MANCHESTER SAFEGUARDING CHILDREN BOARD

Manchester Safeguarding Children Board

A Serious Case Review

'Child Z'

The Executive Summary

September 2013

This report has been commissioned and prepared on behalf of Manchester Safeguarding Children Board and is available for publication on the 5th October 2015.

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1.1 Introduction

1. The death of a child is a traumatic experience for families and professionals. Child Z died in September 2012 after being left unsupervised in a bath at the family home. Child Z was the younger of two siblings who lived with their parents in Manchester. The family are white British whose first and only language is English. The parents are unemployed.

2. Following the death of Child Z, a cannabis farm was discovered in one of the bedrooms. The house was in a neglected condition. The house was filthy with dirty clothes and nappies, used and clean, evident on the floors in many of the rooms as well as on a kitchen work surface. The bedding in Child Z's cot was very dirty and also contained a large pillow. There was a cricket bat on the stairs and an axe handle/cosh was upstairs. Child Z's feeding chair was covered in food residue and was generally in an unhygienic condition. There were bare floor boards in several rooms and the stairs had no covering and were showing signs of splintering. There were holes in some internal walls.

3. The post-mortem examination of Child Z confirmed the child to be well grown and the state of nutrition appeared to be good. The sibling was also well nourished.

4. The parents were arrested on suspicion of the ill-treatment of a child and the production of cannabis and remained on police bail. They were both charged with child cruelty. FZ was charged with the production of cannabis and MZ was charged with allowing the production. The parents were acquitted of the charges of child cruelty in December 2014. FZ was convicted of growing cannabis and was given a six month community order with a condition that he complete 42 hours unpaid work. MZ was conditionally discharged for six months for allowing cannabis to be grown in their home.

5. There had been a high level of involvement with this family by health and criminal justice services. The Family Nurse Partnership[1] had begun during the pregnancy with

[1] FNP is a national and licensed programme across England that has three aims: to improve pregnancy outcomes, improve child health and development and to improve parents' economic self-sufficiency. FNP is a voluntary, preventive programme for vulnerable young first time mothers. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until age two. FNP uses in-depth methods to work with young parents, on attachment, relationships and psychological preparation for parenthood. Family nurses aim to build trusting and supportive relationships with families, guide first-time young parents and use behaviour change methods so that they adopt healthier lifestyles for themselves and for their babies, to provide good care for their babies and toddlers, and to plan their futures. The Healthy Child Programme for the early life stages focuses on a universal preventative service, providing families with a programme of screening, immunisation, health and development reviews, supplemented by advice around health, wellbeing and parenting. Family Nurses are trained nurses with post registration specialist training and hold a Health Visitor and / or Midwifery qualification. The Family Nurse Partnership (FNP) is a preventative programme for vulnerable, young, first time mothers. It offers intensive and structured visits delivered by specially training nurses from early pregnancy until a child is two years old (*The Evidence Base for Family Nurse Partnership, undated*). This programme began in England in 2007 with testing in 10 sites and with over 50 sites across England offering places to up 6500 families (*The Evidence Base for Family Nurse Partnership, undated*). FNP was implemented in Manchester in 2007 and was one of the test sites.

the elder Sibling 1 and there was an enhanced level of support during the second pregnancy (Child Z) through the Healthy Child Programme. The involvement of the FNP had been the result of a randomised selection for the programme within a research trial. The family nurse (FN1) contact involved 36 visits to Child Z's older sibling and 15 of these occurred after Child Z's birth.

6. There was involvement by other services such as the probation service in regard to Father (FZ) and there had been four referrals to children's social care (CSC) between November 2010 and June 2012. These referrals indicated concerns about domestic violence (although CSC did not have a referral from the police who dealt with an incident in 2010 that had included disclosures by Mother (MZ) of more than one incident), neglect and one report of a bruise to the older sibling. There had been no ongoing involvement by social workers and the children had never been the subject of multi agency child protection processes. They were not regarded as being at risk of significant harm and there was general optimism shared by different professionals in contact with the family that the parents were coping well despite their difficulties.

7. The considerable historical involvement by services with the families of both parents was not fully known and understood by most of the professionals who became involved after the birth of Child Z and the older sibling. Much of that historical involvement was recorded in paper based and archived files that were not indexed to current electronic systems.

8. MZ who was the youngest of six siblings, had grown up in a home where there were longstanding concerns about cleanliness and risk for the children. There was a history of mental illness for one of MZ's parents, domestic abuse and 'marital disharmony' (suggestive of domestic abuse). This information about MZ's childhood was contained in the records of the GP but was not accessed and therefore was not known when MZ became pregnant and she became a parent.

9. In November 2009 MZ had attended a local hospital emergency department following an alleged overdose; she had been reluctant to wait however and left without receiving treatment. The police were subsequently asked to carry out a 'welfare check', which they did. MZ was found to be at her mother's home and agreed to attend at the hospital emergency department later that day.

10. FZ had been subject of a child protection plan when he was a child. In 1992 he was on the child protection register (replaced by child protection plans in England from April 2008 following the Laming Inquiry) for eight months as a result of physical abuse after sustaining an injury during an argument between his parents. The information about

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FNP Wave 2, which contains a second team of Family Nurses commenced in January 2009 and has contributed to the randomised controlled trial of the partnership.

FZ's childhood history was also not accessed and therefore not known when MZ became pregnant and the two children were born.

11. FZ has a history of mental health and substance misuse dating back to 2009 involving self harm and attempted suicide. He has been reluctant to acknowledge these difficulties and therefore to accept help and support.

12. FZ also has a domestic abuse history involving previous partners, as well as his current partner, since 2003. He also has a criminal history between 2003 and 2010 involving offences of criminal damage, burglary, affray, assault, racially aggravated damage, robbery, offensive weapon, racially aggravated public order and theft. FZ was injured in an assault from an air rifle in 2010.

1.2 Rationale for conducting the Serious Case Review

13. 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 were set out in chapter 8 of *Working Together to Safeguard Children (2010)* but now amended and found in chapter four of *Working Together to Safeguard Children (2013*) issued in April 2013.

14. The LSCB should always undertake a Serious Case Review when a child dies and abuse or neglect is either known or is suspected to be a factor in their death.

15. The reason for undertaking this review is that Child Z may have died as a result of neglectful parental care. There had been historical concerns including domestic violence, mental illness and use of drugs. The home conditions in which Child Z and the sibling were living when Child Z died were very poor.

16. The overall purpose of the review is to establish if lessons are learned from the case through a detailed examination of events, decision-making and action. In identifying what those lessons are, to improve inter-agency working and to better safeguard and promote the welfare of children in Manchester.

1.3 Communication and contact with the family subject of the review

17. In view of the separate investigation by the police as well as the Coroner's enquiry the Serious Case Review panel had to ensure that all contact with the family was the subject of appropriate consultation and advice. The panel used the national guidance agreed

between Chief Police Officers, the Crown Prosecution Service and the Directors of Children's Services in England[2].

18. The parents were made aware of the Serious Case Review when it was commissioned, in a letter sent on the 22nd February 2013. Further contact with the family had to be postponed until the criminal investigation and criminal proceedings had been concluded.

1.4 The methodology of the Serious Case Review

19. A Serious Case Review panel was convened of senior and specialist agency representatives to oversee the conduct and outcomes of the review. The panel was chaired by an independent and suitably experienced person.

20. Work began on compiling a chronology in December 2012, which coincided with the appointment of the Independent Chair of the Serious Case Review panel and of the Independent Author of the Overview Report.

21. This Serious Case Review was completed using the methodology and requirements set out in current government national guidance that applied at the time of the review being commissioned and completed. That guidance has been extensively revised in the latest edition of *Working Together 2013* following the publication of the Munro Review's final report and recommendations in 2011.

22. The Manchester Safeguarding Children Board (MSCB) was already working on how future Serious Case Reviews could be developed in order to provide a more effective insight into the local systems for safeguarding and protecting children using system learning within Serious Case Reviews such as developed by SCIE (Social Care Institute for Excellence).

23. The analysis in the final chapter of the Overview Report uses some of the framework developed by SCIE to present the key learning within the context of the local systems. 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[3]. The final chapter of the Overview Report for example, explores the influence of family and professional interactions, the

[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

[3] *A study of recommendations arising from serious case reviews 2009-2010*, Brandon, M et al, Department of Education, September 2011 The study calls for a curbing of 'self perpetuating and proliferation' of recommendations. Current debate about how the learning from serious case reviews can be most effectively achieved is encouraging a lighter touch on making recommendations for implementation through over complex action plans

responses to incidents and the tools that are used by professionals to help inform their judgments and decisions.

24. It is important to state that although the panel has sought to place the learning from the review into a framework of systems learning this is not a SCIE review that has used systems methodology to collect and analyse information from the people directly involved with the family. The evidence is analysed to explore how the local systems both promote and in some circumstances inhibit professional practice and decision making.

25. The panel agreed case specific terms of reference that provided the key lines of enquiry for the review and were additional to the terms of reference described in national guidance. The panel established the identity of services in contact with the family during the time frame agreed for the review. For services that had significant involvement they were required to provide an Independent Management Review (and are listed in section 1.5). These reports were completed by senior people who had no direct involvement or responsibility for the services provided to the children and their parents.

26. An overview of the health agencies was provided in a Health Overview Report (HOR) provided by the Designated Doctor for NHS Manchester.

1.5 Details of the timescale and conduct of the Serious Case Review

27. The review was commissioned by Ian Rush, the Independent Chair of the Manchester Safeguarding Children Board (MSCB) on the 19th November 2012. The delay in making the formal decision was to allow clarification regarding the persistence of neglect in the case. The Serious Case Review panel was chaired by Valerie Charles who is independent of all services involved. The panel members are listed below. Peter Maddocks is the author of the Overview Report.

Position	Organisation
Valerie Charles	Independent Chair
Peter Maddocks	Independent Author
Interim Head, Safeguarding and Improvement Unit	Manchester Children's Social Care
Designated Doctor (and Author of the Health Overview Report)	NHS Manchester
Partnership Manager	Greater Manchester Probation Trust
Head of Business Effectiveness and Communications	Northwards Housing
Detective Sergeant	Manchester Police Service
District Head of Centre	Sure Start and Early Years Services

Assistant Director	Barnardos
Business Support Officer	MSCB
Business and Performance Manager	MSCB
Consultant/Designated Nurse	NHS Manchester

28. The following agencies had contact with the family at various times. They all conducted management reviews of their agency's actions and decision making which contributed to the overview report's analysis and findings:

    - Health services in the Greater Manchester area that include:

        - Central Manchester University Hospitals NHS Foundation Trust (provided the Family Nurse Partnership service that had extensive contact from the birth of Sibling 1 until the death of Child Z; because there was intensive FNP support there was no health visitor contact);
        - Pennine Acute Hospitals NHS Trust (provided midwifery services during both pregnancies; the specialist midwife referred MZ to the Family Nurse Partnership managed by the CMFT);
        - Manchester NHS General Practitioner (FZ and MZ were registered with different GP practices until November 2011; the GP practice had neither as patients until MZ had first registered in January 2011 after MZ's previous GP practice closed due to the death of the GP in early 2011); the family also used walk-in medical services;
        - North West Ambulance Service (made one referral to CSC in regard to suspected neglect observed when called to transport MZ to hospital in June 2012 and provided the emergency paramedic and ambulance response when Child Z had been found in the bath);

    - Greater Manchester Police Service (extensive involvement with FZ in respect of crime detection and dealt with one recorded incident of domestic abuse between FZ and MZ);
    - Manchester Children's Social Care (four referrals but no ongoing involvement and did not receive a referral from the police in regard to the domestic abuse);
    - Northwards Housing (the provider of housing from June 2011; prior to this date MZ and FZ had lived in privately rented property);
    - Greater Manchester Probation Trust (FZ was subject to a community supervision order; although MZ occasionally attended at probation with FZ there was no formal involvement with MZ);
    - Sure Start and Early Years Service (MZ was registered from 2009 although was an infrequent user of the services).

29. Information was sought from other services although these agencies were not required to provide an IMR:

    - Connexions who had contact with MZ as a school leaver and who she sought help from when she was told to leave her family's home when she was three months pregnant;
    - Family Action (a national charity providing support to children and families through approximately a 100 projects across the UK) who had two contacts with MZ in Manchester; one of those was with the Credit Union and the second was a large open access activity;
    - Greater Manchester West Mental Health NHS Foundation Trust (GMWMHT) had limited historical involvement with FZ in 2010 when he was referred for psychiatric assessment by the probation service in relation to self harm; a self inflicted stab wound and had taken an overdose in November 2009;
    - University Hospital of South Manchester NHS Foundation Trust (UHSM) provided surgical care when FZ injured his hand in March 2011;
    - Manchester College in regard to courses attended by MZ.

30. There were additional discussions with the FNP National Unit, the Chair of the panel and the Designated Nurse panel member to explore and clarify issues to support the learning from the review. These focussed on discussing the mismatch between the evidence of neglect and disengagement that became apparent in the information collated by the panel and the generally optimistic accounts from the local FNP service provider in particular that was influential in some aspects of multi-agency contact. The FNP National Unit was able to clarify that the strength based approach should be balanced with a sophisticated and ongoing assessment of the families' ability to make use of the programme and institute change. There are a number of approaches, national guidance and tools within the programme to facilitate this. Discussions also included the extent of the application of the FNP National Guidance within the local context. This is discussed within the analysis provided in the full Overview Report and summarised in a later section of this Executive Summary.

31. In compliance with national guidance an Overview Report was provided on behalf of the various health services that contributed to the review. The Overview Report for the entire Serious Case Review was completed by Peter Maddocks who attended every meeting of the case review panel. He is independent of all the services involved and he presented the Overview Report to the MSCB in July 2013. This complied with national requirements for the completion of a Serious Case Review in England.

32. All of the report authors, together with the Overview Author, were required to collate information and provide analysis in response to several key lines of enquiry identified by the panel and agreed by the MSCB.

33. The period under review is from the 17th July 2010 when MZ was subject of a domestic assault at 14 weeks into her pregnancy with the older sibling until the day after the death of Child Z in September 2012 in order to capture the paediatric response at the hospital and the post mortem examination and analysis of how Sibling 1 was safeguarded.

34. The key lines of enquiry, which are additional to the terms of reference set out in national '*Working Together*' guidance were:

    a) Analyse agencies recognition and response to needs and risk identified during the antenatal periods of Child Z and Sibling 1;

    b) Consideration as to how the assessments of parenting took into account the following risk factors and how this informed the safeguarding of both children:

        i. Teenaged parents
        ii. Parents with learning difficulties
        iii. Offending history
        iv. Domestic abuse
        v. Self harm
        vi. Housing
        vii. Substance Misuse
        viii. Mental Health
        ix. Engagement with services;

    c) The effectiveness of agencies recognition and response to indicators of neglect and their potential impact on the wellbeing of the children and analyse whether there was tolerance of neglect;

    d) To what extent, if any, did agencies communicate effectively and work together to safeguard and promote the continued well-being of both children. Examine whether partnership working was affected by assumptions in relation to the services provided by other agencies;

    e) During the time frame of this review, there were episodes of concern. Analyse the effectiveness of agencies response to these incidents in relation to child protection procedures;

    f) To what extent did agencies and services take account of issues such as lifestyle, economic status, community integration, race and culture, language, age,

disability, faith, gender and sexuality and how did this impact upon agencies assessment and service delivery?

1.6 Summary of the Serious Case Review

35. The Serious Case Review panel identified several examples of good practice:

    a) The detail of information contained in the referral from PO1 was of good quality;

    b) The Police Officers who dealt with the assault on MZ by FZ showed sensitivity and persistence in securing information about the incident and initiating the domestic abuse protocols;

    c) FN1 showed great persistence and resilience in maintaining a relationship with MZ;

    d) The allocation of the paramedic to accompany the crewed ambulance on the journey to hospital provided additional support to Child Z;

    e) The allocation of PO1 to provide the second pre-sentence report provided consistency.

36. The IMRs and Health Overview Report have identified recommendations to implement learning for their specific services as a result of the review. All of these recommendations are included as an appendix to this executive summary.

1.7 The summary of the events examined by the review

37. It is unclear from records where Child Z's parents had first met although it is known that they had both received treatment in regard to their use of alcohol and drugs. Both MZ and FZ were patients at Hospital 1 in early December 2009 following an overdose although it is not clear they knew each other, although at least one of the IMRs thinks that they probably did know each other at this time. Their first child was born 13 months later. The pregnancies were booked late. MZ who had been living with her parents when she first became pregnant with Sibling 1 was told to leave their home.

38. Although there have been previous serious case reviews that have emphasised the importance of checking historical records for teenagers who become pregnant, this did not happen in this case. The referral in June 2010 by the midwife to the FNP was not the result of identified need or vulnerability over and above MZ being a first-time pregnant teenager; MZ was not seen as being a particularly vulnerable pregnant teenager partly

because there was insufficient knowledge about FZ and the risk factors associated with his history and lifestyle. The involvement of the FNP service meant that the family received a high level of contact from a community health practitioner who had been trained in the use of an internationally validated programme.

39. In July 2010 the police were called to respond to an incident of domestic violence. MZ's disclosures of domestic abuse over several months were not reported to CSC who therefore remained unaware of that information as were the primary health professionals.

40. In terms of the home conditions various health and housing services had been assisting to ensure that adequate repairs and support including access to facilities were put in place. There was a problem with the shower (that took several weeks to resolve during 2012). There was often clutter in the house and some visitors to the home were concerned about cleanliness and care routines for the children.

41. The first referral to children's services was in November 2010 from the probation officer (PO1) regarding MZ who was due to give birth in January 2011 and requested a pre-birth parenting assessment of both parents ability to care for Sibling 1 owing to MZ's perceived lack of compliance with ante natal appointments and her ability to keep herself safe due to a history of domestic abuse between the couple. In mid July 2010 MZ had made an emergency telephone call to the Police asking for assistance to deal with a domestic argument.

42. PO1 also described FZ's history of offending and substance misuse. The information was reported to the Community Midwife Service with the intention of offering MZ involvement in the Vulnerable Babies Service which has a focus on reducing the incidence of sudden unexpected infant deaths through promoting for example safe sleeping practices; MZ had declined this and there was no direct conversation between CSC and the midwifery service.

43. A plan agreed with the specialist midwife and PO1 to develop a CAF (common assessment framework) plan in late December 2010 was not followed up before or after the birth of Sibling 1. The FNP service continued to be in regular contact. FZ had expressed his unhappiness that information about domestic violence had been shared with the midwifery service. This type of response is common on the part of perpetrators of domestic abuse.

44. After the birth of Sibling 1 in early 2011, the hospital midwifery service had consulted CSC and highlighted concern about the erratic attendance for ante-natal appointments and frequent moves between different addresses. Although the CSC out of hour's service advised that MZ should not be allowed to discharge from hospital with her baby, no other action was agreed or taken. The hospital had no legal powers to prevent the discharge from hospital.

45. Following the discharge from hospital there were visits by the midwifery service and FNP. There was general consensus that the parents appeared to be coping well and they appeared to be willing to accept contact and advice. The detailed examination of evidence from the review indicates that this apparent willingness to have contact with practitioners probably disguised an underlying pattern of neglect and non-compliance with the advice that was compounded by reliance on what the parents disclosed about aspects of their lifestyle.

46. An example occurred in May 2011 when a routine screening for domestic abuse (MZ was already nine weeks pregnant with Child Z) produced a misleading and false response from the parents. There were other examples in regard to issues such as their use of alcohol and drugs.

47. In June 2011 the ambulance service made a referral to CSC describing concerns about the neglect in the home and in the care of Sibling 1 that included observing the child being prop fed from a bottle; no assessment took place following a discussion with FN1 who believed that the parents were coping adequately and were accepting of help and advice.

48. In the summer of 2011 the family moved into the property where Child Z died. This followed the eviction of MZ and the children from their previous home which had been in a poor state of repair. MZ was advised by the landlord about taking on a property that only had a shower although MZ appeared to be confident she could live with this. In fact this became a significant issue that was exacerbated by the condition of the shower deteriorating over several weeks and the protracted discussions that were eventually resolved when a survey established that the shower was uneconomic to repair and a bath was fitted to the property.

49. In June 2012 a referral was made from the duty nurse at the hospital emergency department; the referral contained reference to the neglected condition of Sibling 1, a report of a bruise to the child and information about FZ's 'odd' presentation of information. This was followed up with a joint visit that involved FN1 and an initial assessment was completed that recommended no further action was required by CSC and case was closed. Intensive contact by the FNP service continued.

1.8 Key themes from the review

50. The panel have not identified any occasions where any single agency or individual practitioner could have prevented the tragic death of Child Z. The panel have identified opportunities for managing the response to Child Z's family differently that would probably have reflected a more assertive style of engagement and provided clearer

leadership for that involvement. The panel believe that neglect was a significant factor in this case but was not recognised at the time by the professionals who had the most extensive involvement with the family.

51. There appeared to be a high reliance for example on the Family Nurse Partnership programme being able to deliver positive outcomes for the children. There is good research evidence that such strengths based support can work very effectively with many families living in circumstances similar to Child Z. In delivering the programme, there was an inability to identify and give enough attention to indicators of risk from the family history of both parents and from their lifestyle and health problems.

52. Those indicators included the underlying reluctance of both parents to commit with enough openness and resolve to the support that was available from different services; there was evidence of underlying abuse in the relationship between the parents; the physical conditions in the home were at best inconsistent and possibly never were good enough for the appropriate care and safety of very young children.

53. The age of MZ when she first became pregnant, the fact that she became pregnant again very quickly after the birth of her first child, the absence of appropriate housing for a significant period of time and the apparent isolation from positive sources of help and support were indicators of vulnerability that were not given sufficient inference at the time; part of this may be due to the fact that they are characteristics shared by many other young parents in the same area. It may also have been partly a product of the intensive support that was in place and the associated research evidence for aspects of that support that encouraged a belief in good outcomes being achieved.

54. There was evidence of significant substance misuse that never really attracted the level of inquiry required; the panel retain a belief that some professionals may have taken a tolerant approach to aspects of behaviour that may have been different if it had been exhibited in a different part of the city; in other words a process of 'cultural relativism' applied to some judgments in matters such as cleanliness of the house and cannabis use for example.

55. This should not be taken as direct criticism of professionals who have to reconcile difficult dilemmas. For example, when faced with adults with marginal lifestyles who avoid and withdraw from contact, they have to try and find ways to develop sufficient trust or alternatively have sufficient evidence to take a more authoritative and assertive approach if it is seen as necessary to ensure a child's needs are being given sufficient attention. The emotional impact on professionals working with families facing high levels of need is also a factor examined by the review and is a factor identified in national research and evaluation.

56. Significant influences on how the case was managed included insufficient collation of historical information about either of the parents or their respective extended families;

for example they had both experienced levels of childhood trauma and abuse. A significant contributing factor were the gaps in electronic data systems being able to identify archived and historical information in CSC (and in other services) that was only accessed as a result of the strategy meetings held after Child Z had died and was provided by other services other than CSC.

57. If the assessment had involved more rigorous and extensive enquiry with services such as the GP it would have provided an opportunity to identify the significant and relevant history for both parents. Both parents have some learning difficulties which were not identified until the start of the criminal investigation; MZ was diagnosed with moderate learning difficulties as a child and at the age of nine was about four years behind her peers. The probation service and police recognised that FZ had unspecified learning difficulties.

58. There was not enough attention given to the history of the relationship between the parents, the circumstances and attitude to the pregnancies or their use of support. FZ has an extensive history of substance misuse and violence and had been unwilling to acknowledge his need for help in regard to mental health and educational or employment support. His lifestyle has represented risk to himself and to members of a household where very young children were living. He has been subject of assaults as well as being involved in assaults on others. There was evidence in the house for example of objects such as bats that could be used as weapons which with the exception of the police do not appear to have aroused any particular curiosity.

59. The absence of historical information may have contributed to an apparent down playing of information about the parents' current circumstances and lifestyle. The parents have difficulties associated with their mental health and FZ in regard to substance misuse although at the time were largely in denial about the significance. This led to misdirection when some professionals used self reporting and disclosure tools with the parents upon which they subsequently made important judgments.

60. There was evidence of domestic abuse which apart from one occasion in 2010 when MZ contacted the police, was largely denied and hidden. There are well known factors associated with why domestic abuse is very often hidden that are described in later sections of the Overview Report. There was an apparent absence of knowledge and curiosity displayed by many of the professionals who generally relied on the positive interpretation that MZ in particular provided when confronted occasionally on issues such as dirt or chaos.

61. There was a belief that the parents were open to and willing to accept help and support. In reality, there was an underlying pattern of missed appointments that begun during the first pregnancy and continued, behaviour that did not put the children's needs foremost (for example in MZ self discharging from hospital after the first birth), and a

reliance on parents saying they would make required changes without enough evidence of what was actually achieved.

62. Some of this reflects a misplaced empathy with parents being seen to overcome a range of personal difficulties, possibly an over confidence in the ability of a particular model of working being able to overcome and deliver improved outcomes, some professionals being under significant workload pressures and competing demands, not enough organised collation of information that could have highlighted important historical information as well as identifying for example behaviour that was indicative of disguised compliance.

63. The HOR for example highlights that during the ante natal care of Sibling 1, MZ missed eight appointments one of which was a joint appointment with the Midwife and FN1. The HOR points out that three of the appointments were during the later stages of pregnancy and therefore increased the level of risk for the unborn child as well as for the mother.

64. This pattern of missed appointments resulted in very concerted efforts especially by FN1 to secure improved contact and it may have led to a defensive rather than assertive approach being taken. Although there is evidence that there was an improved level of contact, FZ became less available and involved from late 2011.

65. The panel has identified five particular events that are significant for learning lessons from this case:

    a) The referral in June 2010 by the midwife to the FNP was not the result of identified need or vulnerability; MZ was not seen as being particularly vulnerable as a pregnant teenager partly because there was insufficient knowledge about FZ;

    b) The contact by the police in July 2010 to deal with MZ's disclosures of domestic abuse over several months was not reported to CSC who therefore remained unaware of that information; the systems that applied at the time relied on the use of fax information that did not log and allocate responsibility to specific people in different services; this practice has already been changed;

    c) In November 2010 the unqualified probation officer (PO1) who was undertaking professional training made a referral to CSC outlining their concerns about the history of FZ and the pregnancy of a teenage partner; in the absence of other historical information or making sufficient and completed enquiries the information was passed to the midwifery service without any direct conversation; a misplaced assumption was made by CSC that a targeted service through the vulnerable babies service would

be offered and the midwifery service knew that FNP were becoming involved (neither of the services addressed specific risks identified in the referral); in the absence of any specific concerns specific to the child; no further action was considered necessary;

d) In June 2011 the ambulance service made a referral to CSC describing concerns about the neglect in the home and in the care of Sibling 1; no assessment took place following a discussion with FN1 who believed that the parents were coping adequately and were accepting of help and advice; with hindsight this was an example of a judgment that relied too much on what the parents said they intended to do rather than what they were actually doing; the review highlights in later sections for example that in spite of sessions in regard to issues such as hygiene and home safety there was evidence of this advice not being taken seriously; for example, at the time Child Z died there was an electric kettle in the bathroom on an extension lead and filthy baby equipment as well as the overall evidence of neglect described in the introduction to this summary and in the overview report;

e) In June 2012 a referral was made from the duty nurse at the hospital emergency department; the referral contained reference to the neglected condition of Sibling 1, a report of a bruise to the child and information about FZ's odd presentation of information. Although this was followed up with a joint visit that involved FN1 it seems that a prevailing mindset was unable to overcome MZ's ability to rationalise and explain away information; in the opinion of the panel this was the clearest opportunity to have completed a more rigorous assessment about the needs and risks in regard to the children; it is highly unlikely that either child would have been removed from their parents care although there should have been a formal and structured multi agency enquiry and assessment and sharing of information;

f) The strategy meeting held promptly after the death of Child Z did not result in any recorded decisions being made in regard to Child Z's sibling or any other action in regard to the joint enquiries following the sudden death of Child Z. Information about the paternal family's history was not identified or discussed until the second strategy meeting the following day when both parents were in police custody. Although the police had agreed to use their police powers of protection to keep Sibling 1 safe this did not extend beyond the immediate need to place Sibling 1 who had been apparently left with the paternal family. The reliance on a voluntary agreement with MZ and FZ for Sibling 1 to be looked after meant that the local authority did not acquire any shared parental responsibility for Sibling 1 in making arrangements.

66. The last referral in June 2012 was probably sufficient, given the evidence of neglect and a physical injury, for conducting formal S47 safeguarding enquiries. If this had resulted in a child protection conference (CPC) there would have been opportunity to have shared the information more fully. If there had been a CPC and it had agreed a child protection plan (or a CIN plan) was required, it would have meant that the case would have been subject to more explicit arrangements for sharing information and coordinating professional involvement. It would not have meant that Child Z or Sibling 1 would have been removed from their parents care.

67. There were opportunities for using the common assessment framework (CAF) to coordinate information; this had been planned to take place as early as 2010 but was never done, initially being overtaken by the late birth of Sibling 1 and not being followed through because the concerns had been lost and FN1 thought she could address the issues.

68. The recommendations and action plan developed in response to the IMRs and Health Overview Report set out a detailed response to support learning and improvement. The final chapter of the Overview Report provides critical challenges for the MSCB that provide an opportunity for further work on developing the systems in response to the insights that the case provides about general patterns rather than addressing the specific issues highlighted from this case.

1.9 Priorities for learning and change as a result of the review

69. The review panel have focussed on identifying lessons that help to continue with the development of effective systems and practice rather than trying to address the unique features of one particular case. It is for these reasons that the panel have not made traditional interagency recommendations but have instead provided a series of reflections and challenges for local services in regard to the learning from the case; these are placed within a context of systems learning that explores the influence of human biases on decision making, the response to information and the use of tools for example.

70. The most important points of learning from the review are:

    a) The influence of human biases (cognitive and emotional): *empathy for helping families overcome personal and social disadvantage has to be balanced with appropriate levels of sceptical and knowledgeable curiosity to prevent the development of collusion and over reliance on self reported information and intentions;*

b) Responses to incidents and information; *effective enquiries and management of information have to identify the relevant underlying patterns of behaviour, inconsistencies and inherent factors of vulnerability of risk;*

c) Longer term work; *the impact of environmental factors associated with long term substance misuse, mental health and domestic violence have implications for longer term support and involvement by individual practitioners and services;*

d) Tools to support professional judgment; *the use of tools are not sufficiently utilised to explore the historical context and circumstances of the family and identify and analyse indicators of risk from issues such as neglect as they relate to children's emotional, physical and psychological safety and rely too much on self reported information and disclosure*;

e) Management and agency systems; *the implementation of new or revised working arrangements and information systems can represent additional barriers to effective information searches, collation and analysis; supervision and semi-structured peer discussion does not yet provide sufficient opportunity to deal with the ethical and legal complexities associated with assessing the risks arising from more marginal lifestyles.*

1.10 Critical challenges for future development of child safeguarding in Manchester

71. Having considered the Overview Report, the Manchester Local Safeguarding Children Board and the local agencies have agreed to consider the following issues to improve future practice. This is in addition to the agency action plans being implemented by services as a result of their Individual Management Reviews that are included in the appendix to this report.

Influence of human biases

1) To what extent are professionals helped to develop the appropriate emotional and mental skills that can balance empathy with the right degree of knowledgeable sceptism and professional assertiveness?

2) Is the MSCB satisfied that professionals have a sufficiently clear framework of personal and professional standards that can prevent inappropriate normalisation of behaviours such as substance misuse and neglectful behaviour?

3) Is assessment of risk to children sufficiently focussed on lifestyle issues such as substance misuse and is there a good enough understanding about the risk associated with substances such as cannabis in adults caring for very young children in particular and especially where mental health is an additional factor?

Response to information and incidents

1. To what extent is the absence of an adequate family history by the health and social care professionals who had significant contact with Child Z and parents a representative example of current practice?

2. To what extent do agencies secure a good enough chronology and narrative to support adequate analysis of information?

3. To what extent are there barriers that prevent professionals using the CAF and to what extent are they understood?

Longer Term Work

1) Is the evidence from this case in regard to the management of complex long term need representative of models of local help and support?

Tools to support professional judgment

1. How are the lessons identified in this review to inform how preventative programmes are developed and implemented with families with more complex levels of need?

2. Do professionals have access to and encouragement to use relevant tools or frameworks to help collate and analyse information about emotional and physical neglect?

3. Can health and social care practitioners in particular be encouraged to rely less exclusively on direct observation and triangulate information from third party and historical information?

Management and agency systems

1) Does the MSCB feel sufficiently well informed about the implementation of revised working arrangements and management of new services and the possible implications for safeguarding arrangements?

2) Is it reasonable to expect practitioners to be able to identify for themselves the ethical and legal issues that require challenge and reflection in professional supervision?

72. A formal response and action plan will be published by the MSCB. Progress will be overseen by the MSCB. The Serious Case Review has been submitted to the Department of Education. The Serious Case Review will not be the subject of a formal evaluation by Ofsted; that arrangement was ended in July 2012. The Serious Case Review and the associated action plans will be examined as part of the unannounced inspection of arrangements to protect children that takes place in all English local authority areas with children's social care responsibilities.

Signed

Ian Rush **| Independent Chair of the MSCB**

20th August 2013

APPENDIX: The recommendations of the individual agencies and the Health Commissioning Overview Report.

Single Agency Recommendations

Children's Social Care

1. Background system checks will be made within MiCARE which now include POCC records, and identify when there is a SCi record. The names of all known family members will be checked, which will highlight a known Social Work History in the Family. The historic Child Protection database can also be checked.

2. Additional guidance to staff when undertaking assessments to ensure that they have checked all necessary background information, and evidence that this is analysed in their assessment and recommendations.

3. Where an Assessment has been requested, then one should be carried out, unless there is a subsequent discussion following which the referrer agrees that one is not required.

4. An annual workshop to be considered for front line management to reinforce and support skills around analysis, reflection, and quality assurance in their role.

5. Practice workshops with practitioners and managers to be planned to improve reflection re the analysis and the conclusions in casework documents.

6. Where a child has been seen by a medical professional, and a referral received, the worker should obtain details of that contact in order to be able to discuss any concerns fully and clarify any information required.

7. Contact Centre management continue to ensure timeliness for incoming referrals/faxes to be passed to First Response Team.

Central Manchester Foundation Trust

1. It is recommended that when any 'additional needs' are identified; a MCAF should be implemented by the FN's. There is a sharper focus on CAF and the Family Nurse Supervisors discuss with FN's the reasons why a professional decision has been made not to undertake a MCAF when additional needs have been identified.

2. It is recommended that FNP National Unit Record Keeping Guidance (2011) with regards to father's health needs and other house-hold residents is reviewed and is fully implemented

across the service by the FNP. There will be a requirement to ensure that this is achieved and therefore an audit of records will be required.

3. It is recommended that the CMFT Children's Community Services Directorate ensures that all assessment or contacts with a child /family detail within the records clearly what the daily lived experience feels like.

Greater Manchester Police

The Greater Manchester Police IMR Author stated "There are no recommendations or single agency action plan arising out of this review."

Northwards Housing Trust

1. Officers from Northwards Housing should ensure that, when other agencies contact us on a tenant's behalf, we ask appropriate questions about the nature of their involvement with the tenant. This will ensure that we have access to all relevant information in order to work most effectively together to protect children living in or visiting the homes we manage. This will be incorporated into Northwards' safeguarding policy and procedure and reflected in staff training.

North West Ambulance Service

1. Update and reiterate in the Sudden Unexpected Death of Children Procedures that during any Acute Life Threatening Event (ALTE) or sudden unexpected death of a child, the Police must be notified by the relevant Emergency Operations Centre EMD.

2. Further develop the Address Flagging Procedure to include flags for sharing information about vulnerable children and adults.

3. Lessons from this review are communicated to Senior Managers within the Trust

NHS Manchester

1. GP practices to consider making enquiring as to the presence of children and any safeguarding risk factors before removing an adult who is a parent or legal guardian from the practice register.

2. GP practices to ensure that if they aware of women enrolled onto the Family Nurse Partnership programme, there should be active two way information sharing and a method of highlighting this involvement, for example using alerts on the electronic records.

Pennine Acute Hospitals Trust

1. The Trust safeguarding team will undertake a record keeping audit to measure compliance with the Trust policy re: documentation standards and mandatory questions about patients' caring responsibilities.

2. An improved electronic information sharing system will be developed to improve the quality of information sharing between hospital and community staff.

Greater Manchester Probation Trust

1. For Greater Manchester Probation Trust in the City of Manchester to assess the quality and timeliness of supervision provided to Probation Service Officers taking into consideration whether opportunities are provided to examine cases where risk of serious harm might be escalating, particularly in relation to domestic abuse and child safeguarding concerns.

2. For Greater Manchester Probation Trust in the City of Manchester to commission a piece of work to examine whether Probation Service Officer staff are holding domestic abuse cases and assess whether these are appropriately allocated to this grade of staff, in line with the Domestic Abuse Policy and Practice Directions.

3. For Greater Manchester Probation Trust to examine the use of home visiting across the Trust to assess whether they are being used effectively to aid risk assessment, management and decision making where child safeguarding concerns exist.

4. For Probation Operations Managers and Probation Service Officer staff to be reminded of the Domestic Abuse Practice Direction which states that domestic abuse cases must be allocated to Probation Officer grade staff unless a manager's approval is granted and recorded on the case file.

5. For Greater Manchester Probation Trust to issue updated Safeguarding Children Policy and Practice Directions that will make explicit reference to children and unborn babies.

Health Commissioning Overview Report Recommendations

1. When a family is enrolled with the FNP there should be a trawl of all agencies for information about the family and this should always include the GP.

2. When FNP is working with a family, there should be ongoing two way liaison with other involved agencies.

3. FNP supervisors should receive specialist training on “The Ten Pitfalls” document and should use the additional knowledge when supervising practitioners.

4. All families enrolled in the FNP should be discussed regularly in supervision.

5. If another agency raises concerns about a family enrolled with FNP this should automatically trigger:
i) discussion with the named nurse for safeguarding
ii) a joint visit with the FNP supervisor
iii) a “team around the child” or case planning meeting.

6. The FNP Board should oversee ongoing FNP work and ensure governance.