case Review Sub Group recognised that the review would need to be as robust and transparent as the former SCR process and should be measured by the extent to which it would make a difference and improve Manchester's multi-agency safeguarding response.

2.3 The analysis in this report uses some elements of the framework developed by SCIE to present key learning within the context of local systems in Manchester. This also takes account of recent work that suggests that an approach of developing over prescriptive and SMART recommendations have limited impact and value in complex work such as safeguarding children. For example, a 2011 study of recommendations arising from Serious Case Reviews 2009-2010, (Brandon, M et al), calls for a limiting of 'self-perpetuating and proliferation' of recommendations. Current thinking about how the learning from Serious Case Reviews can be most effectively achieved is encouraging a lighter touch on making recommendations and simplifying of action plans to implement them.

2.4 The Serious Case Review was designed and led by Clare Hyde MBE, Independent Reviewer, from The Foundation for Families (a not for profit Community Interest Company). Ms Hyde developed a review model that would enable participants to consider the events and circumstances, which led up to the tragic death of Child D1.

2.5 A Serious Case Review Team was convened of senior and specialist agency representatives to oversee the conduct and outcomes of the review.

2.6 The Review Team agreed specific key lines of enquiry for the SCR. The key lines of enquiry included:

How much was known about FD1 and his involvement and role in this family?

Evaluation of the timing and sequencing of the 'step down' arrangements for MD1 and Child D1.

The multi-agency response to MD1's own needs and wellbeing on becoming a mother given her background.

How did agencies respond to disclosures of domestic abuse?

Were interventions / contacts with FD1 focused on risk to mother or baby?

Was the extent of substance use by FD1 and MD1 fully known?

The level and detail of information gathered as part of the SUDC process. Including the decision making process regarding whether or not to undertake investigations (child protection and or criminal).

2.7 The Review Team established the identity of services in contact with the family during the time frame agreed for the review.

2.8 The SCR aimed to provide an innovative 'whole system' approach involving key front line practitioners (and their line managers) who worked with Child D1 and adults of Child D1's family in a Learning Event. In this way, Child D1's 'story' was to be central to the Learning Event. In preparation for the Learning Event, practitioners were asked to complete a chronology identifying key practice episodes and describing:

- What could / should have been done differently?
- What worked well and how was this evidenced?

INDEPENDENCE

2.9 The Lead Reviewer was Clare Hyde, Director at The Foundation for Families. Clare has over twenty years' experience in developing and delivering services for people and families with complex needs. She has been involved in a number of Serious Case Reviews since 2012 and was a member of Baroness Corston's Review Team which was commissioned by the government following the deaths of 12 women in custody. Clare has held various operational and strategic roles and led the transformation of adult social care programme in the Yorkshire and Humber region.

SERIOUS CASE REVIEW TEAM

2.10 The Review Team met on 4 occasions between November 2014 and April 2015. The overview report was ratified at the MSCB meeting on 11th June 2015 following an extraordinary meeting convened to receive and respond to the findings on the 11th May 2015.

2.11 The Review Team comprised of:

Title	Organisation
Independent Lead Reviewer	Foundation for Families
Business and Performance Manager	Manchester Safeguarding Children Board
Service Manager	Connexions
Head of Safeguarding	Manchester North, Central & South CCG's
Improvement Manager	CAFCASS
Policy Officer	Manchester City Council, Housing
Team Manager	Youth Justice Service
Operations Manager	Lifeline Eclypse
Manager	Lifeline Eclypse
Detective Sergeant	Greater Manchester Police
Consultant Paediatrician	Central Manchester Foundation Trust
Looked after Nurse	Central Manchester Foundation Trust
Safeguarding Advisor	Barnardos
Senior Manager	Cambian Group
Service Manager	Addiction Dependency Solutions
Team Manager	Children's Services
IOM Spotlight Manager	Cheshire & Greater Manchester Community Rehabilitation Company (Probation)
Operations Manager NPS – City Partnership & Quality Lead	Probation
Team Manager	NSPCC
Doctor/SUDC Lead for Greater Manchester	SUDC
Business Support Officer	Manchester Safeguarding Children Board

CONFIDENTIALITY

2.12 Working Together to Safeguard Children 2013 clearly sets out a requirement for the publication in full of the overview report from Serious Case Reviews:

> *"All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the MSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case."*[1]

FAMILY INVOLVEMENT

2.13 Both parents were notified that a Serious Case Review was taking place and were invited to contribute through a meeting with the Lead Reviewer and a Review Team member. MD1 agreed to a meeting but on the appointed date, sent her apologies stating she was no longer willing to be part of the review. MD1 was offered the option of a telephone conversation with the Lead Reviewer, but has not taken advantage of this offer to date. Should contact be made with MD1, an addendum to the report will follow.

DISSEMINATION OF LEARNING

2.14 The learning from this review will be fully disseminated to professionals in Manchester following the membership of Manchester Safeguarding Children Board formally dealing with the findings in the near future.

RACE, RELIGION, LANGUAGE AND CULTURE

2.15 Child D1 was of mixed heritage (MD1 was of English heritage and FD1 mixed white/ black/ Caribbean). Religion is not thought to have been a feature of Child D1's life.

[1] Working Together to Safeguard Children 2013 p71

BACKGROUND INFORMATION

MD1 and FD1

2.16 There were several indicators that MD1 and FD1's parenting capacity may have been compromised and that Child D1 may have been at risk. MD1's history in particular is very relevant and known details are given below.

MD1

2.17 MD1 became a looked after child at the age of 7.

2.18 MD1's mother died from a drug overdose when MD1 was aged 2 and MD1 was looked after by her maternal grandmother (MGM).

2.19 MGM was an alcoholic and was unable to care for MD1.

2.20 MD1 was voluntarily placed in care in July 2005 whilst her Grandmother was unwell and again in February 2011 until March 2014. The majority of this time was spent living in a children's home.

2.21 MD1 had early and frequent involvement with Youth Justice Services. MD1's offences included assaults.

2.22 MD1 met FD1 (who was also known to criminal justice agencies) when she was 15 and he was 19.

2.23 MD1 went missing from care on a regular and frequent basis and was reported to be at the home of FD1 on the majority of those occasions.

2.24 In March 2012 when MD1 was 15, she requested a 'virtual baby' via the Sexual Health Nurse and by June 2012 at her LAC Review it was recorded that MD1 had taken 3 pregnancy tests and it was believed that she was actively trying to become pregnant.

2.25 At the same review it was noted that MD1 was possibly using cannabis and that her boyfriend FD1 was possibly a drug dealer.

2.26 A Sexual Health Worker worked with MD1 and MD1 'looked after' a virtual baby and completed sessions on the reality of having a baby. On completing the sessions MD1 stated that she did not want a baby at the present time.

2.27 MD1 received support around her alcohol use in 2010, 2011 and for alcohol and cannabis use 2012.

FD1

2.28 FD1 experienced a bereavement in 2003 when his brother drowned in an accident.

2.29 FD1 was subject to a short term exclusion from primary school after he assaulted a member of staff.

2.30 FD1 was aged 11 when he first had contact with Youth Justice Services for theft and robbery.

2.31 The Youth Justice Service identified that FD1 needed to work on anger management and conflict resolution.

2.32 FD1 attended a Pupil Referral Unit (PRU) between 2004 and 2005 and his behaviour was sometimes aggressive and abusive.

2.33 Youth Justice Services referred FD1 to the Eclypse service as he was using cannabis.

2.34 In 2005 FD1 was excluded from the PRU for attempting to attack another pupil with a knife. When later asked about the incident he said he would have used the knife (a teacher prevented him from doing so).

2.35 It was recorded that staff were 'very concerned about FD1's capacity to be able to switch from being pleasant to suddenly getting out of control with anger and wanting to hurt someone'.

2.36 In 2005 FD1 was assessed as having special educational needs; attention span/behavioural problems and literacy and numeracy problems.

2.37 In April 2012 FD1 appeared at Crown Court where he was convicted of two drugs offences; those being concerned in the supply of Heroin and Crack Cocaine where he received a suspended sentence (24 months) and an electronic curfew. He pleaded guilty to these crimes. There were three further cases of Possessing a Class A (other); Heroin and Crack Cocaine with intent to supply that were not proceeded with on the same date.

2.38 FD1 was assessed as posing a low risk of serious harm to the public in the pre-sentence report. He had no previous convictions as an adult.

NARRATIVE AND SUMMARY OF KEY EVENTS

2.39 There are more contacts with health practitioners, social care and others than are referred to in the following summary of professional contact with Child D1 and the family. This summary provides an account of the most significant events and decisions from the different services involved during the timeframe of the SCR. This summary was used as a core element of the Learning Event and enabled practitioners to see the 'whole family' multi –agency involvement.

2.40 MD1's pregnancy with Child D1 was confirmed in March 2013.

2.41 MD1 was then aged 16 and was living in a children's home.

2.42 FD1 was then aged 20 and was living with his mother (where he continued to live as his main place of residence throughout the period of this review).

2.43 March 2013; MD1's Social Worker (SW1) visited MD1 at the children's home and discussed her pregnancy. SW1 told MD1 that there would be a Pre-Birth Assessment for the unborn baby

and MD1 did not react well to this and was uncooperative. It appears that MD1's relationship with SW1 began to break down from this point onwards.

2.44 At this time MD1 expressed her wish to live independently to SW1 and to her Barnardo's Personal Adviser (BPA).

2.45 March 2013; the children's home referred MD1 to the Family Nurse Partnership (FNP) when she was approximately 5 weeks pregnant.

2.46 April 2013 MD1 was discussed at a Family Resource Panel and a decision was made that the Eclypse service (substance misuse service) would attempt to re-engage her.

2.47 April 2013 a Looked After Child Review took place for MD1 and a decision was made to allocate a Social Worker to the unborn child and that a Pre-Birth Assessment would be carried out.

2.48 Also in April 2013; FD1 attended an appointment with his Probation Support Officer (PSO) and disclosed that his girlfriend (MD1) was pregnant. He also disclosed that he was unsure about MD1's involvement with Social Services stating that he believed that their involvement with her would end in after she turned 18. However he had previously told the Probation Worker that MD1 was 16. The PSO advised FD1 that Children's Social Care would be '100% involved' in the child's birth and development.

2.49 The PSO telephoned SW1 to confirm what FD1 had told him following FD1's appointment and also discussed FD1 with a Senior Probation Officer and a decision was made to transfer FD1 to a Probation Officer because of the level of safeguarding concerns. This allocation to a Probation Officer took place in April 2013.

2.50 April 2013; MD1 attended her antenatal booking appointment at 13 weeks' gestation. She disclosed that the baby's father was FD1 aged that he was aged 20. There were no medical conditions of note and MD1 did not disclose any mental health, alcohol or drug addiction. MD1 stated she had a Social Worker as she was a 'Looked After Child' (LAC). MD1 was seen by the Specialist Midwife (SM) for young parents. SM referred MD1 to Social Care for a Pre-Birth

Assessment, to the Education Training and Employment Service and to the Family Nurse Partnership with consent. A referral was also made to 2 residencies for supported accommodation to be considered.

2.51 May 2013; MD1 attended an appointment with a Substance Misuse Practitioner (SMP) and it was recorded that MD1 was 11 weeks pregnant and had stopped using cannabis and alcohol 3.5 weeks earlier. MD1 reported finding it very difficult and that she had been experiencing lots of cravings around cannabis. MD1 was still currently smoking cigarettes and would like to address this. MD1 spoke about her partner FD1 and that he smoked cannabis. MD1 asked if the Substance Misuse Service could support FD1 to reduce his cannabis use.

2.52 As MD1 was engaging with YJS, the SMP obtained copy of their Comprehensive Asset Assessment.

2.53 June 2013; at a meeting with her Barnardo's Personal Advisor (BPA) the BPA up-dates MD1's Risk Assessment- which outlines a slight suspicion that there may be Domestic Violence in MD1's relationship but this was denied by MD1. Concerns about cannabis smoking are recorded (it is noted that the Substance Misuse Service are working with MD1). MD1's previous angry outbursts are also discussed and it is noted that MD1 was working hard to address this.

2.54 June 2013; the Family Nurse (FN) from the Family Nurse Partnership carried out a visit to MD1 to introduce herself and the FNP programme. MD1 was keen to enrol on the programme and for FD1 to access programme material and support for fathers. The visit was carried out in the lounge in the children's home and MD1 reported that it was difficult being in the home and pregnant and that there was a lack of privacy.

2.55 June 2013; a LAC Health Assessment was completed by the LAC Nurse and MD1's health plan was reviewed and it was noted that MD1 was 17 weeks pregnant was still smoking cigarettes but not using any other substances.

2.56 The LAC Nurse recorded that MD1 was really happy to be pregnant and she felt well in herself. MD1 wanted to live independently and was open and receptive to the support on offer to her.

2.57 MD1 also reported that she did not have lots of friends and mostly spends time with her boyfriend. It was noted that this was an age appropriate relationship.

2.58 June 2013 at a home visit, the FN briefly discussed MD1's mother's death (MD1 was aged 2 years when her mother died) and the difficult relationship between MD1's grandmother and grandfather. MD1 witnessed domestic abuse as a child and told the FN that she would not tolerate abuse and control in her own relationship.

2.59 It was also noted at this visit that there were still tensions between MD1 and MD1's key-worker from the children's home and that these were because of MD1's previous difficult behaviour (which had improved).

2.60 June 2013; MD1's unborn baby (Child D1) was allocated a Social Worker (SW2) and MD1 was introduced to him at a meeting with SW1.

2.61 Attempts to secure a placement for MD1 at a mother and baby unit were ongoing during this period of time and in June 2013 at a meeting with her Substance Misuse Practitioner (SMP) which took place at the children's home, it is recorded that one of the possible placements had refused MD1 a place due to her criminal record and that she was quite upset.

2.62 It was also noted that FD1 had completed a Pre-Birth Assessment which she felt had gone well but had not received any feedback.

2.63 It was also noted that MD1 had continued to reduce her smoking and that MD1 would like FD1 to address his cannabis use. The SMP advised that she would be happy to meet FD1 and discuss it.

2.64 June 2013 at an appointment with the FN, it was recorded that MD1's self-efficacy was discussed and that MD1 reported learned resilience and a determination to improve her own life chances for the sake of her unborn child.

2.65 The FN completed a Relationship Assessment; MD1 reported that she had not been emotionally or physically abused by her partner or anyone important to her and had not been forced to have sexual relations (within the last year).

2.66 Since becoming pregnant, MD1 reported that she had not been hit, slapped, kicked or otherwise hurt and reported not to be afraid of any current or previous partners/someone close to her.

2.67 July 2013 at a Case Planning Meeting attended by MD1, a worker from the children's home, SW1, FN, and MD1's BPA; MD1 stated that she would not accept a mother and baby placement and that she wanted to be independent. The children's home staff supported MD1 in this. It was recorded that MD1 was no longer smoking cannabis. SW1 advised that the Pre-Birth Assessment would probably result in a Case Conference for the unborn baby. MD1's BPA stated that as long as support from the FNP was in place and support from the accommodation provider in her tenancy the professionals views are that independence would be viable option for MD1.

2.68 Also in July 2013 a formal request for an unborn baby assessment was made to Children's Services.

2.69 August 2013 – Child and Family Assessment completed. Section 47 Strategy Discussion – outcome referral for initial child protection conference.

2.70 July 2013; MD1's application for a place at a second mother and baby unit is also rejected.

2.71 During this period of time FD1 continued to be managed by the Probation Service however he missed several of his appointments and was issued with breach notices on these occasions.

2.72 In July 2013; FD1 sustained a fracture to his jaw and told A & E staff that he had fallen from his push bike after drinking 3 glasses of vodka. MD1 at a meeting with her SMP however disclosed that FD1 had been attacked by a group of Somali men. MD1 denied that FD1 himself was involved in any gang activity.

2.73 July 2013; FD1's breach of his probation conditions was to be heard at Preston Crown Court.

2.74 July 2013; FD1's Offender Manager (OM1) telephoned SW2 who was conducting the Pre-Birth Assessment and stated that although there were concerns that FD1 was continuing to deal drugs, there was no verifiable evidence at this stage. On that basis, SW1 was reported to have authorised overnight stays for MD1 at FD1's address.

2.75 Also in July 2013 OM1 telephoned SW1 who confirmed that MD1 was having overnight stays at FD1's address and had been providing dates and times in advance to the children's home; and had been returning as instructed to do so. SW1 had visited the address and regarded it as suitable.

2.76 SW1 stated that initially a Child Abduction Order was sought to prevent FD1 and his mother from contacting MD1 - but that this course of action had discontinued because of MD1's age and because she was regarded to be capable of making an informed choice to stay in a relationship with FD1, whom she met with he was also in late adolescence.

2.77 SW1 explained that MD1's mother and grandmother were heroin addicts; and that her father was a drug dealer, so some there were concerns that she would not regard FD1's alleged dealing to be inappropriate.

2.78 SW1 also stated that a referral to conference will take place for the unborn baby as a baby of a LAC child and that Child in Need or Child Protection arrangements would be necessary.

2.79 It was agreed that OM1 would inform SW1 and SW2 of any relevant police intelligence and outcomes.

2.80 Also in July 2013 OM1 checked with the Public Protection Investigation Unit (PPIU) that there were no recorded domestic abuse incidents involving FD1.

2.81 July 2013; OM1 moved to another role in the probation service and FD1's case is transferred to a new offender manager (OM2).

ANALYSIS

3.1 This Serious Case Review covers a relatively short period of time however there was significant agency involvement with Child D1, MD1 and FD1 during this period. Key events will therefore be analysed briefly against the key lines of enquiry, the outcome of the Learning Review and research in order to draw conclusions and identify lessons learned by professionals involved in the case as well as the learning for the wider membership of the Safeguarding Board.

3.2 The following specific key lines of enquiry for the SCR are addressed in the analysis:

- How much was known about FD1 and his involvement and role in this family?
- Were interventions / contacts with FD1 focused on risk to mother or baby?
- How did agencies respond to disclosures of domestic abuse?
- Was the extent of substance use by FD1 and MD1 fully known?
- How effective was the multi-agency response to MD1's own needs and wellbeing on becoming a mother given her background?
- Evaluation of the timing and sequencing of the 'step down' arrangements for MD1 and Child D1.
- The level and detail of information gathered as part of the SUDC process. Including the decision making process regarding whether or not to undertake investigations (child protection and or criminal).

HOW MUCH WAS KNOWN ABOUT FD1 AND HIS INVOLVEMENT AND ROLE IN THIS FAMILY?

3.3 With one known exception (FD1's GP), the practitioners who worked with FD1 knew that he was in a relationship with MD1 and that he was the father of Child D1.

3.4 It is unclear however; beyond the period MD1 spent in the foster placement exactly how much was known about the extent of FD1's contact with MD1 and Child D1 on a day to day basis or to what extent he was involved in or influenced MD1's decision making and activities.

3.5 This did not seem to have been explored with MD1 or FD1 in any detail and the occasions on which practitioners observed MD1 and FD1 together (before and after Child D1 was born) only provided a 'snap shot' of his role in the family.

3.6 FD1 was managed by the Probation Service throughout the period of time covered by this review. During that time FD1 was allocated 4 workers (and saw a further Probation Worker on one occasion in February 2014).

3.7 Two of the Offender Managers 'managed' FD1 after the birth of Child D1 however FD1 was not seen by either of the two Offender Managers following the birth as he failed to attend his appointments.

3.8 FD1 had a statutory requirement to engage with the Probation Service and his Offender Managers were therefore, in a unique position to determine how involved he was in MD1 and Child D1's life and to then contribute to and inform safeguarding plans.

3.9 Other practitioners (HV2 and SW3) visited MD1 and Child D1 at their home when FD1 was present and MD1 also told practitioners that FD1 stayed over a couple of times a week.

3.10 This information was not used to determine FD1's involvement in the day to day care of Child D1 or given what was known about his continued cannabis use and reports of domestic abuse; the impact of this on the child's safety and well-being.

3.11 The FN attempted to assess the impact and risk of FD1's involvement in MD1's life (before Child D1 was born) and arranged a joint visit to FD1's home however this again only provided a 'snapshot' of his involvement.

3.12 The impact of and risks presented by FD1's presence in the life of Child D1 and MD1 was largely unknown and there was no reference to him in the CIN meeting records once MD1 moved from foster care into her own property.

WERE INTERVENTIONS/CONTACTS WITH FD1 FOCUSED ON RISK TO MOTHER AND BABY?

3.13 Individual risk factors are explored in more detail later in this section, however, it is important not to lose sight of the whole picture and to consider the opportunities available to practitioners to recognise and focus on concerns over a relatively short period of time and assess the potential risk to a very young baby and a vulnerable young mother.

3.14 There were a number of factors present in this case which are well known to be associated with risk to children, yet these were not adequately assessed as a whole or acted on when known.

3.15 Child D1 was born into a relationship dynamic which had inherent risk factors and to two individual parents who had current and historical difficulties which were indicators of risk to Child D1. In other words, MD1 and FD1's individual difficulties may well have been compounded by them coming together as a couple.

3.16 Additionally, based upon what is known about the profile of men/fathers who harm their partners and/or children, FD1 did pose a risk to both mother and baby.

3.17 Whilst some of the specific risk issues were recognised e.g. drug use and domestic abuse, there did not appear to be a collaborative, multi –agency assessment or shared ownership of risk.

3.18 Learning from other Serious Case Reviews where children have died or been seriously injured provides a useful reference for identifying and responding to risks. For example, analysis of 183 child homicides in 83 different Local Authority areas was carried out in 2009 by Ferguson and Oborne (Ferguson L, Oborne P, The Children Britain Betrayed (2009) Channel 4 Media Publications) revealed that:

- Children under the age of one are the most vulnerable – one third of all cases (34%).
- Domestic violence was a background factor in 41% of the cases.
- 30% of the parents and carers who killed children had substance abuse problems – 20% drug abuse and 11% alcohol abuse.
- A disproportionate number of very young parents were responsible for killing their children; around one in three child homicides involved a parent or carer (most often the young mother's new boyfriend) who was aged 22 or under.

3.19 MD1 told the manager of the children's home that she had a 'new boyfriend' in February 2012 but would not say who he was. She was then aged 15.

3.20 At this time MD1 was missing from care on an almost daily basis. On other occasions she returned to the children's home very late at night or in the early hours of the morning; and was also found walking on the streets around the home and in other areas of the city.

3.21 MD1 also returned to the children's home drunk or under the influence of cannabis.

3.22 Given the context of her history of childhood exposure to domestic abuse, neglect and trauma and her current behaviours she was extremely vulnerable to sexual and other forms of exploitation and abuse and any 'new boyfriend' should have been assessed in relation to this vulnerability.

3.23 By March 2012, MD1 had requested a 'virtual baby' and there was no evidence that this was explored with MD1 by the school nurse (or any other practitioner) in the context of her relationship with her new boyfriend.

3.24 April 2012; following a telephone call to the Police by MD1's concerned grandmother the Police located MD1 at FD1's home. MD1's grandmother had told the Police that MD1 was smoking cannabis and drinking. The Police located MD1 at FD1's home and conducted a 'safe and well' check. Again, given the level of MD1's vulnerability and FD1's status as an offender, this contact should have triggered a consideration of exploitation or abuse at that point.

3.25 Whilst there is no suggestion that FD1 was physically violent to Child D1 his drug use whilst the baby was present was a significant harm of which he was aware.

3.26 Additionally; childhood exposure to domestic abuse is also known to be harmful and linked to physical and emotional developmental problems and to other forms of abuse.

3.27 FD1 was being managed by the Probation Service throughout the period of time included in the scope of this Serious Case Review. There were occasions when Probation Practitioners demonstrated a good understanding of the potential risk posed to MD1 and Child D1 (before the child was born) however there were also occasions when FD1's disengagement with his Offender Manager i.e. repeated missed appointments which were not viewed as a potential increase in risk

and neither were these missed appointments communicated to other agencies (these missed appointments were dealt with as a breach of FD1's order and were dealt with at Preston Crown Court).

3.28 OM2 in his 'handover' notes as he left his role recorded his concerns about FD1's parenting capacity. This did not alert OM3 to contact Children's Social Care or any other agency when FD1 disengaged with the Probation Service.

3.29 The Police also held intelligence on FD1 which, if shared with the relevant agencies, could have informed their assessment of the potential risk posed to MD1 and Child D1. (This information concerned FD1's possible links to gangs, that he was a suspect in incidents of phone snatching, linked to a vehicle theft, and that he was stopped and searched and found to be in the possession of cannabis for which he was cautioned).

3.30 There were examples of good practice in relation to the focus on risk to MD1 and Child D1 in particular from the FN.

3.31 These examples include the FN's request that the Pre-Birth Assessment considered FD1 as she believed him to be a high risk to MD1 and Child D1.

HOW DID AGENCIES RESPOND TO DISCLOSURES OF DOMESTIC ABUSE?

3.32 SW1 asked MD1 about domestic abuse in March 2012 although it is unclear what prompted this discussion. MD1 denied that there was any abuse occurring.

3.33 In January 2013 at a LAC Review Meeting, a Police Officer who was present recorded that MD1 was also present at the meeting and was aggressive and emotional. It transpired that her relationship with FD1 had finished and MD1 intimated that in the past he had hit her. After the meeting the Police Officer spoke to MD1 however she refused to give any further details and she gave MD1 contact details and advice about domestic abuse and asked her to think about giving details and making a report.

3.34 On the whole domestic abuse was known or suspected to be occurring throughout MD1's relationship with FD1 and MD1 was asked direct and indirect questions about domestic abuse on several occasions.

3.35 There was however no specific domestic abuse risk assessment carried out (e.g.CAADA DASH) and this was a missed opportunity to ask more detailed and questions of MD1 and properly assess the risk posed to her and to offer specific support.

3.36 In addition, there did not appear to be a sustained focus on domestic abuse at the professionals meetings held in respect of MD1 or Child D1.

3.37 Given what we know about how, when and to whom victims of domestic abuse disclose the abuse; MD1 may well have declined to complete the DASH Risk Assessment and may well have continued to deny that any abuse was occurring; however there were missed opportunities to speak to MD1 alone and to use different, age appropriate ways to ask her about her relationship with FD1.

WAS THE EXTENT SUBSTANCE USE BY FD1 AND MD1 FULLY KNOWN?

3.38 The extent of substance use by FD1 and MD1 was not fully known.

3.39 MD1 admitted using cannabis whilst she was pregnant with Child D1 and she continued to smoke cigarettes during the pregnancy but denied using alcohol.

3.40 In September 2013 (when she was 7 months pregnant) MD1 told the SMP that she had used cannabis after the Child Protection Case Conference. The SMP did not share this information with any other agency.

3.41 At a Core Group discussion in October 2013 it was recorded that MD1 told SW2 that she had last used cannabis June 2013 although staff at the children's home believed that she was regularly 'under the influence when she returns from being out'.

3.42 It is obvious from these events that MD1 was not truthful about the extent of her cannabis use and told two practitioners different things. What is not in doubt however is that she did continue to use cannabis throughout her pregnancy.

3.43 Hair strand tests were planned to be carried out on MD1 for a period of time after Child D1's birth. However; there were only 2 hair strand tests ever carried out on MD1 in January 2014 and again in March 2014 (under Court direction) and it was recognised by practitioners who attended the Learning Event that random drug testing should have continued for a much longer period of time especially when MD1 moved out of the foster placement.

3.44 The focus of enquiries by practitioners was, on the whole, on the couples cannabis use and not on their alcohol use or use of other substances. This is particularly relevant because FD1 had been convicted of 'being concerned in the supply of Heroin and Crack Cocaine' and he received a suspended sentence (24 months) and an electronic curfew. He pleaded guilty to these crimes.

3.45 It does not appear that FD1 or MD1 were asked about the use of these substances.

3.46 FD1 was open about his cannabis use and did not engage with the Substance Misuse Service to which he was referred by MD1's SMP. This was not communicated to other agencies.

3.47 The link between cannabis use and other types of harm, neglect and abuse was not discussed with FD1 or MD1. After birth, Child D1 may have been exposed to many sustained or intermittent risks as a result of the parents' drug use. Known risks include poverty; physical and emotional abuse or neglect; dangerously inadequate supervision; other inappropriate parenting practices; intermittent or permanent separation; inadequate accommodation and frequent changes in residence; toxic substances in the home; interrupted or otherwise unsatisfactory education and socialisation; exposure to criminal or other inappropriate adult behaviour; and social isolation. They often interact with and exacerbate other parental difficulties such as educational under-attainment and mental health problems.

3.48 MD1's history meant that her ability to parent safely and effectively was compromised and her use of substances would have compounded this significantly.

3.49 It is also notable that FD1's substance use and the risk this posed to Child D1 did not receive equal consideration. There was no statutory requirement for him to undertake hair strand tests or restrictions on his contact with Child D1 because he had not voluntarily engaged with Substance Misuse Services. FD1 undertook hair strand testing in the care proceedings in January 2014.

HOW EFFECTIVE WAS THE MULTI-AGENCY RESPONSE TO MD1S OWN NEEDS AND WELLBEING ON BECOMING A MOTHER GIVEN HER BACKGROUND?

3.50 The multi-agency response to MD1's own needs and wellbeing on becoming a mother were only partly effective.

3.51 There was a 'perfect storm' of individual events which combined to create a loss of focus on MD1.

3.52 These individual events included:

- SW1 had been MD1's Social Worker for a significant period of time and had provided some continuity in MD1's life. It is not clear what caused MD1 to complain about SW1 and request a change of Social Worker (as was her right) but MD1's request was granted in October 2013 when she was 8 months pregnant. This meant that MD1 had to form a relationship with a new Social Worker at a crucial time and that SW1's understanding of MD1 and of her history was partially lost.
- In addition, SW1 communicated well with FD1's Offender Manager (and with other practitioners) and proactively sought and shared information. This good communication and seeking out and sharing of information was not sustained by MD1's future Social Workers.
- MD1 was allocated two further Social Workers SW4 and SW5 during the time scale of this review.
- SW4 contributed to MD1's LAC Review in September 2013 and carried out a LAC Visit in November and December 2013 and February and March 2014.

- The scheduled LAC Review for April 2014 was postponed twice and SW4 did not communicate well with other practitioners including the IRO which meant that MD1's review did not take place until May 2014.
- SW4's record keeping was also an issue and MD1's case notes on the Micare system were not regularly updated and vital information e.g. MD1's move from foster care to a private rented home was therefore not shown.
- SW4 was replaced by SW5 in April 2014.
- SW5 did not meet MD1.
- MD1's case notes record 4 contacts in May and June between SW5 and the IRO, trying to arrange the Discharge Planning Meeting ending MD1's LAC status.
- An additional loss of effectiveness occurred when MD1 moved into foster care with Child D1.
- The foster placement which was secured for MD1 was outside of the Manchester area. This meant that the FN who had established a relationship with MD1 and who demonstrated a good understanding of the issues MD1 would face on becoming a mother, was no longer able to work with her.
- HV1 who attended MD1 and Child D1 whilst she was living in the foster placement was unable to continue working with MD1 once she returned to the Manchester area.

3.53 More importantly, to be effective, the multi-agency response to MD1 when she became a mother should have been underpinned and informed by what we know about the outcomes for LAC and specifically for girls who become pregnant whilst still a LAC.

3.54 MD1 had experienced significant historical traumas and loss and became a looked after child at the age of 7.

3.55 MD1's experiences were indications of need and were also, in themselves, clear indicators that her parenting may have been compromised and that her child could be at risk.

3.56 Factors that are known to be associated with risk to babies and very young children (Ward et al 2012) include parents who have experienced abusive childhoods themselves and have not come to terms with the abuse. Additional risk factors include domestic abuse and environmental

stressors such as housing. Significant protective factors are the presence of a supportive non-partner, wider family and informal support and parent's insight understanding and capacity to change. Severe risk of harm is most likely where there is an absence of protective factors. *Ward, H., Brown, R., and Westlake, D. (2012) Safeguarding Babies and Very Young Children. London: Jessica Kingsley Publishers.*

3.57 Additionally; children who are emotionally or physically neglected as children can develop many long-lasting problems. Intimacy and nurturance skills are typically underdeveloped and can lead these children to have relational problems later in life with other adults and their own children. Some children who experience neglect will form quick, over-involved and inappropriate attachments with others. This leaves them vulnerable to abuse.

3.58 MD1 was an extremely vulnerable young woman whose early childhood had been traumatic. Other than the psychological assessment carried out as part of the care proceedings for Child D1, there was no indication that practitioners sought relevant information about MD1's experience as a child *specifically* to inform assessments of the support she was likely to need as a parent in her own right. Nor was the information from the psychological assessment or from MD1's historical records used to assess the potential benefit of therapeutic interventions for any unresolved trauma. [n.b. professionals would have been led by the psychologist who did not recommend therapeutic intervention].

3.59 MD1 shares a similar history with other young parents whose children become the subject of Serious Case Reviews both in Manchester and across the UK.

3.60 Teenagers who become parents are known to experience greater educational, health, social and economic difficulties than young people who are not parents, and their children may be exposed to the consequences of greater social deprivation and disadvantage.

3.61 These outcomes have been demonstrated to be more adverse still in the case of looked after children who become parents because this group are more likely than others to be unemployed, have more mental health problems, be expected to be independent, and to have little social or economic support. Until recently there had been no systematic monitoring of health

progress and health outcomes in looked after children , but it is now recognised that the health and educational needs of LAC are different from and greater than many other groups of children and young people. LAC are exposed to greater risk factors for teenage pregnancy than many other groups. Young people in care are recognised as being one of the principal groups to experience social exclusion.

3.62 There is also a strong link between teenage pregnancy and age at first intercourse and LAC are known to become sexually active earlier than other groups of children. As a result, looked after young people are two and a half times more likely to become pregnant as teenagers. It is estimated that one in four young women leaving care are either pregnant or already mothers, and almost half of female care leavers become mothers between the ages of 18 and 24. *SCIE Briefing 'Preventing Teenage Pregnancy in Looked after Children' August 2004*

3.63 In Manchester in December 2014 there were:

- 114 young people supported by the Leaving Care Service who are parents.
- An additional 15 young people who are parents but do not have full care of the child.
- 22 children have been removed from parents - 18 female parents and 4 male parents (i.e. 19% of those children in the full care of a formerly looked after child).

EVALUATION OF THE TIMING AND SEQUENCING OF THE 'STEP DOWN' ARRANGEMENTS FOR MD1 AND CHILD D1

3.64 The timing and sequence of the 'step down' arrangements for Child D1 were influenced by the outcome of the family court proceedings.

3.65 However the plans which were made after the 'step down' were not informed by what we know about the needs and risks of very young mothers who share similar histories to MD1's.

3.66 MD1's history and the difficulties she experienced as a result of her own exposure to abuse and neglect meant that she would require significant support and supervision in her role as a parent.

3.67 MD1's placement with the foster carer was a success. During the time she and Child D1 were there, MD1 received significant support and supervision and was also provided with a role model.

3.68 Whilst in the foster placement MD1 demonstrated that she could meet Child D1's needs and had bonded well with her baby.

3.69 At a Child Protection Case Conference for Child D1 in December 2013 the decision to 'step down' from Child Protection to Child In Need arrangements was unanimously agreed. It was noted that 'everyone was extremely complimentary over the progress MD1 had made and her efforts with engaging with all services'. It was also noted that MD1 was living in a specialised foster placement in Area 1 with the baby. She was settling in well and had been meeting all the needs for Child D1. The notes also record that MD1 was hoping to move to independent living in the future.

3.70 At this point MD1 was still aged 17, was still a LAC and Child D1 was only 2 months old.

3.71 The fact that MD1 was meeting all of Child D1's needs and was engaging with all services was precisely *because* she was living in a foster placement specific to her needs.

3.72 It is also striking that FD1 was not present at this meeting (he was in the same building but was looking after Child D1). At this point in time:

- FD1 had not engaged with the ADS (the SMP who was present at the meeting stating that he had engaged with her but he had in fact failed to engage with ADS- the service to which she referred him).
- FD1 had not engaged in ante natal care.
- FD1 had only engaged once with the FN.
- FD1 was still being supervised by the Probation Service. At that time, his attendance at appointments with his Offender Manager was a statutory requirement. This meant that his Offender Manager (OM2) saw and spoke to him on a regular basis. OM2 expressed concerns about FD1's capacity to parent. The Offender Manager was not asked to/did not contribute to the meeting and consequently this vital information was not shared.
- Intelligence gathered by the Police about FD1 was not shared with the meeting.

3.73 The meeting records however state that FD1 had engaged well with professionals.

3.74 MD1 moved into her own property in February 2014 (still aged 17 and still a LAC). Child D1 was 4 months old.

3.75 The arrangements for continued CIN meetings for Child D1 and floating support for MD1 did not replicate the environment of the foster placement and practitioners were optimistic and unrealistic about MD1's ability to sustain her engagement and progression in her role as a mother.

3.76 Practitioners who attended the Learning Event and contributed to the review when asked what 'good would have looked like' for MD1 and Child D1 agreed that MD1 should have remained in the foster placement until Child D1 was older and the mother's ability to care independently was better assessed. It was also thought that the fostering agreement would be in respect of MD1 and Child D1 as individuals as well as a mother and child 'unit'. In other words, if MD1 could not safely and effectively parent Child D1 the child could remain in the foster placement in her own right whilst permanence was determined.

THE LEVEL AND DETAIL OF INFORMATION GATHERED AS PART OF THE SUDC PROCESS INCLUDING THE DECISION MAKING PROCESS REGARDING WHETHER OR NOT TO UNDERTAKE INVESTIGATIONS (CHILD PROTECTION AND/OR CRIMINAL)

3.77 The local SUDC protocol was followed in this case. MD1 and FD1 were the subject of a criminal investigation undertaken by GMP. Upon completion of the investigation GMP consulted with the Crown Prosecution Service (CPS) for a charging decision. The conclusion of CPS was that neither parent should be charged with any offence. In terms of the outcome of considerations for criminal prosecution in cases of this nature; the Review Team considered that there were parallels with a previous Serious Case Review in Manchester, Child C1. In that review, the findings included a recommendation for Manchester Safeguarding Children Board to seek discussions with the CPS regarding the possibility in some complex Child Protection cases, of the involvement of Children's Services in an advisory capacity. In this case the GMP investigating officers and the CPS were notified that a Serious Case Review had been commissioned but there was no request by them for information held by the review.

ADDITIONAL ANALYSIS

3.78 The author of this report has included additional analysis which, in her opinion is relevant to this case.

HOW WELL INFORMATION WAS SHARED, UNDERSTOOD AND RESPONDED TO BETWEEN AGENCIES AND ACROSS GEOGRAPHICAL BOUNDARIES?

3.79 Timely and up to date sharing of information between professionals and local agencies is essential for identification, assessment and service provision, especially where there are complex issues such as those experienced by MD1 and Child D1.

3.80 There are a number of episodes of poor communication and information sharing between agencies which include the following examples:

- The SMP did not appear to share information about MD1's disclosure of cannabis use with other agencies.
- The ADS worker did not inform other agencies when FD1 engaged and then failed to engage with their service.
- The Discharge Planning Meeting for MD1 as she left hospital after the birth of Child D1 was hampered by poor communication.
- OM3 did not share information with other agencies to let them know that FD1 had disengaged with the Probation Service or that his order had finished.
- SW4 did not respond to the attempts to contact her by HV2; this was at a crucial time in MD1 and Child D1's life as they moved out of the foster placement.

3.82 There were also examples of **good practice** which include the FN's 'handover' of MD1 and Child D1's care to HV1 in the foster placement area. This was a comprehensive and balanced sharing of information and context.

HOW WELL WAS CHILD D1 LISTENED TO AND UNDERSTOOD?

3.83 Child D1 was too young to verbalise any feelings but it would be possible to imagine what the child's daily life had been like whilst living with MD1 in the foster placement. During this time, MD1 responded to the child's needs, bonded with the child and was supported by an experienced

foster carer in a protected environment. We also know that MD1 did not use cannabis during this period of time; second hair strand testing was inconclusive due to hair colour applied to hair in December 2013.

3.84 What is less clear is what Child D1's lived experience was like once MD1 moved into her own home. We do not know if MD1's care of Child D1 was compromised when FD1 'stayed over'. We do not know if the couple argued or were violent towards each other. We do not know how often they used alcohol or other substances whilst caring for Child D1. We do not know how often MD1 had friends or neighbours visiting and how this may have impacted on Child D1. Certainly in the hours leading up to the child's death, Child D1's needs were ignored.

CONCLUSION

4.1 It is only by considering MD1's family history over the last three generations and understanding the impact of trauma and loss on her ability to keep herself and her child safe that we would see the need for a much more pro-active and less optimistic approach to assessing risk and need in relation to MD1's parenting capacity.

4.2 MD1 demonstrated that in the right environment and with the right support and supervision in place, she was able to respond to Child D1's needs and she and the baby had bonded well.

4.3 MD1 and Child D1 required a long term, highly personalised care and support package which included therapeutic interventions, family fostering arrangements, and gender specific trauma informed approaches to address any unresolved issues.

4.4 FD1's role in the family and the risk he presented to MD1 and Child D1 was poorly understood. The issues of FD1's continued cannabis use, his offending behaviour, and his lack of engagement with services, his disengagement with the Probation Service and the reports of domestic abuse were not given sufficient consideration by all of the practitioners working to safeguard MD1 and Child D1.

LESSONS LEARNED AND CHANGES TO POLICY AND PRACTICE SINCE JULY 2014

4.5 There have been lessons learned and changes to policy and practice since Child D1's tragic death in July 2014. These include:

THE LEAVING CARE SERVICE

- Increased use of supervision and scrutiny about cases where young people are parents.
- Discussion with the Local Authority about the need for full information to be given about a young person at the referral stage.
- CSE training of staff is ongoing.
- An audit is taking place about young people who are parents and the levels of risk in such cases.

- Discussion has taken place with staff about the need to escalate concerns about a child, decisions which are made, or drift in a case.

CHILDREN'S SERVICES

- The policy and practice in relation to looked after children who go missing from care has been changed and has resulted in significant improvements in the numbers of incidents of 'missing from care'.

GREATER MANCHESTER POLICE

- Following recommendations made by Her Majesty's Inspectorate of Constabulary (HMIC), Greater Manchester Police have carried our significant work to raise awareness of domestic abuse and to provide training for staff (which all front line staff have received).

ADDICTION DEPENDENCY SOLUTIONS

- The service has carried out a review of how they contribute to the CAF process and ensure that safeguarding processes around information sharing are better embedded into practice and monitored through Management oversight.

ALL AGENCIES

- Policy and practice in relation to children and young people who may be at risk of child sexual exploitation has improved since MD1 was herself a looked after child. This includes ongoing staff development and awareness raising.

RECOMMENDATIONS AND CHALLENGES TO MANCHESTER SAFEGUARDING CHILDREN BOARD

5.1 It is recommended that the MSCB conducts a thematic review of the LAC cohort of girls with a specific focus on:

- preventing teenage pregnancy; and
- where girls do become pregnant developing and adapting new ways of working which would include consideration of therapeutic interventions, long term family fostering arrangements, and highly personalised gender specific and tailored support packages for mothers who have been looked after and/or experienced neglect, trauma and abuse.

5.2 Where looked after children or care leavers have children who are removed from their care consideration should be given to the multi-agency response to this cohort of young people who may well go on to have more children (given their very young age). The loss of children into care is known to be a factor in multiple pregnancies resulting in more than one child from the same family becoming looked after.

5.3 It is recommended that LSCB partners review their practice in relation to fathers or other significant males who are involved in the lives of children about whom there are concerns. This should include:

- A systematic, proactive and dynamic approach to recognising, assessing and responding to risks such as domestic abuse, sexual exploitation, substance misuse and other criminal activities.
- A review by GMP/Probation/Substance Misuse Services of how they share information *and* intelligence about parents/partners with child welfare agencies and how this can be improved.

Single agency action plans are attached to this report at Appendix 1. The following agencies considered that there was no learning to be gained from this serious case review and have not therefore provided single agency action plans.

- Greater Manchester Police
- Housing.

REFERENCES

1. Working Together to Safeguard Children 2013 pg. 15 & 17.
2. Department for Education guidance on information sharing 2008.
3. Ferguson L, Oborne P, The Children Britain Betrayed (2009) Channel 4 Media Publications.

   Ward, H., Brown, R., and Westlake, D. (2012) Safeguarding Babies and Very Young Children. London: Jessica Kingsley Publishers.
4. SCIE Briefing 'Preventing Teenage Pregnancy in Looked after Children' August 2004.

GLOSSARY OF ACRONYMS USED THROUGHOUT THE REPORT

Glossary of Acronyms	
ADS	Addiction and Dependency Service
BPA	Barnardos Personal Advisor
Cafcass	Children and Family Court Advice and Support Service
CFCA	Cafcass Family Court Adviser
CIN	Child in Need
CPP	Child Protection Plan
CSC	Children's Social Care
DI	Detective Inspector
Dr 1	MD1's GP
Dr 2	A & E Consultant
Dr 3	SUDC Paediatric Consultant
FD1	Father of Child D 1
FN	Family Nurse
FNP	Family Nurse Partnership
FRP	Family Resource Panel
GMP	Greater Manchester Police
HV	Health Visitor
ICPC	Interim Child Protection Conference
IRO	Independent Reviewing Officer

Glossary of Acronyms	
LAC	Looked After Child
LCW	Leaving Care Worker
MD1	Mother of Child D1
MGM	MD1's maternal grandmother
MSCB	Manchester Safeguarding Children Board
OM	Offender Manager
OW	Outreach Worker
PSO	Probation Support Officer
SCRSG	Serious Case Review Sub Group
SM	Specialist Midwife
SMP	Substance Misuse Practitioner
SMS	Substance Misuse Service
SUDC	Sudden Unexpected Death of a Child
SW1	MD1's first Social Worker
SW2	Child D1's first Social Worker
SW3	Child D1's second Social Worker
SW4	MD1's second Social Worker
SW5	MD1's third Social Worker
YOS	Youth Offending Service

APPENDIX 1

ADDICTION DEPENDENCY SOLUTIONS						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	To ensure that all learning from SCR D1 is shared with Team Leaders and Practitioners	To devise and deliver staff briefings & information packs to ensure all staff familiar with learning points from D1 SCR process WITHIN 4 MONTHS.	Share Training attendance lists / feedback summary with LSCB nominee.	Staff group aware of learning points and able to incorporate these into practice.	LT – with assistance of Team Leaders	W/E 01.05.2015
2.	To ensure that all staff employed within the Service have undertaken basic level safeguarding children training and that safeguarding children professional development is embedded within the PPDA process.	Develop a register of all staff and training completed to date, along with renewal dates – identify nominated person to have responsibility for maintaining WITHIN 8 WEEKS.	Able to share register with LSCB nominees.	<u>The following outcomes relate to all the specific actions set to achieve the overall recommendation:</u> Staff group all completed mandatory basic level training – improved K&U of processes / wider context / referral process / delivery of higher standards of practice.	LT – with assistance of Team Leaders	W/E 03.04.2015
		Complete TNA with Team Leaders to identify targeted approach to training for named members of staff and continual professional development approach with whole staff group WITHIN 12 WEEKS.	Share TNA and Training Plan with LSCB nominees.	Increased staff familiarisation with ADS internal safeguarding children procedures.		W/E 01.05.2015
		Build record of training / achievement into individual supervision / PPDA process WITHIN 12 WEEKS.	Share PPDA / Supervision document with LSCB nominee.	Safeguarding better embedded into CPD process and fostering a culture of motivation to engage with training.		W/E 01.05.2015
		To devise and deliver staff briefings & information packs to ensure all staff familiar with ADS internal Safeguarding Children Procedures to include: • Voice of the Child • Disclosure / Confidentiality / Information sharing	Share Training attendance lists / feedback summary with LSCB nominee.	Better Leadership / Management oversight of gaps in staff knowledge and practice and improved mechanisms to address deficits.		By end of May 2015.

APPENDIX 1

ADDICTION DEPENDENCY SOLUTIONS						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
		• LAC processes • Role within Conference / Core Group • CSE – signs & actions WITHIN 4 MONTHS.				
3.	To develop processes for ensuring safeguarding practice is adhered to and followed and identify mechanisms for reporting exceptions to process	Develop 'tracking system' for all cases with identified risks related to children BY END OF MAY 2015.	Share Process / Staff Briefing notes with LSCB nominee.	The following outcomes relate to all the specific actions set to achieve the overall recommendation:	LT – with assistance of Team Leaders	By end of May 2015
		Develop Professional Meeting type forum, where individual staff, Team Leader / Service Manager discuss cases identified with risks / potential risks to children to foster a culture of sharing / discussing practice and accountability for practice around safeguarding BY END OF MAY 2015.	Share Process / Staff Briefing notes with LSCB nominee.	Better Leadership / Management oversight of gaps in staff knowledge and practice and improved mechanisms to address deficits.		By end of May 2015
		Develop Peer Review process to allow all Team Leaders to jointly review staff practice BY END OF MAY 2015	Share Process / Staff Briefing notes with LSCB nominee.	Improved ability to identify deficits in practice earlier and create the opportunity for rectifying those identified deficits		By end of May 2015
4.	Improve practitioner use of CAF process to divert low level cases away from Child Protection (where appropriate)	Service Manager to liaise with SCB / Probation / CRC colleagues regarding CAF process and seek ways to implement BY END OF MAY 2015	Share Process / Staff Briefing notes with LSCB nominee.	The following outcomes relate to all the specific actions set to achieve the overall recommendation: Increase in use of CAF process, decrease in referrals to SC units / CP units / improved confidence in staff in being able to deal successfully with	LT– with assistance of Team Leaders	By end of May 2015.
		Service Manager / Team Leaders to access CAF training via MSCB BY END OF MAY 2015	Record of training logs submitted to MSCB.			

APPENDIX 1

ADDICTION DEPENDENCY SOLUTIONS						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
		Develop Staff training / briefing events to embed CAF process into practice –BY END OF MAY 2015	Share Process / Staff Briefing notes with LSCB nominee	lower level CAF / TAC management.		
5.	Ensure local project learning is disseminate across the wider organisation and positively influences ADS Safeguarding Practice	Service Manager to link with Director lead for Safeguarding to share D1 learning BY END OF MAY 2015	SM to update LSCB nominees.	D1 learning influencing ADS organisational wide practice	LT Director QSP Team	By end of May 2015
		Service Manager to link with Quality Standards Team to build learning into future organisational development.	SM to update LSCB nominees.	D1 learning influencing ADS organisational wide practice		By end of May 2015
6.	Develop and implement an adequate 'transitions policy' to ensure that services are tailored to meet the specific needs of this group.	SM to complete review of what 'transition work' currently takes place and complete gap analysis END OF MAY 2015.	SM to update LSCB nominees.	Better provision for 18 – 25 yr olds, more specific to their individual needs.	LT	By end of May 2015
		SM to use gap analysis to implement service wide improvements to working with this age group BY END OF SUMMER 2015.	SM to update LSCB nominees.	Better provision for 18 – 25 yr olds, more specific to their individual needs.	LT	By end of June 2015

APPENDIX 1

BARNARDOS SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	To continue the process of training staff about child sexual exploitation, and to note concerns about a young person in the pathway plan.	Training audit to identify staff who require the training. Staff to access the training. CSE and plans to be discussed in supervision and team meetings.	Audit which will identify staff who need training, and completion of training. Minutes of meetings.	Staff are better informed about CSE. CSE forms part of discussion and planning in meetings and supervision	KH CSM	30.5.15
2.	To review the protocol for referral of young parents to a local children's centre	Review of protocol and communication to staff. Audit of young parents and referral to children's centres	Minutes of review meeting. Audit of young parents and actions arising.	Young parents receive support from a local children's centre. Staff are aware of the need for referral.	KH CSM	30.4.15
3.	To review the pathway plan when a young person becomes a parent, to ensure that the necessary support is in place.	Plan to be reviewed Team leaders to discuss in supervision re. current cases. Contact with key agencies e.g. health, social care.	Record of review meeting, and contact made with agencies.	Young parents receive the necessary support from appropriate agencies. Multi agency work is co-ordinated and documented.	KH CSM	30.4.15

APPENDIX 1

CAFCASS SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	A Cafcass area learning event in relation to detailed risk assessment and 'duty mindedness' in Cafcass casework approach.	Cafcass, (Area A3, Manchester), are holding a learning event for service managers and practitioners (16 March 2015). The event will include the use of case information in relation to D1 case along with outline details of another, similar, case. The key purpose being that of ensuring all staff remain focused on a full understanding of risks to subject children and remain alert to concerning issues as case work progresses	Manchester SCB will be provided with the presentation materials for the event along with a list of attendees. Specific discussions in relation to issues addressed at the learning event will take place with all practitioners at their Performance Learning Review (individual supervision) with their service managers.	Cafcass has a detailed training programme which is nationally delivered. In addition this event has been specifically developed locally as a means of ensuring that staff in the A3 area get the opportunity to reflect on particular issues arising from Serious Case Reviews. The looked for outcomes include: increased awareness of the need to work closely in conjunction with other agencies particularly where a gap in provision may have been identified; continually review new information in relation to emerging or known risks to the subject child or vulnerable adult; sustaining the child at the centre of case work and ensure a full understanding of their day by day experiences.	Senior Head of Service, Cafcass	16 March 2015

APPENDIX 1

CAMBIAN GROUP SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	To create a much more robust MFC report	To include evidence of CSE To include evidence of Exploitation of crime To include what steps should be taken To include consultation with regional Clear guidelines on how many MFC reports before strategy meeting will be held	MFC form improved	The MFC form will clearly show any clear patterns, times, dates, return time and dates, mood, have they returned with anything. Will show communication with all relevant professionals.	QA team	Completed
2	Weekly reports/ significant event logs	To give relevant professionals a complete	Weekly report	Weekly update to show how young people have progressed or not.	Key workers and manager	Completed and ongoing
3	In-depth training	Training for all staff with refreshers annually	Training has been hugely improved.	Improved much more time spent on how to complete the paperwork and how to ensure a young person is ok when they return, if not who to escalate to.	Training department	Completed
4	Persistent MFC to be observed at a higher level	Business Risk Plan is analysed by operations on a weekly basis	Business Risk Plan (BRP)	This ensures that any actions necessary are met within agreed timescales and the BRP is analysed by operations on a weekly basis	Homes/regional managers and operational directors	Competed and on going
5	Multi agency working and escalation	Support given to managers via BRP and MFC reports	MFC BRP Weekly report	Having several levels of management look at young people with cause for concern, discussed on a weekly basis ensures that all actions are taken	Homes/regional managers and operational directors	Competed and on going

APPENDIX 1

CENTRAL MANCHESTER FOUNDATION TRUST SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	Health Practitioners working with Looked After Children who become pregnant to have an increased understanding of how historical abuse and neglect shapes the young person and then their capacity to parent. How does this inform assessment, decision making and intervention.	Scope bespoke training for specialist roles that can then be embedded within CMFT training and supervision. Begin to use tools acquired from level 4 neglect training received on 29.1.15 within supervision.	Audit of supervision record. Neglect training received by FNP and Safeguarding Team on 29.1.15- training package, evaluation and attendance. Scoping of bespoke training.	Enhanced professional knowledge and judgement about young person's history, with an increased understanding and analysis of predisposing and perpetuating risk factors. Effective supervision plans that inform practice and multi-agency decision making. Strengths based risk assessment.	Named Nurse for LAC	Oct 2015
2.	A health pathway to be developed and implemented for LAC/leaving care who become pregnant.	Group to be formed to develop pathway. (To include Midwifery, Health Visiting, School Nursing, Family Nurse and LAC Specialist Nursing team in collaboration with children's services) Pathway and standard to be developed to include: • Antenatal period • Informing pre-birth assessment • Engagement and	Pathway, standard and implementation plan. Audit of cases following implementation of the pathway. Patient experience results.	Child centred co-ordinated healthcare and case management for both the LAC and the unborn/baby/child. Young people feel supported and able to care for their child.	Named Nurse for LAC	Dec 2015 Evaluation and Audit of implementation of pathway from 2016.

APPENDIX 1

CENTRAL MANCHESTER FOUNDATION TRUST SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
		assessment of fathers. • Historical context of LAC. • Referral to Family Nurse Partnership • Multi-agency communication • Risk Assessment • Discharge planning • Postnatal intervention Obtain views and experiences of young parents, particularly those who are/have been a LAC to inform the development of the pathway.				
3.	Further consideration needs to be given to how the Lead Health Professional (other than the GP) is shared information about A+E attendances for LAC aged 16-18 years old so appropriate follow up can become standard.	Explore with A+E implementing a system for information sharing with community lead health professionals, for this age group when it is identified they are a LAC.	Meetings to scope with A+E lead nurse/manager	Lead health professional will be able to follow up the young person following A+E attendance and have the opportunity to review the young person within context.	Named Nurse for LAC	Dec 2015

APPENDIX 1

CHILDREN'S SERVICES SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	That the missing from home episodes for any future Looked after Child follow the now updated procedures, with specified meetings and return to home interviews offered on every occasion.	Missing from home policy to be followed.	The Missing from Home Policy has been updated in Manchester and now includes a mandatory return to home interview offer. Data reports re number of interviews undertaken as part of performance indicators.	That all Looked After Children who have missing from home episodes are offered a return to home interview. To increase the awareness of MFH patterns. To give opportunities for Young people to have the space to discuss their circumstances to someone other than direct carers.	Strategic Lead Children's Services Strategic Lead for Looked After Children	
2.	That if the department is requested to change an allocated social worker, by a child or an involved family, that this is agreed between the team manager and Locality Manager.	Reduce the number of changes to social workers by making this decision more formalised between the Locality managerial team. Guidance for the managers to be drafted, in order to set out suitable examples where this would be appropriate.	That the decisions between Team manager and locality Manager are recorded and then accountable.	An improved continuity of the allocated social worker, this would increase the continuity in case planning. This may reduce any delay or missed opportunities for case planning.	Strategic Lead Children's Services Strategic Lead for Looked After Children	
3.	That the department's LAC procedure of requiring the discharge planning meeting take place on or around the end of care episode be followed in all cases.	Record all Discharge LAC review meetings along with the changes in LAC status, to highlight subsequent arrangements and actions.	To ensure that all discharge plans in place for any children leaving the Looked After system.	To ensure all children who leave care have a discharge plan.	Strategic Lead Children's Services Strategic Lead for Looked After Children Head of Safeguarding	

APPENDIX 1

CHILDREN'S SERVICES SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
					Unit	
4.	That the department implements the CIN planning review process for all children who are on Supervision Orders.	To record in Micare all Child In Need meetings and plans for children on Supervision orders. To include a review at 6 months, by a CAFA, to see whether the department should return to court.	Each child in need meeting and plan is addressing the needs of the children with identified and appropriate support.	To ensure all children in need plans are appropriate and reviewed so as to meet the needs as required.	Strategic Lead Children's Services Strategic Lead for Looked After Children	
5.	That the department tries to address the turn over of case holding Social Work staff, as a matter of priority.	Address the staff turn over within district social work teams.	A reduction in the number of changes to case holding social workers will impact on the numbers of changes in Social workers for each child or family and improve there experience and direct contact with Children's Services.	Having less changes in social workers will give children and families, improved continuity in service. Increases in the service reliability and continuity will improve outcomes for children and families.	Strategic Lead Children's Services Strategic Lead for Looked After Children	

APPENDIX 1

CONNEXIONS SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	Staff should be clear on actions to take when a response from another agency is not as required - Barnardos were unable to provide current caseload worker. This should have been highlighted to the link Personal Adviser/ Manager within Connexions in order to escalate the issue with the other agency so that they could assign a worker for the client.	Re-iterating to all staff of the company Safeguarding Children and Young People Policy and Guidelines and the escalation procedure. Highlight/discuss these procedures during team meeting and re-send the procedures to all staff. Discuss issues such as these during the one to one Practice support sessions, under the safeguarding agenda item.	Copy of the minutes from the team meeting/s. Template of the Practice Support paperwork.	All staff are fully aware of procedures and knowledge and will be updated on regular basis resulting in improved quality support of the client group. Improved communications with other agencies.	AA	February 2015 On-going

GP SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	GP Practices need to receive information about the care of vulnerable children and young people who are registered with their practice.	Information sharing processes to be reviewed between Looked After Children Health Team and GP Practices across Manchester Information sharing processes to be reviewed between midwifery and GP Practices	Single agency audit to ensure that information is present within GP case records Evidence that information shared with GPs has received an appropriate response	Vulnerable children and young people are able to access increased support to meet individual identified need	Designated safeguarding professionals for Looked After Children and Midwifery Services	September 2015

APPENDIX 1

LIFELINE ECLYPSE SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	Review of case allocation approach for clients previously known to service. Case allocation to involve a review of the case file history and productivity of engagement with previous practitioner.	New case allocation protocol to include case file review of known cases when re-referred back into treatment. Address in Manager meeting in January 2015. Implementation February 2015. Update allocation protocol in January 2015 to include these objectives.	Inclusion of the case allocation process in the Lifeline Eclypse case management protocol.	Case allocation to consider attachment issues associated with re-referrals. Increased awareness of Senior Practitioner with regards to history of case to support engagement and intervention. This will serve to improve engagement but also focus work having considered historical work achieved on case.	SR, Manager	February 27th 2015
2.	Ensure participation in multi-agency action plans	Annual case file reviews undertaken by Senior Practitioner to include review of participation in multi-agency action planning. Weekly risk reviews undertaken by Treatment Team practitioners to detail whether involvement is documented in multi-agency care planning. Address issues with Senior team leaders in January 2015	Completed risk review forms inclusive of multi-agency planning	Recorded and evidenced participation in multi-agency casework inclusive of CAF, CIN, Conference, LAC Reviews. Evidences adherence to Working Together protocol which will enhance service delivery to young people and families.	SR, Manager	February 27th 2015
3.	De-escalation process to clarify exit and transitional arrangements when cases are closed.	Discuss at Manager meeting in January 2015. Relay to staff team in February staff meeting. Exit and transitional arrangement process to be updated.	Exit and transitional protocol to be updated by Feb 27th 2015.	Clear guidelines on transitional arrangements at closure in line with Manchester threshold document to safeguard young people as risk issues rise and fall at point of exit from Lifeline Eclypse. Will secure transition of young people into multi agency care planning with partner services to ensure sustainable support continues after case is closed.	SR, Manager	February 27th 2015

APPENDIX 1

MANCHESTER YOUTH JUSTICE SERVICE SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1	To explore and examine the missing from home episodes of young people subject to YOS intervention	CM to identify & notify YOS Manger where an episode occurs. CM to obtain copies of MFH interview and work with yp and residential unit staff to reduce MFH episodes. YOS Manger to discuss case, note grave concerns, highlight support to decrease MFH episodes and vulnerabilities with CM and relevant agencies in Risk Management Meeting / YOS Safeguarding forum. Develop effective responses to address prevention and protection needs for the yp. RMM chairs to send copies of minutes to YOS Safeguarding Lead Manager who will monitor and discuss at YOS Safeguarding Forums. The need for staff to have sufficient training, knowledge, skills and experience for working with child protection and high-risk situations. Case file review as part of quality assurance. The findings of the case file review are integrated into the Performance meetings	Minutes of meetings Training Plan	Increase multi agency awareness. Service wide monitoring of MFH episodes. Each case will receive proper investigative action. Tracking positive outcome and what works. Identify examples of promising practice in relation to protecting children and young people. Increase awareness of the issue of MFH	MB YOS Manager	31/12/15

APPENDIX 1

NATIONAL PROBATION SERVICE SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	For the National Probation Service to ensure that any case where there are safeguarding concerns present that there are clear handover notes provided at the point of any internal transfer between officers.	Production of a case handover document for child in need or Child Protection flagged cases.	Document produced	Case holding Staff in the NPS and their line managers use this document and are aware of the importance of completing this document to support effective case handover details in safeguarding children cases.	SP NPS	01/04/15
2.	For the National Probation Service to ensure that at the point of case closure that contact is made with Child Safeguarding Services	To add a 'termination actions' section to the current child protection case checklist document to prompt staff to advise partners of CRC statutory period of involvement ending.	Document Produced	Reminder/prompt for NPS case managers to take specific actions in communicating to children's services that their statutory involvement has ended in any child safeguarding case.	SP NPS	01/04/15

PROBATION CRC SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	For the CRC Probation Service to ensure that any case where there are safeguarding concerns present that there are clear handover notes provided at the point of any internal transfer between officers.	Production of a case handover document for child in need or Child Protection flagged cases.	Document produced	Case holding Staff in the CRC and their line managers use this document and are aware of the importance of completing this document to support effective case handover details in safeguarding children cases.	DS IOM Strategy Manager	01/04/15
2.	For the CRC Probation Service to ensure that at the point of case closure that contact is made with Child Safeguarding Services	To add a 'termination actions' section to the current child protection case checklist document to prompt staff to advise partners of CRC statutory period of involvement ending.	Document updated	Reminder/prompt for CRC case managers to take specific actions in communicating to children's services that their statutory involvement has ended in any child safeguarding case.	DS IOM Strategy Manager	01/04/15

APPENDIX 1

SUDC SINGLE AGENCY ACTION PLAN						
N.	**Recommendation**	**Key Actions**	**Evidence**	**Key Outcome**	**Lead Officer**	**Date**
1.	There should be clear documentation of who attended the post mortem examination and any actions that result as a result of the provisional post mortem examination findings	Introduction of PM attendance sheet (already being used and attached). Case highlighted to all doctors on the on call rota.	Attached PM examination attendance sheet, and history proforma check list.	Clearer documentation of who attends the PM examination, and actions arising.	LD SUDC lead	Already in place