MANCHESTER SAFEGUARDING CHILDREN BOARD

Manchester Safeguarding Children Board

A Serious Case Review

'Child Z'

The Overview Report

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

Index

1 Introduction and context of the Serious Case Review

1. In late September 2012 the regional ambulance service received an emergency telephone request to attend at Child Z's home; it was mid-morning. Upon arrival the paramedics found Child Z aged nine months to be in cardiac arrest with no response or cardiac output. The paramedics commenced CPR (cardiopulmonary resuscitation) and Child Z was immediately taken by ambulance to the hospital where Child Z was formally certified as having died.

2. The parents provided an account of what had occurred; this summary does not take account of any other information provided in the parallel criminal proceedings and the Coroner's enquiry.

3. Child Z had been ill and had vomited at around 10.00; this had followed loose stools, which had occurred on and off for the previous week. Child Z had however been eating and drinking well and had no fever.

4. Mother (MZ) had taken both of her children up to the bathroom and put Child Z in the bath at the higher end of the bath and filled up the main bath with water, overflowing into the baby bath. Child Z was then put into the baby bath and the older sibling aged 20 months was put into the main bath nearest the taps. This was around 10.30am.

5. MZ had gone downstairs and swapped over parenting tasks with Father (FZ) and then went to a neighbouring house. FZ stayed with his children in the bathroom and played with them for about ten to fifteen minutes. FZ's account was that he had then left both of them playing in the bath and went downstairs to get two nappies and a towel. FZ stated that this had taken approximately two minutes and when he returned to the bathroom Child Z was face down in the water of the main bath. The older sibling had their back to Child Z.

6. FZ pulled Child Z out of the bath who was described as blue and unresponsive. He commenced CPR and Child Z vomited and produced a lot of water out of the mouth. There was then a knock on the front door and he ran downstairs to let MZ in. He put Child Z on the floor and restarted CPR and then a neighbour came to the house and took over. A neighbour had called for an ambulance and CPR was continued with telephone instruction and support from the ambulance dispatcher dealing with the emergency call until a solo paramedic arrived within five minutes followed shortly afterwards by a fully crewed ambulance who immediately transferred Child Z to the local hospital where determined and prolonged effort was made to resuscitate Child Z without success.

7. A post mortem examination concluded that Child Z appeared to be well grown and the state of nutrition looked good. Child Z was generally clean although with some dirt under the finger nails. No signs of injuries were found.

8. The last visit to the family home had been by a community health professional five days previously; this professional had not found anything untoward describing the visit as 'happy'. Both children had been seen and no concerns had been noted about their health and presentation or the house during that home visit.

9. After Child Z's death the family's home was visited later the same day by a Paediatrician, Police Officers and a Social Work Manager. On entering the property there was an immediate and powerful smell of cannabis. A large 'cannabis farm' was found in the back bedroom; the Police have estimated that the street value was substantial amounting to several thousand pounds worth. The room in which the plants were located had extractor fans rigged to subdue the smell although these were switched off and may explain why the health professional who visited a week earlier had not reported any smell of cannabis. When the independent reviewers met the parents in February 2015 after the completion of the criminal court proceedings, FZ confirmed that he had been careful to seal the room and prevent the smell of cannabis being detected by visitors to the house.

10. As part of the routine procedure a comprehensive photographic record was taken of the condition and circumstances of the house. The panel and the Overview Author have viewed some of the pictures that provide graphic evidence of neglect. 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 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 extremely unhygienic. 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. The bath revealed a baby bath 80 cm in length in the shallow end of the bath. This was brim full with water; the main bath itself was empty of water.

11. 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.

12. The Police used their Police Powers of Protection (PPOP) to prevent Child Z's older sibling remaining with the parents and was placed with foster carers and care proceedings were initiated by the local authority. The placement with foster carers was achieved through the parents giving their consent to the arrangement. The local authority subsequently began care proceedings and after they were granted an Interim Care Order (ICO) and this conferred shared parental responsibility for determining arrangements for Sibling 1.

13. There had been a high level of involvement with this family through the Family Nurse Partnership Programme[1] (FNP) which started during the pregnancy with the elder Sibling 1. The Family Nurse (FN1) provided an enhanced level of support during the second pregnancy (Child Z) through the Healthy Child Programme. FNP is a preventative maternal and public health programme providing targeted and specialised support to vulnerable first time young parents under 20 years of age.

14. Families are not referred onto the programme due to particular identified vulnerability need. It is a voluntary, but targeted programme. In this instance, the family were introduced to the programme as part of a national randomised control trial. The programme is led nationally by the FNP National Unit that provides extensive implementation guidance to local sites, who in turn have responsibility for local implementation and integration of the service with others in the locality. The Family Nurse contact involved 36 visits to Child Z's older sibling and 15 of these occurred after Child Z's birth. Family members had also received services, and had contact with a number of other agencies during this time.

15. The Health Overview Report (HOR) provided an opportunity for the authors to review the medical records of both parents and highlights for example that 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 contained in the records of the GP was not accessed and therefore was not known when MZ became pregnant and became a parent.

16. In November 2009 MZ had attended North Manchester General Hospital A & E 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 and agreed to attend at A & E later that day.

17. FZ has a history of mental health and substance misuse dating back to 2009 involving self harm and attempted suicide. There were four referrals to Children's Services

[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 can hold a Health Visitor /, Midwifery or other nursing qualifications 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 91 local areas sites across England offering places to up 11,500 families (*The Evidence Base for Family Nurse Partnership, undated*). FNP was implemented in Manchester in 2007 and was one of the initial test sites. FNP Wave 2, which contains a second team of Family Nurses (FN) commenced in January 2009. and has contributed to the randomised controlled trial of the partnership

between November 2010 and June 2012. These referrals indicated concerns about domestic violence, neglect and one report of a bruise to the older sibling.

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

19. FZ also has a domestic abuse history involving previous 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.

1.1 Rationale for conducting a Serious Case Review

20. 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.

21. 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.

1.2 The methodology of the Serious Case Review

22. 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.

23. 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 this Overview Report. Neither the Chair nor the Overview Author has worked for any of the services contributing to this Serious Case Review. Further information about their relevant experience and knowledge is provided in section 1.8.

24. 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.

25. The LSCB in Manchester was already working on how future serious case reviews could be developed in order to provide a more productive window into the local systems for safeguarding and protecting children[2] using system learning within serious case reviews such as developed by SCIE (Social Care Institute for Excellence).

26. The analysis in the final chapter of this 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 review for example explores the influence of family and professional interactions, the responses to incidents and the tools that are used by professionals to help inform their judgments and decisions.

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

28. 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 1.4). These reports were completed by senior people who had no direct involvement or responsibility for the services provided to the children and their parents.

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

---

[2] Analysis of clinical incidents; providing a window on the system not a search for root causes. CA Vincent; *Quality and Safety in Health Care*, 2004; The article argues that incident reports by themselves tell comparatively little about causes and prevention, a fact which has long been understood in aviation for example and is the basis of developing a systems learning approach to serious case reviews in England.

[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

1.3 Reasons for the review and terms of reference

30. The reason for undertaking this review is that Child Z may have died as a result of neglectful parental care. The death was reported to the Manchester Safeguarding Children Board (MSCB) and was reviewed by the Serious Case Review Sub-Group on the 7th November 2012 who recommended to the Independent Chair of the LSCB that the circumstances of Child Z's death met the criteria for a mandatory Serious Case Review.

31. 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. A Serious Case Review panel was convened.

32. The Serious Case Review panel at their first meeting on the 12th February 2013 confirmed the scope and terms of reference for the SCR. These were routinely discussed and updated at subsequent panel meetings to take account of any new or emerging information and reflection.

33. The purpose of the review is to establish what 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 better safeguard and promote the welfare of children in Manchester.

1.4 The scope of the Serious Case Review

34. 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.

35. There is significant earlier involvement by some universal and specialist agencies in the lives of the parents. Therefore organisations were asked to include any earlier information about both parents, especially where it had a bearing on understanding their capacity as parents, including any evidence of violent or sexual behaviour, mental ill health or substance misuse.

36. All information known to a service providing an IMR was reviewed. Any information regarding involvement prior to the period of the detailed chronology and analysis was summarised in the IMR and the Health Overview Report.

37. All agency chronologies included detailed information about when the child was seen or observations were made about them.

38. Agencies that identified significant background histories on family members pre-dating the scope of the review provided a brief summary account of that significant history.

39. Reviews of all records and materials were considered including:

- Electronic records
- Paper records and files
- Patient or family held records.

40. Individual management reviews were completed using the template provided by the Manchester Safeguarding Children Board (MSCB), and were quality assured and approved by the most senior officer of the reviewing agency.

41. The following agencies have provided an individual management review that was to be completed in accordance with *Working Together to Safeguard Children (2010)*, Chapter 8 and the associated LSCB guidance and relevant procedures.

- 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[4]
- Northwards Housing (the provider of housing from June 2011; prior to this date MZ and FZ had lived in privately rented property);

[4] The first referral to CSC in regard to Child Z or Sibling 1 was at the end of November 2010 from the trainee probation officer requesting a pre-birth and parenting assessment to be completed in regard to Sibling 1.

- 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 (registered from 2009 although MZ was an infrequent user of the services).

42. 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 sought help from that service 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.

43. There were additional discussions with the FNP National Unit and 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 on-going 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 later sections of this report.

44. Information was also sought from the family and is described in section 1.9.

1.5 The terms of reference in national guidance

a) Keep under consideration if further information becomes available as work is undertaken that indicates other agencies should carry out Individual Management Reviews;

b) To establish a factual chronology of the action taken by each agency;

c) Assess whether decisions and action taken in the case comply with the policy and procedures of the Manchester Safeguarding Children Board;

d) To determine whether appropriate services were provided in relation to the decisions and actions in the case;

e) To recommend appropriate inter-agency action in light of the findings;

f) To assess whether other action is needed in any agency;

g) To examine inter-agency working and service provision for the children;

h) To establish whether interagency and single agency policies adequately supported the management of this case;

i) Consider how and what contribution is sought from the family members;

j) To develop a clear multi agency action plan from the Overview Report.

1.6 Particular issues identified by the SCR Panel for further investigation by the Individual Management Reviews[5]

45. In addition to analysing individual and organisational practice, the Individual Management Reviews should focus on:

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;

[5] These are the detailed issues that are analysed by the IMRs and in the detailed analysis.

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?

1.7 Membership of the Case Review Panel and access to expert advice

46. The Serious Case Review panel that oversaw this review comprised the following people and organisations:

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	Greater Manchester Police
District Head of Centre	Sure Start and Early Years Services
Assistant Director	Barnardo's
Business Support Officer	MSCB
Business and Performance Manager	MSCB
Consultant/Designated Nurse	NHS Manchester

47. The Independent Author of the Overview Report attended every meeting of the panel.

48. The panel had access to legal advice from a Solicitor in the council's legal service. The panel also had access to other specialist advice if it had been required.

49. Written minutes of the panel meeting discussions and decisions were recorded by a member of the LSCB staff team in Manchester.

1.8 Independent Author of the Overview Report and Independent Chair of the Serious Case Review Panel

50. The Independent Chair of the Serious Case Review panel was Valerie Charles. She works as an Independent Consultant and is registered with the Health and Care Professions Council. Valerie has been qualified since 1991 and has a professional social work qualification and MA. She has extensive experience of working in children's services in both the local authority and voluntary sector. She was a senior manager for NSPCC from 2006 to 2012. Valerie has worked in different roles within Local Safeguarding Children Boards, including chairing serious case reviews and has experience in systems methodology case reviews.

51. Peter Maddocks was commissioned in December 2012 as the Independent Author for this Overview Report. He has over thirty-five years' experience of social care services the majority of which has been concerned with services for children and families. He has experience of working as a practitioner and senior manager in local and national government services and the voluntary sector. He has a professional social work qualification and MA and is registered with the Health and Care Professions Council (HCPC). He undertakes work throughout the United Kingdom as an Independent Consultant and Trainer and has led or contributed to several service reviews and inspections in relation to safeguarding children. He has undertaken agency reviews and has provided overview reports to several LSCBs in England and Wales as well as work on Domestic Homicide Reviews. He has undertaken work as an Overview Author on two previous Serious Case Reviews in Manchester. Apart from this, he has not worked for any of the services contributing to this Serious Case Review. He has also participated in training for overview authors including the application of systems learning.

1.9 Parental and family contribution to the Serious Case Review

52. 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[6].

[6] 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

53. 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 prosecution had been concluded.

54. The parents subsequently agreed to meet the independent reviewers in February 2015. They acknowledged that they had withheld information from professionals. FZ said that he had not understood the seriousness of some of his lifestyle in terms of implications for a young child; this included his habitual use of cannabis that he had used since early adolescence. He says that he has now stopped using cannabis for several months.

55. The parents also discussed how their lifestyle had not been much different to a lot of other people living in their neighbourhood at the time. For example the use of drugs; MZ says she has never used drugs.

56. Both parents felt that professionals had readily accepted what they told them without sufficient challenge or scepticism. They acknowledged that they did not ask for help and support when they needed it for fear of what they perceived as potential consequences (potential removal of their children).

57. Both parents recognised that they both had difficult childhoods and that their family backgrounds and isolation from family support did not appear to be sufficiently considered by professionals working with them.

58. Both parents spoke positively about the work being done by the current group of professionals.

59. FZ and MZ acknowledged some of the difficulties faced by parents, particularly young parents, who are not sufficiently aware of risks and that this is a possible area that they felt could be further improved upon in the future such as raising awareness of risks associated with bathing and co-sleeping.

60. It was notable that the property the couple were living in when the independent reviewers met them in February 2015 was in positive contrast to the photographs of their previous property.

1.10 Timescale for completing the Serious Case Review

61. The Serious Case Review panel met on five occasions between February 2013 and June 2013. The initial chronology of services involvement was completed by January 2013. The first draft agency reviews were completed in late January 2013. Individual discussions also took place with agencies providing an IMR with the Chair and members of the panel, the Independent Author and MSCB Business and Performance

Manager. The first draft of the Health Overview Report was completed in May 2013. This Overview Report was presented to a meeting of the MSCB in August 2013.

1.11 Status and ownership of the Overview Report

62. The Overview Report is the property of the Manchester Safeguarding Children Board (MSCB) as the commissioning board.

63. Since June 2010, all overview reports provided to LSCBs in England have to be published in full. This Overview Report provides the detailed account of the key events and the analysis of professional involvement and decision making in relation to Child Z and the family.

64. The report has to balance maintaining the confidentiality of the family and other parties who are involved whilst providing sufficient information to support the best possible level of learning.

65. In reading this report, it is important to remain clear about the purpose of the overall review and of this overview report in particular. The review examines with the benefit of hindsight, if it possible to identify whether alternative judgments and decisions could or should have been taken, and whether different outcomes might have been achieved for Child Z. The review does not investigate the circumstances of Child Z's death. That is a matter for the coroner and for the police.

66. The review aims to be very challenging of all services for the purpose of building on the considerable knowledge and expertise that has developed in relation to the safeguarding of children in the UK. In doing this work, the panel are mindful about how complex or unclear some of the information and events may have looked to practitioners at the time of events.

67. An Executive Summary was provided at the conclusion of the review. This provides a brief summary of events and the most significant points of learning identified as a result of the review. The LSCB will determine how and what further information is provided to the family at the conclusion of the review and following the submission of the Overview Report and Executive Summary to the Department of Education[7].

1.12 Previous Serious Case Reviews

68. The LSCB in Manchester had undertaken ten previous Serious Case Reviews between 2009 and 2012[8].

[7] In England, Ofsted have the responsibility for evaluating the thoroughness of the serious case review. The executive summary includes a statement about that evaluation.

[8] The coalition government's notice issued on the 10th June 2010 under section 16(2) of the Children Act 2004 which amended the previous national guidance in *Working Together to Safeguard Children* requires that both the executive summary and the overview report with suitable redaction to provide confidentiality are published. The coalition government ended the formal evaluation of SCRs from the 5th July 2012.

69. Reference is made by several IMR authors to some of these and other previous Serious Case Reviews completed in other parts of the country and is also referenced where relevant in this Overview Report. The purpose of this is to highlight where similar issues or themes have been identified in previous reviews. This ensures that action already recommended is not unnecessarily repeated.

70. Subsequent chapters of this review describe in greater detail the specific lessons to emerge from a detailed analysis of this Serious Case Review and include comments on how learning from previous reviews has been used.

1.13 Inspections of services for children in Manchester

71. All children's services in England are subject to inspections. Manchester's annual children's services assessment in November 2011 judged that Children's Services were adequate. This means that services were meeting minimum national standards.

72. In late 2010 there was a statutory inspection of safeguarding and looked after arrangements in Manchester[9]. This evaluated safeguarding arrangements as adequate in Manchester with a good capacity for improvement; Child Z was not the subject of any child protection plan. The inspectors recommended that improvements to the quality of assessments and the workload of social workers should be accelerated and this required an action plan to be implemented.

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

74. The Common Assessment Framework (CAF) was underdeveloped as a process for identifying children's needs and it was not sufficiently embedded with partner agencies. This had a negative impact on early intervention and resulted in high levels of re-referral to social care services. Senior managers were aware of this issue and had plans in place to address it. This had been an area for development at the previous inspection. The CAF was not used in this case and is highlighted as one of the themes for the review.

75. Some caseloads were high and this was leading in certain instances to delays in information being recorded on the electronic recording system. Some staff reported

[9] The inspection was carried out under section 138 of the Education and Inspections Act 2006. It contributes to Ofsted's annual review of the performance of the authority's children's services, for which Ofsted will award a rating later in the year, subject to any changes that the coalition government may introduce. The inspections are part of a national programme of enhanced inspection of children's services introduced in 2009 following the death of Peter Connolly (Baby P) and the two subsequent serious case reviews in Haringey.

working excessive hours in order to meet the deadlines required to safeguard children and additional posts had been created to address this issue. This had been an area for development at the previous inspection. The panel had insufficient information about workload of the practitioners involved with Child Z although issues in regard to accessing historical information and recording were themes in this case.

1.14 Summary conclusion of the Review Panel

76. The purpose of conducting a Serious Case Review is to undertake a detailed examination of the events within the context of understanding how the judgements, decisions and actions were taken by the various professionals involved with Child Z and the family for the purpose of drawing out learning to inform future policy, service development and individual practice.

77. The Munro Review commissioned by the coalition government in 2010 emphasised the importance for learning and improving services and practice by looking at information within the context of people's professional and organisational arrangements and the information they knew at the time of events. Hindsight can distort and mislead the quality of analysis and cause the focus to fall on how individuals behave and act rather than understanding how they are influenced by a range of contributory factors.

78. The influences on practitioners doing their work effectively include the stability of the organisation they work in, their personal workload and more generally of their services, the quality of their training and knowledge, their use of tools for assessing need and risk, the clarity of working arrangements in matters such as recording and sharing essential information as well as their cognitive functioning (how they are processing and analysing information). These were all important in understanding this case.

79. In order to extract the best level of learning from the review the panel have looked for the most significant episodes of practice. In doing this, the panel are looking for the various factors that shaped how judgments and decisions were made at the time. As with all complex human interaction and with the benefit of hindsight and detailed collation of information, it is possible to identify the options that could have been explored. The purpose in all of this is to keep on adding to and developing the collective knowledge and expertise in regard to the identification of children who maybe vulnerable.

80. The panel have not identified any single agency or individual practitioner who 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 with 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.

81. 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 well with many families living in circumstances similar to Child Z. In this instance of delivering the local programme, there was an inability to identify and give enough attention to indicators of risk.

82. 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 in probability never good enough for the appropriate care and safety of very young children.

83. The age of MZ, the fact that she became pregnant 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; 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 that encouraged a belief in good outcomes being achieved.

84. 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 household cleanliness and cannabis use for example.

85. This should not be taken as direct criticism of professionals who have to reconcile difficult dilemmas. For example, when faced with adults 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.

86. 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 that was only accessed as a result of the strategy meetings held after Child Z had died and was provided by other services.

87. If the assessment had involved more rigorous inquiry 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.

88. 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.

89. The absence of historical information may have contributed to an apparent down playing of information about the parents' current circumstances and lifestyle. Both parents have difficulties associated with their mental health and substance misuse although largely denied these problems. This led to misdirection when some professionals used self-reporting and disclosure tools with the parents upon which they subsequently made important judgments.

90. 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 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.

91. There is clear evidence of misdirection occurring in the case. 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, 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.

92. 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.

93. 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 the FNP. 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.

94. This pattern of missed appointments resulted in very concerted efforts especially by the FNP 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.

95. The panel had identified five particular events that are significant for learning lessons:

    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 changed;

    c) In November 2010 the unqualified probation officer (PO1) who was undertaking professional training made a referral to CSC outlining 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 direct conversation; a misplaced assumption was made by CSC that a targeted service through the Vulnerable Babies Service (VBS)[10] 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;

[10] The VBS was set up in 2004 to tackle infant mortality in Manchester, in particular sudden unexplained death of infants (SUDI). The VBS also plays a public health role in preventative practices; leading on safe sleeping policies across the city and strategically informing practice to improve outcomes for infants.

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 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.

96. 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 Child In Need 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.

97. There were opportunities for using the Common Assessment Framework (CAF) to coordinate information; this had been planned to take place as early as 2011 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 FNP thought she could address the issues.

1.15 The family and other significant people and including relevant history

98. Child Z lived with MZ, aged 20 years; FZ who was aged 23 years and the 20 month old sibling (Sibling 1). Both parents had been known to different services.

99. MZ is one of six siblings. She had been known to children's services during her childhood and had a history of interrupted education. She had experienced significant childhood trauma involving a house fire that destroyed all of the family's possessions. According to the HOR one of her older siblings was the subject of a child protection concerns in 1990 because of physical abuse, but although this was taken to a child protection conference there was no child protection plan.

100. MZ had previously allegedly taken an overdose of prescription drugs and alcohol (50 beta-blockers and vodka) in November 2009 but had left hospital before a psychiatric assessment was carried out. MZ had also sought medical attention on two other occasions for a physical injury sustained during domestic arguments; in May 2010, MZ had punched a wall with her right hand, and in early June 2010 she had sustained an injury to her left foot from kicking her brother. MZ also has a medical history of childhood migraine and asthma.

101. FZ has a history of mental health and alcohol issues dating back to 2009 involving self-harm and attempted suicide. FZ was physically and emotionally abused as a child and was subject to a Child Protection Plan for eight months in 1992 when he was aged two years old following an injury as a result of domestic violence between his parents (paternal grandparents). When older, he suffered depression and low self-esteem and he also became known to the criminal justice services and was homeless for a period.

102. FZ has a domestic abuse history as a perpetrator between July 2003 and October 2009. In March 2008, there was an allegation that FZ had thrown a brick at a previous partner whilst she was pushing their child in a pram; no injuries were sustained and no further action was taken. In July 2010, MZ alleged an assault by FZ but was unwilling to formally complain. No action was taken. In May 2011, FZ and MZ were both warned under the Harassment Act not to cause harassment to his previous partner and family.

103. FZ 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.

104. Both parents have had some contact with mental health services although some of that support was disrupted for example because FZ was at times not registered with a GP; FZ was deregistered from the GP in late 2012 after he had failed to keep three medical appointments. There are also some gaps in information how information was recorded and summarised in regard to family history and the involvement of different services such as the Family Nurse Partnership (FNP).

105. FZ received treatment for a self-inflicted stab wound in March 2010 that had occurred following an argument, as well as longer term for his use of alcohol, drugs and depression; he was prosecuted for having a bladed article in a public place and was subsequently made subject to a 12 month community order with supervision by a probation officer in April 2010.

106. During one of his early supervision discussions he disclosed that he was using £20 of 'skunk' cannabis a day[11] and in later sessions it seems clear that FZ was using the cannabis to 'self-medicate' and ameliorate his symptoms of depression and to try and reduce his reliance on alcohol; his effort to reduce alcohol may also have been influenced by knowledge that MZ was in the early stages of her pregnancy. He resisted advice and suggestions to accept a referral to mental health services to help with the depression. He did attend six sessions of ADS (Addiction Dependency Solutions) extended brief interventions for probation clients experiencing problematic substance misuse (alcohol and drugs) which lasted until June 2010.

107. In May 2010 he had told the Substance Misuse Practitioner (SMP) at the Addiction Dependency Service (ADS) that he had reduced his consumption now that his partner (MZ) was pregnant.

108. In May 2010 he was shot with an air rifle and wounded. He declined medical treatment and was reluctant to speak with the police. FZ was extremely agitated and angry and made threats to those who had inflicted the injury. The probation IMR discusses the implied risk of ongoing conflict resulting from the incident and with better reflection should have been more explicitly risk assessed at the time in consultation with other services. Further comment is provided in later sections of the report. CSC for example was not aware of this incident until this SCR.

109. 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. In November 2009 MZ had attended North Manchester General Hospital A & E department following an alleged overdose, she was reluctant to wait however and

[11] Skunk is the generic name often used to describe a potent form of the cannabis plant. Skunk is only one of 100 or so varieties of cannabis plant which have high levels of tetrahydrocannabinol (THC). There is evidence that users are more likely to develop psychotic illnesses and exacerbate pre-existing mental health difficulties.

left without receiving treatment. The police were subsequently asked to carry out a 'welfare check', which they did. MZ was found to at her mother's home and she agreed to attend at the hospital A & E service later that day.

110. 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. In May 2010 MZ received treatment at a NHS Walk in Clinic for an injury to her right hand sustained by hitting a wall; there are no further records about the incident or regarding the location or circumstances. Such injuries have an association with incidents of domestic abuse; pregnancy is also a time when domestic abuse can become evident.

111. It was around this time that FZ was informing his probation officer about the pregnancy and was trying to reduce his use of skunk cannabis. In June 2010 MZ was treated for a displaced fracture to her foot following an argument with her brother. It was in June 2010 that the first record of the parents living together was made.

112. There is a brief history of four previous referrals[12] to children's services (CSC). In November 2010 there was a referral from the Probation service regarding MZ who was due to give birth in January 2011; and there was a request for 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. The 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 had a focus on reducing the incidence of sudden unexpected infant deaths through promoting for example safe sleeping practices; she had declined this and there was no direct conversation between FRT and the midwifery service. Further information and analysis is provided in later sections of the report.

113. 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 clutter in the house and the floor in the living room was dirty. There were no floor coverings in most of the house. The children's bedrooms were checked and found to have adequate beds and bedding. Further information about the visit and assessment is provided in later sections of this report.

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

[12] The issue of whether the four occasions were referrals is considered in more detail in later sections of this report along with the action that was taken.

114. Child Z's maternal and paternal families are white British. Their first and only language is English and there is no recorded physical or learning disability by the services involved with Sibling 1 or Child Z until the first strategy meeting after the death of Child Z when there is reference to the parents having unspecific learning difficulties.

115. Child Z was living with both parents and the older sibling in rented accommodation at the time of the death in an area of Manchester that is amongst the ten per cent of the most deprived areas in England. Both parents were and remain unemployed.

116. The area has a higher concentration of white British people compared to the city's overall population profile. The area has higher levels of children living in poverty, with ill health and experiencing crime. The area has a higher concentration of adults who have no educational qualifications.

117. Although the particular ward that Child Z lived in is not the most deprived district in Manchester it is an area which is one of the most deprived areas in England. In spite of the social challenges in the area, it is a place that appears to be one where people are relatively settled based on factors such as tenancy turnover, transfer requests and length of time people remain in their homes and living in the area.

118. There is evidence that Child Z's family were part of an informal community that provided support and practical help and for example shared or swapped items of household and baby equipment. The FN1 had not seen the filthy baby chair found in the house on the day that Child Z had died.

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

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

121. The 2007 Index of Multiple Deprivation ranked Manchester as the fourth most deprived local authority area in England. In 2009, 77 per cent of pupils lived in one of the 20 per cent most deprived areas in England. The area in which Child Z lived is one of the 10 per cent most deprived areas in England. In 2010, 37 per cent of primary school pupils and 34 per cent of secondary school pupils were eligible for free school meals, significantly more than nationally. In the 2001 census, 31 per cent of children and young people aged 0 to 19 years were from minority ethnic groups compared with 26 per cent for the total population. According to the January 2010 school census, 35 per cent of primary school pupils and 30 per cent of secondary school

pupils spoke English as an additional language, well above other areas of the country. Over 170 languages are spoken across schools in Manchester.

2 Synopsis of agency involvement

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

123. For example both parents had routine consultations with the GP that are not included in detail in this chapter; this includes detail about the missed appointments in regard to MZ for ante natal care. There were 46 individual contacts by the FN1. The Probation service arranged six sessions of brief intervention treatment at the Addiction Dependency Solutions service for FZ that are not all recorded in this narrative as well as the other work related support for example at the Achieve service on helping FZ improve his employment prospects through work skills assessment and development.

124. Similarly there was a high level of contact by the housing provider in regard to repairs at the third and final address, some of which are described when relevant to this summary of key events. MZ was registered with the local Sure Start service from early February 2009 up to January 2012 but was an infrequent user of those activities.

125. This summary, and indeed the whole Overview Report, has to strike a balance between protecting the confidentiality of the children, their family and the various people who were in contact with them whilst providing a sufficiently detailed account of events in order to draw out the points for learning and development in the later chapters. It is also the first time that the overall story of Child Z and the family has been collated as a result of the detailed work for this SCR.

126. The pregnancy with Sibling 1 was formally booked at 15 weeks into the pregnancy in June 2010; a first ante natal check is usually between eight and twelve weeks. A specialist Teenage Pregnancy Midwife (TPM) identified that MZ had received historical support from a social worker and had a history of some depression in the past; referrals were made to Connexions and to the Family Nurse Partnership (FNP)[13]. The referral to the FNP was subject to some delay before the Specialist Nurse (FN1) saw MZ that was attributed to allocation methods that existed at the time and a period of illness between early March and early July 2010.

127. MZ had been living with her family but she was told to leave in June 2010. It is not known if the pregnancy, which by this stage was confirmed, was the catalyst for this. MZ sought help from Connexions to address her homelessness.

128. Around the time the pregnancy was confirmed and a referral was made to the FNP, FZ was formally warned about missing a scheduled activity under the terms of

[13] The FPN was being established at the time and was the subject of a formal programme of research and evaluation designed to collate empirical evidence to help inform further development to of the service model and practice at local and national levels.

his community order; up until that point he had been complying well with the order which was in marked contrast to his response following previous offences. He had been using supervision sessions to discuss his current circumstances including his use of cannabis and the fact that his girlfriend was pregnant. He talked about his abuse as a child and apparently the relationship with the paternal grandfather was still an abusive relationship. In later sessions in July 2010 it became evident from the recording that FZ was resisting any advice in regard to drugs, health or employment; he superficially complied by turning up for supervised appointments and engaging in discussion but showed very little motivation or determination to address his areas of difficulty in spite of the fact that he was due to become a father.

129. In mid-July 2010 MZ made an emergency telephone call to the police asking for assistance to deal with a domestic argument that was ongoing with FZ. A uniformed police officer arrived within three minutes although FZ had already left the property. MZ said that she had been in a relationship with FZ for about a year and although there had been previous arguments this had escalated to physical violence.

130. MZ informed PC3 that she had been in an 'on/off relationship' with FZ for approximately a year and that they had been arguing all day in relation to splitting up. MZ stated that although they often argued she had never called the police before. It had escalated when MZ had intervened in preventing FZ from taking MZ's brother's computer X-Box from the property[14]. MZ told the officer that she was pregnant although declined to confirm who the father was. MZ declined to make a formal written statement because she did not want to get FZ into further trouble.

131. A report of the crime was submitted and an application for special measures was also completed; all of this information was given to MZ with the objective of ensuring that she received reassurance that the police were treating the domestic violence as a serious matter for her and for the baby.

132. A referral was made via the police Domestic Violence Unit (DVU) to the Health Visitor although there is no record of this being received in the health records. Attempts were made to achieve an early arrest of FZ which is consistent with a proactive and positive action policy towards domestic violence although as part of that effort a voicemail message was placed on FZ's mobile phone to inform him that the police wished to speak with him. This was naïve as it could have increased the risk of further violence towards MZ. Further analysis is provided later in this report as well as in the police IMR regarding the management of domestic abuse and the common difficulties associated with investigation and prosecution and in particular when responding to families who may feel suspicious and wary of services such as the police.

133. During this police response to deal with the domestic violence, potential weapons were observed hanging from nails in the living room wall. These included a wooden

[14] Although the IMRs do not state any further information in regard to why the attempted theft was being made it is probably relevant that FZ was still using significant quantities of cannabis and was unemployed.

rounder's bat, a large piece of plastic and metal gas piping, a metal coping saw and an axe with a wooden handle. MZ claimed that all of the weapons had been placed in the room by FZ and she handed them over to police for their destruction. No more weapons were on visible show although there were numerous pairs of large sharp scissors around the house which could be used as a weapon. This information about weapons was logged for police intelligence purpose although it is less clear whether it was included in the information provided to the Health Visitor which was never apparently received.

134. Given the information in regard to the domestic violence involving a pregnant woman and evidence of weapons in the house it would be expected practice for a safeguarding referral to be generated from the police to CSC. This was not done and it remains unclear what factors caused this.

135. In late July 2010 MZ missed a planned ante natal appointment. This was reported to the TPM who subsequently followed it up by a home visit from FN1 to see MZ the following day. MZ was out but she subsequently contacted FN1 and apologised and spoke positively about the pregnancy and was generally talkative. Commitments were made to complete relevant paperwork for a support session and an agreement for a follow up home visit to be made a week later in early August 2010.

136. The IMR author comments about a previous SCR having introduced a requirement for the specialist health practitioners to check historical archived health records for teenagers who are pregnant which was not done in this case; it was a recent action and just being introduced at the time. The same IMR also points to the effort given to establishing a positive relationship with MZ at the outset and working to overcome any initial resistance; this is important and sensitive practice especially in relation to young mothers who may have very poor experiences of statutory services that leaves them fearful and unwilling to have contact and ongoing help. This is explored further in later analysis in the report.

137. In late July 2010 a police intelligence report identified that FZ and his brother, BFZ, who was living with FZ and MZ, might be responsible for a physical assault on two teenage boys (13 and 16 years old). Although the police IMR confirms that the information was managed in compliance with the police service standards there does not appear to have been any cross reference to the incident of domestic violence that the service had responded to less than two weeks previously and the information in regard to FZ having a history of violence and was living with a pregnant and young partner.

138. In mid-August 2010 the FN1 completed a national monitoring form during a home visit to MZ which provided a structured collection of relevant information associated with the pregnancy. The form asked for information in regard to lifestyle such as diet and smoking by both of the parents, explored MZ's emotional and psychological as well as physical health as well as seeking information about evidence of domestic abuse.

139. The questions were all answered in such a way as to provide a positive picture about the pregnancy but were not necessarily true. For example MZ said there was no domestic violence in spite of the request for police help in July 2010 and the disclosure that there had been previous arguments including with her brother that had resulted in her being injured in June 2010.

140. Although MZ did disclose domestic abuse this was attributed to the maternal grandmother. There was no reference to the use of cannabis. Further analysis is provided in the IMR and in later sections for this report in regard to the difficulties facing professionals relying on such self-disclosed information from parents.

141. MZ was admitted to a hospital gynaecology ward on two occasions during August 2010. There is no reference to any screening for domestic violence and it is not apparent that the hospital was aware of the incident in June or July 2010 or the general history of FZ.

142. In late August 2010 the Probation service completed the four monthly review OASys assessment. The review highlighted some ongoing accommodation issues but was otherwise positive; this is also based primarily on self-reported information; FZ has reported that he was feeling more positive through an improved lifestyle and an improvement in his relationship with his Father (FFZ). The IMR highlighted the absence of any reference to the shooting incident and the risk management plan was 'vague'.

143. The home visit by the FN1 at the beginning of September 2010 includes reference to the house 'falling down' and the family having to move out by the end of the week. This is the first reference to the physical condition of the house which appeared to be unsatisfactory for habitation by a young child; neither of the parents were tenants of the property which appeared to have been rented by FZ's brother. The IMR notes that the family did not meet the thresholds for the Vulnerable Babies Project (apart from being homeless) but would have if other vulnerabilities had been known. The FN1 also refers to the inability to have her phone call to the homeless families service answered.

144. A further home visit two days later found MZ in a 'brighter mood' with plans to return to college. She completed the HAD[15] questionnaire that identified some milder depression (four) and anxiety (ten) but included no information about MZ. The IMR explains that a combined total of ten or more is moderately high indicating some follow up but not for more urgent help.

145. In September 2010 the GP was made aware that MZ had contracted an infection during pregnancy. This represented some enhanced risk to MZ's baby and for a premature birth. The GP was told that MZ had not attended for treatment on four occasions.

[15] The Hospital Anxiety and Depression Scale is a screening tool validated for use in health services.

146. On the 10th September 2010 the FN1 found the family home front door boarded up. She attempted unsuccessfully to contact MZ by phone. The FN1 had no alternative contact details. There followed two failures to attend antenatal appointments until FN1 was able to arrange to meet MZ in a car park on the 24th September 2010. MZ agreed to meet at the car park again on the 28th September to take FN1 to the new house as it 'was difficult to find'. Although this might appear naïve it was another example of the dilemmas that face health and other professionals trying to establish and sustain a relationship with young vulnerable adults. Further analysis is provided in later sections of the report.

147. The planned follow up meeting in the car park did not take place; FN1 tried to contact MZ by mobile without success. The TPM spoke with FZ on the 5th October 2010 who said that MZ was at college and would contact TPM as soon as possible. An arranged visit was achieved on the 26th October 2010.

148. On the 5th October 2010 the Probation service withdrew a warning letter to FZ for his non-attendance when the Probation Officer was told that FZ had been moving house on the day in question. The following day the Probation service put a Child in Need (CIN) 'flag' on the electronic records; this appears to have followed receipt of information about the domestic violence incident in July 2010 and 'other information received from other agencies including DV unit and social services'.

149. The IMR author is unsure of why the CIN flag was inserted and identifies some confusion in regard to the Trainee Probation Officer's understanding about the process. This is explored in later sections of the report; the significance here is not so much whether a procedure was sufficiently understood and complied with but rather the degree of insight and understanding about the significance of CIN indicating a child who may be prevented from appropriate development as a precursor to more serious concerns about significant harm; in this case Child Z had yet to be born and therefore there was no child to be the subject of any process.

150. On the 6th October 2010 there was consultation with a Senior Probation Manager regarding the case that included the police service's interest in arresting FZ in regard to the domestic violence and other issues. Advice was provided to check whether children's services were aware of MZ and to consider making a referral and to also consider whether a MARAC[16] was required. The referral was not made to CSC until the 29th November 2010.

151. FZ attended with MZ at a police station on the 11th October 2010 and was arrested in regard to the domestic violence in July 2010 and the alleged assault on the two adolescents. He was interviewed by the police and provided a different account of the circumstances of the incident of domestic abuse with MZ in July 2010; he attributed it to MZ being jealous. MZ made a statement of retraction. No charges were made in regard to any of the assaults due to absence of witness evidence. MZ and FZ were staying with the maternal grandmother. Further analysis about the

[16] Multi agency risk assessment conference

detection and investigation of domestic violence and working with reluctant witnesses is provided in later sections of this report.

152. The following day FZ told his Probation Officer that he had been to the police who were dropping their interest in the domestic violence which he did not wish to discuss. He also said that he was living at his father's home with MZ in contrast to the information provided to the police. The Probation IMR identifies concerns that the information about MZ sharing a house with FFZ was not regarded as significant given the known history of abuse and violence and the implication it had for the parents and the unborn baby. The probation officer emailed the police DVU asking for further information about the domestic violence although did not have a date for the incident.

153. The IMR from Probation comments that the information about domestic violence should have resulted in a re-categorisation of the case to a higher level; the significance would have been for the officer's workload. A re-categorisation could have resulted in the individual workload being adjusted to allow improved capacity to undertake relevant work related to the domestic violence.

154. On the 28th October 2010 FZ was issued with a third warning about his failure to keep to an appointment with his probation officer; he claimed confusion again about arrangements this time in relation to the job centre. The Probation IMR explains that three warnings require a referral to a manager which did not take place in this case. This pattern of missing appointments that is not apparent to the individual practitioners at the time and offering a plausible explanation is an underlying pattern familiar in reviews; it is sometime symptomatic of disguised compliance that is a theme relevant to this case and is explored in later sections.

155. In early November 2010 MZ accompanied FZ for an appointment with the Probation Officer. She was talkative and communicative and both seem agreeable to FZ being referred again to Achieve to help with work related skills and self-esteem and confidence. The Probation IMR comments that all of this was very relevant given the family's circumstances and the need to keep FZ occupied. MZ was asked about the midwife's details; a first name was provided based at a local clinic indicating some reticence in sharing too much information.

156. The following day the Probation Officer (PO1) consulted the Probation MARAC[17] representative to inquire whether there are any referrals to the panel pending in respect of MZ. There are not and PO1 is advised that a referral can be made if it is considered appropriate but the deadline for the next panel was the next day. PO1 was told that the police had made a referral to social services and health due to the pregnancy.

[17] The Multi Agency Risk Assessment Conference, or MARAC, is a regular, multi-agency meeting to support high risk victims of domestic violence and abuse.

157. On the 15th November 2010 FN1 made contact with MZ who apologised for not being in touch; she had changed mobile number, had been on holiday, her nephew had died and MZ provided the new address. FN1 gave condolences and arranged to meet on 22nd November 2010. The IMR comments that MZ had been disengaged from support for six weeks.

158. The following day FN1 has a supervised discussion with FN2. Key issues for the baby were identified as MZ having recently moved in with her boyfriend (FZ); MZ appeared to be attached to baby, she had been doing work prior to moving and then losing contact (rather than being seen as disengagement), was living in an area of significant deprivation, had engaged initially but then moved, had lost contact and had changed her phone. FN1 had managed to find MZ who had an appointment to restart the programme. The recorded summary of documented analysis was a history of family abuse with a poor attachment to her MGM. Protective factors that were identified included MZ being in college, she enjoyed the FNP work, had a stable relationship with her boyfriend, and had been re-housed via homeless services.

159. Further analysis is provided in later sections of this report in regard to some of the misdirection that had taken place inadvertently and in spite of the structured analysis it was highly reliant on self-reported information and short episodes of observed behaviour. This is not to criticise FN1 or other colleagues who were showing persistence in overcoming obstacles to MZ being accepting of help and support and were working with a framework of collating information and subjecting it to critical dialogue and analysis.

160. On the 18th November 2010 MZ again accompanied FZ to Probation and was again talkative and open in her communication. She discussed the fact that because she was a pregnant teenager she was having support from a specialist midwife. It was agreed that a referral would be made to CSC although there is no explicit record of this being discussed with MZ or FZ. The referral was not made until the 29th November 2010. A telephone call was made to CSC and a telephone discussion between PO1 and a social worker established that MZ was known to CSC as recently as 2009 although it was 'through her mum'.

161. There is no clarity about what this means in the discussion or in recorded log of the call. The enquiry confirmed that a referral to CSC was required. The Probation IMR acknowledges that it was a good example of multi-agency information sharing although the referral is not made for ten more days. This could be a reflection of several different factors such as other tasks that PO1 was simultaneously involved with but are not described or analysed.

162. A home visit on the 22nd November 2010 by FN1 provided an opportunity for discussion with MZ and FZ about preparing for the birth; MZ was eating and sleeping well and both parents were agreeable to looking at material including DVDs as part of their preparation for the baby's birth in January 2011. MZ missed a scheduled ante–natal appointment a week later on the 29th November 2010.

163. The referral to CSC from PO1 on the 29th November 2010 provided a summary of information known to PO1 and asked for a pre-birth assessment to be undertaken by CSC; there had not been a home visit by PO1 and there never was during the entire length of the community sentence.

164. The information included the following; under 18 pregnancy; difficulties in contacting Midwives and Health Visitor; MZ had been previously known to social care services in 2009; there had been a domestic violence incident in July 2010; she was currently sharing a property with a close relative of FZ who was a known domestic abuse perpetrator and has also been flagged by the probation service as a "risk to staff"; FZ's mental health and self-harm issues, previous hospitalisation for depression and self-harm in 2009, current offence of possession of bladed article which involved FZ stabbing himself.

165. The referral requested that children's services should conduct an assessment of FZ and MZ's parenting abilities and their compliance with pre-natal appointments and advice; MZ's ability to keep herself and the unborn child safe; the suitability of the current address given concerns regarding FZ's relationship with FFZ and his history of abusive behaviour. The referral also requested to know the contact details of the Midwife and Health Visitor and any inter-agency working agreements.

166. A health habits form completed by MZ in early December 2010 again presents a positive lifestyle response in relation to diet and issues such as ingestion of alcohol or drugs as well as stating here was no domestic abuse; the form again does not include information specifically about FZ.

167. On the 2nd December 2010 CSC sent a fax to the midwifery service confirming that they had received a referral from PO1. The fax incorrectly suggested that MZ may have had another child who was in local authority care; it is not clear whether PO1 or CSC had added this detail. The fax asked whether this was a case for the Vulnerable Babies Service (VBS) and stated that CSC would not take any further action until they had a response.

168. The role of VBS is to reduce sudden death of babies through promoting good practice in regard to leading on issues such as safe sleeping. Although the VBS would almost certainly have accepted a referral if all the risk factors had been known, there was insufficient information provided to prioritise such a referral and therefore VBS did not become involved.

169. Further analysis is provided in later sections of the report in regard to how the enquiries by CSC were handled and the circumstance under which the responsibility for an initial assessment of MZ's circumstances were being delegated.

170. CSC contacted PO1 who confirmed the details of the midwife involved with MZ. The duty worker advised PO1 that CSC would close the case. A significant factor recorded on the probation log of the conversation appeared to be the belief by CSC that there were already a sufficient number of professionals already involved.

171. Given the overall workload pressures on the service and the known potential for families to become overwhelmed by too much contact with too many different professionals this was not an entirely unreasonable judgment. However, neither service had addressed the risk factors that had been set out in the referral from PO1 to CSC.

172. Although the CSC recorded that details of the situation were explored with relevant agencies the only evidence of any contact is the fax to the midwifery service and the telephone discussion with PO1. The referral was signed off as NFA (no further action) by the appropriate manager. A letter was sent to PO1 confirming the outcome.

173. On the 8th December 2010 and after a further failed appointment by MZ the previous day with the TPM, she had a telephone discussion with FN1 to discuss the information that had been sent from PO1 together with the information of missed appointments. Although they record that a plan was agreed it is unclear what specific actions were to take place and by whom.

174. For example they discussed whether a CAF was appropriate. They considered the vulnerable baby project but that was considered as not available because the family were no longer homeless (although they did not have their own tenancy). The CAF was the 'expected plan' due to the additional needs being identified. The conversation did not appear to identify and discuss any of the indicators of risk.

175. On the 10th December 2010 the TPM made a home visit and saw MZ and voiced her concerns about her 'lack of engagement with antenatal care'. The 'lack of engagement' may have been expressed more explicitly in person and during the conversation with MZ but the use of quite abstract language especially with a young parent who seems nervous and resistant to services and did not complete her education is fraught with the potential for miscommunication and misunderstanding.

176. Two days later on the 12th December 2010 the TPM completed a Special Circumstances Form (SCF)[18]. The SCF has some significant and misunderstood information and does not include evidence of risk from facts such as a history of violence in this and previous relationships. The SCF states MZ has not attended all of her antenatal clinic appointments, that FZ was (rather than is currently) known to a 'Parole Officer' (rather than a Probation Officer subject to a community sentence) due to anti-social behaviour. The SCF refers to the 'Parole Officer' having raised concerns about MZ and FZ's ability to parent. Children's Social Care (CSC) were contacted with the concerns however, TPM was informed that no further action was necessary. Family Nurse Partnership (FNP) Nurse had been contacted and she had stated that initially MZ was difficult to contact, however she felt that MZ's ability to parent was acceptable.

[18] The SCF is a record of concerns / actions that is sent to the safeguarding team, community midwives and health visitors with a copy placed within the patient notes to ensure all staff are aware of the concerns

177. There was no information recorded about how the judgments being expressed and recorded were evidenced. The SCF states that a referral to the Vulnerable Babies Service was offered and had been refused. An assessment and plan using the Common Assessment Framework (CAF) had been discussed and MZ had consented to this assessment. The plan was to re-visit MZ and complete the CAF in conjunction with the FNP on the 16th December 2010. Further analysis is provided in later sections and in the IMR.

178. A supervision session for FN1 on the 13th December 2010 discussed the information. The focus was on whether the parents could be good enough parents; there was no explicit discussion about the evidence of risk factors and it was acknowledged that the history of both parents was incomplete.

179. The planned visit to MZ on the 13th December 2010 by the TPM and FN1 was cancelled due to MZ not being in. The visit had been prearranged with the purpose of discussing the pattern of missed appointments and to talk about the planned CAF. The IMR acknowledges that the cancellation probably contributed to concerns becoming lost. There were two further missed appointments before Christmas although MZ did attend for an obstetrics appointment at hospital.

180. The updated OASys in December 2010 identified that FZ continued to be assessed as at "high" risk of reoffending and at a "Medium" risk of serious harm. During a telephone discussion at the end of December between PO1 and the TPM agreement was made to undertake the CAF in January 2011.

181. A visit by FZ to the probation office in early January 2011 made clear that FZ was unhappy that information about domestic violence had been shared with the TPM.

182. Two days later Child Z's older sibling was born at 41 weeks gestation and weighing 3240g and was physically well baby. MZ had been admitted via ambulance; she denied having missed any antenatal care although the SCF completed by the TPM was available to the hospital.

183. A midwife at North Manchester General Hospital contacted CSC through the Emergency Duty Service (EDS) informing that MZ had given birth to Sibling 1 and highlighting concerns that she had not accessed ante natal care, had frequently moved home and had declined support from the vulnerable babies' service. FZ was also known to the probation service that had concerns that he was known for weapons, homelessness, alcohol problems and previous incidence of domestic abuse. FZ smelt of cannabis and MZ appeared drowsy.

184. EDS requested that MZ was not to be allowed home with the baby although the hospital stated they had no grounds upon which to prevent her leaving. Although MZ had initially agreed to stay in hospital for 48 hours, she self-discharged against medical advice the day after the birth; she had raised blood pressure which had some significant risk to MZ's health associated with pre-eclampsia.

185. The TPM visited the day after discharge. The CAF checklist was not completed. CSC was told that MZ had discharged herself. FN1 made a home visit two days later and observed both parents caring for and interacting with their baby positively; she recorded that there was evidence that this was 'a much wanted baby'. The significance and meaning of babies for new parents is seen as an increasingly important area for professional assessment when working with new born and very young children and is explored in later sections of this report.

186. On the 21st January 2011 the TPM discussed undertaking a CAF with the FN1. FN1 felt that a CAF was not required as MZ was coping well with the support of the FN1.

187. At the end of January 2011 MZ transferred to a new GP practice. Although no reason is recorded in the patient records the IMR believes that the transfer was caused by the previous practice closing due to the death of the GP.

188. In early February 2011 FZ and MZ were warned by the police under the Harassment Act 1998. This had followed a confrontation on a street in Manchester involving FZ's previous partner; FZ was reported for threatening to smash windows on a motor vehicle and MZ was also reported to have used threatening words to the ex-partner; the relationship with FZ had apparently ended over three years previously. The warning was administered in mid-February and an entry made on the harassment register. This information was not shared with any other service and there is no information about the circumstances of how the confrontation occurred.

189. In mid-March 2011 FZ received treatment for an injury to his hand; he had fallen in the street as he walked home from the pub in the mid evening. Five days later the police dealt with a domestic incident that was phoned in by an anonymous caller who was overhearing FZ and MZ screaming at each other with sounds of a distressed child in the background. Two uniformed police officers attended within six minutes although found no domestic incident to be evident; FZ had reported shouting up the stairs to MZ who had just woken. The call was logged as being with 'good intent'.

190. In early April 2011 FZ completed his community sentence and supervision by PO1 came to an end. FZ had missed two appointments during the first four months of 2011. The closing assessment concluded that FZ had improved stability in his life and that all sentencing objectives had been met.

191. In May 2011 MZ was confirmed to be nine weeks pregnant with Child Z. The booking included a routine screening for domestic violence (a negative and misleading response was provided from MZ) and noted a history of some depression; MZ also said that she had never had social work support. The booking noted that MZ had been supported by the FNP; it also recorded brief details about FZ being unemployed.

192. The midwife history taking in relation to the pregnancy with Child Z revealed a significant history of childhood death in MZ's family. The circumstances of the deaths

were not apparently enquired into. It is not clear if the information was known to the GP.

193. In June 2011 the family were offered their own tenancy. In mid June 2011 MZ was taken by ambulance to hospital having been vomiting. A referral was made by the ambulance crew to CSC; they were concerned about conditions in the home; they reported the house to have rubbish thrown on the floor, dirty nappies on the floor, smell of faeces. Sibling 1 was described as being propped up with a cushion; the child was dirty and wrapped in blankets even though it was a warm day. Sibling 1 became upset and the crew noted that the child was not acknowledged by either parent.

194. SW1 in CSC contacted health services, who reported that FN1 was routinely involved with the family. FN1 was contacted and reported positively on MZ's level of care and stimulation, and she felt that MZ would be upset if contacted by CSC. FN1 agreed to visit and discuss with MZ in the first week of July (two weeks after the referral). The family was due to move house the following week. CSC informed the regional ambulance service of the outcome to their referral.

195. FN1 made the agreed home visit and discussed the referral. Sibling 1 was seen to be very happy, to smile and was 'interactive'. FN1 discussed introducing different foods, finger foods, floor time, to encourage rolling and use of upper body to promote crawling. Sibling 1 was seen sitting with parents, happy, smiling and sociable. MZ informed of the concerns raised by ambulance crew which was recognised. The issue of 'clutter' was not apparently addressed according to the IMR.

196. The following week MZ contacted the police to report that she had been forced out of her property by the landlord over a dispute regarding payment of the rent. The landlord had refused to allow MZ to get her belongings out of the house. Whilst she was on the phone the landlord had returned and had allowed access to the property to recover her property. MZ confirmed she did not require police assistance and that she had an address to move to. Details were not taken. Information was not shared with any other service.

197. In mid-July 2011 Sibling 1 was diagnosed with oral thrush; the IMR comments that the indication of poor hygiene was a significant factor.

198. In August the demographic update on the Infant Care Form records that Sibling 1 was not fully immunised and MZ was no longer at college. No information was recorded about FZ; the IMR comments that this was a limitation of the data collection form that was used at the time. Sibling 1 was seen in clinic and was putting on weight appropriately and appeared to be developing and was in good health.

199. At the end of August 2011 complaints were made about anti – social behaviour at or around the house. This included noise, groups of people gathering and rubbish being thrown in the street. MZ attended an interview with the housing officer; during

the interview MZ said that FZ was not a member of the household; she suggested he was there on a daily basis but left mid evening.

200. In early September 2011 it was noted that MZ had missed several ante-natal appointments. The community midwife made a home visit to follow up; MZ put the missed appointments down to moving house.

201. From late October 2011 FZ was less involved in visits and contact by FN1; the IMR from CMFT comments that up until this point FZ is not involved in the Partners in Parenting Education (PIPE) and was not present at visits from this stage onwards which was unusual[19]. There are times when he was in the home but did not fully engage in the activity as he had previously. FN1 had stated that FZ had shown great involvement in the programme and this could have prompted further exploration at the time. The key issues summary completed in early November stated that FZ and MZ were both engaging well which reflected the established pattern up to this point. The same summary also refers to an improvement in the clutter observed in the house although is non-specific and includes no indication as to whether conditions were regarded as satisfactory.

202. In mid-November 2011 FZ registered with a new GP who was the GP that MZ was already registered with.

203. In mid-December Sibling 1 was taken to A&E by MZ in the early hours; the child had been generally unwell for about a week. MZ reported having seen the GP and Sibling 1 being prescribed an antibiotic; there is no record of a consultation being sought with the GP apart from a consultation for MZ about a sore throat. The HOR comments that it raises the possibility that Sibling 1 had been given the antibiotics that had been prescribed for MZ. After two hours MZ said that Sibling 1 was much better and left the hospital. MZ did not make an appointment with the GP the following day as agreed in the discharge paediatric letter.

204. The demographic update form that was completed at the end of December provided a positive summary of the parents' relationship and their care of Sibling 1. The IMR comments that there was no evidence that information was collected from FZ and there is no reference to FZ's use of cannabis or to the previous involvement of probation and safeguarding concerns. This information was collated just prior to Child Z being born at the end of December 2011 at 40 weeks gestation and a birth weight of 3360g.

205. MZ and Child Z were discharged on the day of the birth and it was recorded that they were living at the grandmother's home although no indication as to whether this was the paternal or maternal grandparent.

---

[19] PIPE provides a major component of the FNP programme's approach to the development of competent parenting and aims to develop the understanding and skilfulness of the clients in relation to their care giving role, in order that their babies receive the responsive and sensitive care that will enhance their development and the caregiver/infant relationship.

206. The health IMR comments that the GP was notified about the birth but was unaware of the involvement of FN1; the midwifery service also appeared to be unaware of the FN1's Involvement. FN1 made a home visit two weeks after the birth and support was agreed with MZ through the Healthy Baby Programme. FZ was in the home but he continued to be unavailable to professional contact as commented previously.

207. MZ was observed to interact well with Child Z during routine contacts and clinic visits. Child Z was feeding well and putting on weight. MZ was on one occasion described as reading 'beautifully' to Child Z by the end of January 2012; there is no reference to clutter.

208. By the end of February 2012 it was observed that there had been missed appointments and immunisations were required.

209. In March 2012 the family had rent arrears and MZ made enquiries about having a bath fitted to the property rather than relying on a leaking shower.

210. There was an attempted break in to the property while MZ was in the garden that had resulted in the front door being damaged. The police were called. No entry had been gained and no witnesses were identified and house to house enquiries proved negative. A crime scene investigator later attended and took photographs and a gel lift of the foot mark on the front door. MZ was contacted by telephone by the crime reduction unit and a standard victim letter was sent to her. In addition, a reassurance visit by a uniformed patrol was conducted together with cocooning in the immediate area of the address. The police IMR author explains that this is a reactive police strategy to protect against residential burglary that can be employed following a 'spike' in residential burglaries within a certain area.

211. The argument about a bath continued over several weeks with the landlord declining to fit a bath as MZ had been aware of the absence of a bath when she had accepted the tenancy. For MZ, this did not address the issue of whether the property was suitable particularly now that MZ had a second baby. Further analysis and comment is provided in the IMR and in later sections of this report.

212. By the end of March MZ was becoming increasingly upset by the problems with the bathroom; she was washing herself and the children in a bowl due to the shower not working. There were ongoing problems in regard to repairs to the bathroom and front door that continued through to the summer.

213. In mid-April 2012 FZ was again facing criminal prosecution and a pre-sentence report was required. PO1, the Offender Manager who had provided the previous supervision, was again assigned to FZ. Discussion during the initial session focused on identifying what FZ regarded to be the most important factors to be addressed on the new order. The discussion revealed a contrasting picture of problems that do not

appear to have been apparent to other professionals such as FN1 who was optimistic about the family's circumstances and capacity.

214. Issues highlighted by PO1 during the discussion with FZ include his mental health, use of alcohol, not having his own accommodation (disguised homelessness) and building family ties. FZ considered his use of alcohol to be the most important factor to reduce the likelihood of reoffending and PO1 explained that she would make a referral to Addiction Dependency Solutions (ADS) for assessment and on-going intervention; FZ had previously been helped by the service.

215. The family's need for accommodation was explored. FZ was living with MZ and her mother. PO1 had verified with MZ's mother that she was happy for FZ to reside there. All seemed fine. FZ's mental health was explored. FZ had been referred to the community health services by his GP. FZ was not currently on medication as this made him feel worse than previously. FZ had been previously hospitalised as a result of self-harm and an overdose of painkillers and alcohol in December 2009. FZ admitted he could act irrationally and suffered from black-outs.

216. PO1 discussed referral to the Manchester Offenders Diversion Engagement Liaison (MO:DEL) Team[20] for support with these mental health concerns. FZ refused to allow this referral as he felt the issues had already been dealt with by his GP. MZ's relationship status was explored. FZ disclosed that MZ was 17 years old and attended college; she in fact had not been attending for some months. He stated that she did not drink or smoke; she in fact did smoke.

217. In mid-April 2012 MZ reported to FN1 that Sibling 1 had fallen in the shower causing a cut to the head. Work was being undertaken in the bathroom by contractors that had required the removal of some tiling in the shower. It was apparently assumed that Sibling 1 was in the shower with a parent when she fell though this is not detailed in the records. The IMR from CMFT comments that a CAF should have been suggested at this stage due to the housing issues, maternal mental health needs and the impact on child safety. It is apparent from the information revealed during PO1's initial assessment interview with FZ that there were other significant needs that were not being recognised at the time.

218. The OASys assessment that was completed in April 2012 for the pre-sentence report concluded that there was a high risk of re-offending by FZ and that he represented a medium level of risk of harming somebody known to him (low in regard to the general public). The risk of serious harm summary mentioned concerns relating to potential risks to MZ and to MZ's father but little detail were provided about what evidence this was based upon.

219. The sentence plan included objectives to address self-harm and alcohol misuse and the need for acquiring more stable and long-term accommodation. The probation

[20] MO:DEL has won awards for the provision of a multi disciplinary service to work with offenders who have co-morbid mental health needs, learning disabilities or other complex health needs that included substance misuse, homelessness and difficulties in relationships.

IMR comments that although the assessment had met generally expected standards for anybody assessed as posing a "Medium" risk of causing serious harm required a full and thorough risk management plan detailing exactly how the risks would be managed and contained. In this instance the plan was vague about how the risks to FZ's partner and to her father might be managed and by whom.

220. In mid May 2012 FN2 completed the on-going key issues summary that there was no bath and the shower was broken (actually an uncompleted repair). No concerns were highlighted in regard to either Child Z or Sibling 1 though if MZ's mood deteriorated due to the bath/shower this would have an impact on her children. Some tension with the housing association was noted. FN1 had noticed a mood change and felt that MZ would deal with this inappropriately and would have more problems. The IMR Author comments that this could have been an opportunity to organise a CAF but that did not take place. There is no reference to FZ's offending or any of the issues highlighted for example by PO1's OASys assessment.

221. At the end of May 2012 MZ had invoked the housing pre-action disrepair protocol with the help of Shelter having become stressed about the lack of progress in resolving the issue of the shower repair; the involvement of Shelter appeared to indicate an intention to seek legal remedy to the issue of repairs to the shower. In early June 2012 MZ contacted the local credit union to discuss the options for finance to install a bath herself.

222. In mid June 2012 Sibling 1 was presented at A&E. Sibling 1 had a three day history of vomiting at night. Sibling 1 was observed to have a small bruise near an eye and FZ stated that Sibling 1 had fallen down three stairs at the grandmother's house three days previously. When questioned by staff FZ stated that he was not present at the time of the accident and MZ would have brought Sibling 1 at the time if Sibling 1 had lost consciousness. Staff in A&E tried to contact MZ to clarify events, but to no avail.

223. On examination Sibling 1 was observed not to have an obvious head injury; there was a bruise to one eye area and the doctor diagnosed a possible viral illness. Whilst in the department EDN3 contacted CSC and established that Sibling 1 was known to them. EDN1 completed an electronic referral form which identified that Sibling 1 had an unexplained bruise to the face; Sibling 1 appeared unkempt and was wearing dirty clothing. EDN1 requested that there was a home visit to ensure the safety of the children. This information was also sent to the Health Visitor (HV).

224. A joint home visit was undertaken two days later by FN1 and a Social Worker (NSW1) who saw MZ, FZ, Sibling 1 and Child Z. The house was described as 'messy'. They discussed hygiene. MZ reported that Sibling 1 had fallen whilst going up steps (rather than down as reported by the hospital). Sibling 1 had tripped and banged a cheek, had a bruise which was not present at the time of this visit. Sibling 1 had then vomited 2-3 days later. Following the fall Sibling 1 was well. FN1 assessed that MZ was appropriate in her decision making. Issues discussed included hygiene and thorough hand-washing to reduce the risk of gastro-enteritis. NSW1 checked the

rooms (although no further detail was recorded by either worker). The interaction with both children during the visit was recorded as being good. NSW1 was made aware of the housing problem regarding the shower and how this impacted on MZ's mood and that she could not bath the children.

225. The initial assessment by CSC resulted in the case being closed; reliance was given to the fact that FZ had taken Sibling 1 to hospital and both children 'appeared to be fine'. The IMR author comments that the standard and range of recording appears limited and incomplete. The summary of background information and past history was not recorded and left blank; there was no evidence that any previous history was considered in the context of the current situation or measured against previous information or concerns.

226. FZ was not seen or spoken to as part of this initial assessment in spite of the fact that the referral form referred to his confusion and his 'odd answers' during the history taken at the hospital.

227. The timescale and context of the apparent housing problems alongside the reported neglect at home appear not to have been explored or challenged by NSW1 with MZ or indeed by FN1. There was no description of the children, or their clothing. Also they did not appear to have been spoken to and engaged in the initial assessment, nor had NSW1 offered any view on them, their development, or the standard of parenting being provided.

228. The CMFT IMR Author comments that given the information that had emerged during June including the referral to CSC, it would have been appropriate to have discussed the case within the health trust's safeguarding children framework which relies on practitioners to highlight concerns. It did not happen in this case and is explored in later sections.

229. About a week after the hospital visit the GP out of hour's service at a Walk in Centre (WIC) was used by the parents to present Sibling 1 with a vomiting illness. There was no unusual temperature. The IMR Author highlights that the detailed entry about this and some previous health contacts was made on MZ's health records rather than of Sibling 1. This has significance in terms of keeping information attached to the individual history of a child and is explored in later sections.

230. In July 2012 a bath had been fitted. This had followed the previous shower repair being designated uneconomic for the landlord and agreeing to install a bath as the replacement. During the rest of the summer there continued to be regular and routine contact with the family by health professionals. No concerns were noted.

231. In the early afternoon of the 12th August 2012 the police received a 999 call from the landline at the home address of MZ during which the caller requested the police. The police immediately recalled the originating landline number that was linked to the home address of MZ and the operator spoke to a female who gave her name as MZ and provided her date of birth. At the time of recalling the landline number a

baby could be heard crying. MZ stated that the crying baby was Child Z and she provided the child's date of birth.

232. MZ stated that the call to the police was the result of a female friend messing about because she was drunk. MZ provided the forename of the female friend but no further personal information. The GMP incident log was closed with a closing code of hoax calls to emergency services and no further action was taken. The police had taken a silent 999 call from the property in early June 2012 although the IMR explains that on that it had been established that it was unlikely to be linked to MZ on that occasion.

233. The last visit to the home before Child Z died was five days before the admission to A&E by the FN1. No concerns were noted; both children were seen and were well. Developmental checks were done.

234. In late September 2012 Child Z was taken to A&E. The regional ambulance service had received an emergency 999 call from a neighbour at 10.39. The dispatcher took details that identified a baby not breathing and coded the response as red and transmitted the information electronically to a fast response paramedic; this was then upgraded to 'Government Code Red 1' indicating the highest priority response with a required response time of less than eight minutes. A crewed ambulance was also redirected from another call (Crew 2 and Crew 3). The paramedic (Crew 1) was on the scene by 10.41. The dispatcher had been providing verbal instruction on CPR for FZ who was administering it to Child Z. Crew 1 immediately took over CPR on arrival at the scene using a bag-valve mask resuscitator and oxygen. He inserted a nasopharyngeal airway and requested back-up. Crew 2 and Crew 3 arrived on the scene at 10.45. The ambulance left the scene at 10.49 with Crew 1 also on board who with assistance from Crew 2 continued to administer CPR. There was no response and no output and Child Z's condition did not change.

235. On arrival at the hospital at 10.56 the medical care was transferred over to the hospital that had been pre-alerted and who continued to administer resuscitation which was halted at 12.40.

236. The Sudden Unexpected Death of Children (SUDC) Protocol was invoked and CSC, the police and Health Visitor were all notified of the death of Child Z. The police attended the A&E and arrested the parents.

237. Two strategy meetings took place the same day with representatives from Police, CSC, and the head of safeguarding at Hospital 1, the Consultant Paediatrician, FN1 and NN2. An account was initially shared of the circumstances which led to the death of Child Z with the second meeting providing further information after the parents had been initially interviewed and a visit to the home address had been completed. This information was summarised in the introduction to this report.

238. The police together with the Consultant Paediatrician and CSC Manager had visited the house and had found the house in a very neglected condition; it was described as

unhygienic, untidy and as not fit for human habitation, the living room was in a state of chaos, the kitchen was the same and was untidy, there were seven used nappies under the chairs, a hole was found in a wall which someone may have aggressively punched, a cricket bat was in evidence, the stairs were cluttered making access difficult with the consultant paediatrician almost falling whilst attempting to walk upstairs. There was no bedding on the parent's bed. The baby cot was untidy; it was unhygienic and contained a large adult pillow. There was a drawer where milk was prepared which was unhygienic and had the potential to cause health problems. One of the bedrooms contained cannabis plants with a street value of several thousands of pounds.

239. The Consultant Paediatrician shared details that FZ had a medical and criminal history (and this information would be shared at a later date), Hospital 1 had records which doubted FZ's ability to parent following information from the Probation service, MZ had a learning difficulty and the extent was unknown, the house had been photographed and the police agreed to forward to NN2. Sibling 1 was subject to Police Powers of Protection (PPOP) and a Section 20; Children Act would be requested to safeguard the sibling. Sibling 1 was to have a child protection medical examination the following day. Post mortem results were to be shared when available. A Bereavement Support Leaflet was given to FN1 from the Consultant Paediatrician for the parents.

240. Although a detailed plan had been agreed this was not written, signed and shared at the time.

The critical reflection and analysis from the Individual Management Reviews.

2.1 Summary

241. All of the Individual Management Reviews (IMR) were completed using *Working Together to Safeguard Children (2010)* which was also supported with additional local guidance provided on behalf of the LSCB. The IMRs include action plans for implementing recommendations. All the IMRs are countersigned by the senior manager for the individual commissioning agency.

242. Many of the services have already taken action or initiated action in response to improvements or areas of development identified through their individual review.

243. For some of the authors, they were simultaneously working on other IMRs for other serious case reviews. All of the authors were also undertaking their usual range of professional roles and responsibilities.

2.2 Significant themes for learning that emerge from examining the IMRs

244. The agency reviews identify themes that have implications for policy development and staff training that applies to all services working with children. In the summary of the review's findings provided in chapter one there is acknowledgement that some of the issues to come out of this review are reflected in the finding of national evaluation and research. Important messages for learning from this review include:

a) Effective and informed assessment of risk and need in regard to children requires access to and understanding of significant family and parental history;

b) Assessment at any level relies on appropriate triangulation of information and data from observation, collating what is declared or reported by the adults (and children) and checking historical and third party information and looking for underlying patterns and inconsistencies;

c) Families living at the margins of their community or general society will be suspicious and resentful of intervention from social and criminal justice welfare services and will be motivated to resist and misdirect;

d) Adults with complex histories, attitudes and behaviour with chaotic lifestyles can be overwhelming for individual practitioners and especially if the practitioner is relatively inexperienced or not sufficiently knowledgeable;

e) Strengths based help and support can be very effective in helping many families but is liable to be less attuned to the misdirection that can come from disguised compliance or other obstruction;

f) The use of drugs and or alcohol deserves careful attention especially when combined with evidence of poor mental health or other difficulties; a perceived toleration of drugs such as cannabis represents risk to the child and is a misunderstanding about the impact of such behaviour on the emotional, physical and mental health and capacity of a parent;

g) Cognitive and learning difficulties can be an additional barrier to effective communication and understanding in the interaction between professionals and parents; if it is not looked for or recognised, incorrect assumptions can be made in regard to the level of understanding and insight available to the parents or other significant adults;

h) Misplaced assumptions about the roles of different services can undermine judgment and decision making; in this case there was more than one occasion when assumptions were made that services such as the vulnerable babies service or the FNP would address issues highlighted in referrals;

i) Arrangements such as CAF should be used to provide the opportunity to collate information about children who may be vulnerable but are not seen to meet the thresholds of specialist and high tier services such as CSC; it is an opportunity to get a wider perspective that is not available in single agency 'silos'.

245. It is important that constructive feedback and reflection is provided to all the practitioners involved in this case to give them the appropriate positive encouragement for their continued professional development and retention in the workforce.

246. The remainder of this chapter summarises key evidence relating to the terms of reference established for the IMRs.

2.3 Good practice identified through the review

247. To support the learning from the review the panel looked for examples of good practice. To constitute good practice, the panel looked for action or decision making that went beyond compliance with local and national policy, procedures and guidance.

248. Examples of good practice identified by the review include:

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.

249. The remaining sections of this chapter summarise the most significant learning from the IMRs against each of the case specific terms of reference.

TOR 1 Recognition and response to need and indicators of risk

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

250. The Munro Review emphasises the importance of early recognition of need and echoes the work of other reviews that have included Frank Field MP (2010), Graham Allen MP (2011) and Dame Clare Tickell (2011). The recognition that MZ had additional vulnerability by virtue of becoming pregnant as a teenager and therefore allocated to a specialist midwife occurred at an early stage. The lack of engagement with appointments did not attract sufficient attention and especially during the critical latter weeks of the pregnancy that represents risk to the baby and the mother.

251. The involvement of FNP arose from the fact that MZ had additional vulnerabilities by virtue of becoming pregnant as a teenager (FNP is a targeted service for vulnerable first time young parents under 20 years of age), but was not based on an explicitly defined enhanced level of need or risk that has been described in the earlier sections of the report. It is possible that the fact that services such as FNP had been allocated and were working hard to be involved with MZ contributed to other services assuming that the level of need and risk had been addressed without the need for more persistent enquiry. It is a fact that FN1 was influential in how CSC managed aspects of their enquiries and assessment.

252. PO1 who was supervising FZ became aware of the pregnancy and because of knowledge about FZ's history and the age of MZ was sufficiently concerned to make a referral to CSC recommending a pre-birth assessment. The IMR acknowledges that this could have equally have been an opportunity for PO1 to have initiated a CAF. The referral to CSC resulted in that service trying to contact the midwifery service and in absence of any direct conversation with either PO1 or the midwives CSC suggested that the Vulnerable Babies Service might be an appropriate response.

253. There may have been a misunderstanding in CSC about the VBS being a targeted service which required evidence that a child was at higher risk in order to allocate

any resource, being primarily a preventative service aimed at leading on practices that reduced the risk of sudden infant mortality with higher risk children. If the risk factors had been collated and described in a referral to VBS it would probably have resulted in VBS becoming involved.

254. The CSC IMR also describes the problems that had confronted the service in regard to the implementation of new information systems that had not been thoroughly integrated with historical and archived records. This meant that in this case, historical information about the parents' childhoods was not identified as part of the initial enquiry or subsequent assessments.

255. This left CSC more reliant on current information being reported to them from other services such as PO1. In the absence of any current and identifiable risk to a child, there was no compelling reason to undertake more comprehensive assessment. Such decisions also have to be seen within the context of a service that is receiving over 1300 contacts about children each month.

256. Although there was a subsequent plan to complete a CAF this was not achieved on this or any other occasion. The significance in this case is that individual professionals never took an opportunity to share information and intelligence about their interaction with the family. Therefore, the patterns that have become clear during this review such as the avoidance of contact were not as apparent to individual practitioners with the possible exception of PO1 and of FN1 who showed personal persistence in maintaining contact with MZ in particular. None of the services had any historical information to inform their current understanding and observations. The family was largely not regarded as being particularly more vulnerable than many other families in similar circumstances.

257. The identification of vulnerable families and babies and delivering early help and support is recognised as an important aspect of preventing a range of problems developing for a child over subsequent years. It is for this reason that considerable effort is made in trying to identify needs and risk at an early stage that begins with ante natal care.

258. For such strategies to be effective it requires the collective co-ordination of information and behaviour across different services and individual professionals. It relies on relevant information being identified for example by GPs who may have significant information to share and contribute to early identification about domestic violence or lifestyle issues for example; it relies on the midwifery services being able to encourage pregnant women who may have had poor experience of contact with statutory services or feel they live on the margins of their community, to disclose relevant information about sensitive areas of their lives such as the quality of the relationship with their partner, their experience of abuse and their lifestyle as it might effect their children in regard to substance misuse for example.

259. In this case there were challenges facing professionals such as the GP in identifying MZ as a pregnant woman who might be in need of additional help over and above

only being 17 years old when she became pregnant on the first occasion with Sibling 1. MZ had to move to another GP when her original GP died. Although the new GP practice employs a person to specifically provide a summary of historical information it did not happen on this occasion and coincided with several other patients joining the practice at the same time. MZ transferred into the second GP practice from the first practice that had no knowledge of FZ who was apparently not registered with a GP for an unknown period in 2010 and the second GP practice only had information about FZ when he transferred to the same practice as MZ several months afterwards in late 2011.

260. The initial confirmation of pregnancy by the GP did not acquire very much information about FZ or the circumstances for the pregnancy. This is not unusual in terms of the practice of GPs across the UK. The focus is primarily on the health of the pregnant teenager in this case and ensuring that MZ was booked with the midwifery service who would provide oversight and support through to the birth and handover to the community health visiting service.

261. The midwifery service have developed expertise in identifying pregnant women who may require additional support and have access to a range of services some of which operate within the primary health community whilst other are located in the local authority or third sector.

262. There are services such as the children's centres that provide a wide range of activities and help for pre-school children and parents. More information is provided at a later stage about some of these services and their contact with MZ and the family.

263. At the ante natal stage the main need that was identified was MZ's age; she was a teenager expecting her first baby and she was also without a secure home of her own. She was booked for maternity care 15 weeks into her pregnancy with Sibling 1. It was identified that MZ had had a social worker in the past due to school problems and that she had suffered depression in the past. A referral was made to Connexions and to the Family Nurse Partnership by the Specialist Midwife (TPM) who took over the coordination of ante-natal support from August 2009.

264. The Pennine Acute Trust IMR explains that the referral to the FNP by TPM was achieved as a result of the local maternity services participation in the 'building blocks research project' that routinely sought permission from a young mother for her details to be passed to the FNP and then a computer programme randomly selected a family for allocation to the FNP service[21].

265. The significance is that allocation to the FNP was not based on identification of significant needs over and above being a teenaged mother but was a randomised trial of a programme designed to achieve enhanced outcomes for children. The TPM

[21] The local FNP team were participating in the study to test the effectiveness of the FNP intervention; eligible clients were randomly assigned to receive the programme.

offered the FNP to all pregnant teenagers and was then informed which of those had been allocated to the FNP. MZ had missed her first ante natal appointment and missed several more throughout her ante-natal care. She attended at the hospital emergency service with vomiting and bleeding at 18 weeks and was admitted onto the gynaecological ward.

266. In late summer 2010 MZ was routinely screened for anxiety and depression by FN1 that identified high levels of anxiety and moderate depression. This in part reflected the insecure housing that MZ had at the time; the house was described as falling down and in September 2010 MZ left that address. She was out of contact for a period of weeks. The IMR author for the FNP reflects on the importance of anticipating some of the chaotic arrangements that can arise when a parent or family change mobile phones and move house at short notice and there has been insufficient attention to acquiring alternative contact details. The absence of a comprehensive family and social history in health or social care had not captured information about family members and identifying alternative contacts.

267. MZ re-established contact after six weeks and initially met in a car park due to MZ asserting that the new house was difficult to locate. Given the history of missed appointments and keeping services at a distance this appears to have been another form of controlling of contact with professionals by MZ.

268. This was not how it was viewed by FN1 and who continued to be very persistent and diligent in keeping contact with MZ. This is a common dilemma facing professionals working with young adults who are suspicious of and reluctant to accept involvement from professional sources. Families living on the fringes of their community can be reluctant to allow too much information to be disclosed for fear of further intrusion and more far reaching consequences from criminal justice or social welfare agencies.

269. It is these types of dilemma that should be presented in formal supervision and case discussion to prevent inappropriate misdirection of the practitioner's focus.

270. PO1's referral to CSC in November 2010 followed an initial telephone call to the service to establish whether CSC knew the family given the fact that PO1 had become aware that FZ was living with MZ who was pregnant and that FZ had a history of violence and substance misuse. It was for this reason that PO1 wanted a pre-birth assessment to be completed. PO1 could have initiated a CAF which would have provided an opportunity for further information to have been collated prior to the referral but did not. The referral to FRT resulted in a social worker trying to speak with the midwifery service and when that was not possible by telephone, information was faxed to the midwifery service suggesting that the Vulnerable Babies Service might be appropriate and confirming that FRT planned to take no further action. There was no discussion with PO1 regarding the risk factors and concerns that had prompted the referral (although there had been a previous conversation when PO1 wanted to check whether there was any social work involvement) and there was no check of historical information on either of the parents and their families.

271. The TPM was made aware of the information from FRT which coincided with several missed ante-natal appointments. The TPM recognised that there was an emerging picture of need and potential risk when she opened the Special Circumstances Form (SCF) so that information was available to other health professionals who came into contact with MZ.

272. This recorded the fact that there had been missed ante-natal appointments, there was involvement by the probation service (although was non-specific about the circumstances over and above anti-social behaviour), there were concerns about the parents ability to parent raised but that CSC were taking no further action; the fact that CSC were not taking action may have been interpreted as signifying there were no substantial concerns.

273. An offer for support through the Vulnerable Babies Service had been declined although the FNP were involved and FN1 felt that MZ's ability to parent was acceptable; it is not apparent that FN1 was aware of the information provided by PO1 or the history in both families that even at the time of the SCR remained largely unknown to people currently involved with the family.

274. The TPM agreed to complete a CAF in consultation with the FN1 in mid-December 2010. This could have provided an opportunity to collate further information from the parents and to consult other people with knowledge of the family. In the event MZ did not attend for the scheduled appointment at the hospital or at the day unit two days later. When the TPM tried to make a home visit just prior to Sibling 1's birth MZ was out. By this stage MZ was overdue for delivery of her baby and focus appears to have moved to discussion about possible induction to ensure the safety of MZ and her baby. Although there was a discussion with PO1 who asked to be included in the CAF which was postponed until the New Year.

275. In the event, MZ went into labour in early January 2011 just prior to the planned induction. The Special Circumstances Form that was now part of MZ's patient records alerted the hospital to the concerns and issues recorded by the TPM and a telephone check was made with CSC in regard to any plans for MZ and her baby.

276. The Emergency Duty Team (EDT) advised that MZ should not be allowed to go home (the reason is unrecorded and CSC had no direct information about MZ and her circumstances); the hospital recorded that they had no reason to delay MZ going home. There was also a record made of FZ coming to the hospital smelling strongly of cannabis. This information does not appear to have been shared with the TPM, FRT or with PO1. The recording about smelling of cannabis does not identify who saw FZ and smelt the cannabis.

277. MZ looked after Sibling 1 whilst she was in hospital for one day without any concerns being observed; her care and response to Sibling 1 was appropriate. There is no record of when FZ visited or his care of his baby. MZ discharged herself against the advice of medical staff; she had raised blood pressure and remained at risk of a

condition such as preeclampsia. CSC was advised that MZ had discharged herself from hospital.

278. Less than two weeks later FZ received treatment at the same hospital after he fell and cut his hand when returning home from the pub whilst under the influence of alcohol and possibly cannabis or other substance. The IMR for Pennine Acute comments that he was not asked about any caring responsibility for children and this visit to the emergency department was not known about to other services.

279. Becoming pregnant and caring for a very young child represents considerable emotional and physical demands especially for any young first time parent. The first months of a child's life are an important stage in the development of emotional bonds and creating the conditions for successful attachment for example. MZ had become pregnant again by early March 2011 and was booked for ante natal care seven weeks into her pregnancy with Child Z in mid May 2011. MZ was routinely screened for domestic abuse during the booking for Child Z; she indicated that she had never experienced violence in the relationship; this was not true although this is an example of how self-reported evidence can provide misleading information for practitioners to make judgments and decisions; similar problems face people such as probation officers as evidenced in this case. MZ was equally unforthcoming with the FN1 during the screening and monitoring used on the FNP programme that follows a structured process of enquiry and work with parents.

280. The police had dealt with a clear incident of domestic violence in July 2010 (concerning the argument over the computer X-box) and during which she had told the police that her relationship with FZ was 'on and off', that they often argued and that "FZ drank frequently and was aggressive when drunk." The absence of a statutory assessment by CSC during the ante-natal period for either child and the absence of routine checks with agencies meant that the information held by the police (and which included evidence of involvement in crime) was not accessed to be considered alongside the other information that had been provided by PO1 and the ambulance service.

281. The police were initially proactive in dealing with the incident of domestic violence which included a warrant to arrest FZ but did not process the information as a safeguarding referral through the PPU.

282. The notification by mobile telephone to FZ potentially increased the risk for MZ and made her vulnerable to coercion and possibly influenced the outcome of the episode when FZ eventually responded when he went to a police station in the company of MZ who declined to make a formal complaint about FZ's behaviour and did not want to cooperate further. This led to no further action in the absence of independent witnesses or forensic evidence. FZ's presentation of a different version of events that sought to place responsibility on MZ and her mother was significant.

283. PO1 was aware of the domestic violence incident but it was not followed up in the context of the supervisory discussion with FZ; the IMR author highlights this as unsatisfactory.

284. In June 2011 during the second pregnancy MZ had called the ambulance service when she had severe vomiting 13 weeks into her pregnancy. The crew that responded made a referral to FRT reporting that the house was filthy with clean and dirty nappies 'strewn' on the floor and the house smelt of faeces. The crew also reported that Sibling 1 was seen with a feeding bottle hanging from the mouth propped on a chair on a cushion; the child was described as filthy and wrapped in blankets despite it being a warm day and was ignored by both parents despite being distressed[22]; the presence of uniformed strangers in the house would have been an upsetting and unsettling experience for a young child.

285. This was a clear report of neglect that deserved further exploration and if it had been combined with the other information reported by PO1 in late 2010 it should have prompted at the very least multi agency discussion and assessment as a child in need. The historical information about abuse in both parents' childhoods was significant information that apparently remained unknown until this review. CSC had established that a Specialist Midwife from the Family Nurse Partnership was visiting the family every two weeks and no further assessment was judged necessary.

286. MZ missed a series of ante-natal appointments and required persistent follow up throughout both pregnancies. MZ had one further presentation at the hospital emergency service in September 2011. Care was handed over from the TPM to FN1 following the birth of Sibling 1. The TPM was not involved in the ante-natal arrangements for Child Z; in part this appears to have reflected the fact that intensive contact was taking place with the FNP.

287. In June 2012 Sibling 1 had been taken to the emergency department at the hospital with a bruise to the cheek. Sibling 1 was described as being dirty and dishevelled by the Emergency Department Nurse (EDN3) who made a referral to the First Response Team (FRT) in CSC; this detail was lost in the subsequent handover to the neighbourhood team that completed an initial assessment.

288. There were concerns about the way that FZ had answered questions regarding the history of vomiting and circumstances of the bruise, which 'seemed odd'. There was a subsequent joint visit by a social worker and the FN1 to complete an initial assessment; they were not fully aware of all the information reported by the EDN. There were several concerns about the home conditions. Parents provided an explanation that the sibling had tripped and fallen over striking a cheek on a stair, which was accepted.

[22] The information about bottle feeding and ignoring Sibling 1's need for comfort and reassurance is significant evidence that the information about the condition of the house is indicative of neglect; prop bottle feeding has physical risk for the child and is also poor nurturing of a young child who should be getting close physical contact and emotional reassurance from an adult during the feeding.

TOR 2 Quality of parenting assessments

Consideration as to how the assessments of parenting took into account the various risk factors and how this informed the safeguarding of both children.

289. A consistent theme to come from serious case reviews and the inspection of safeguarding work is the challenge of achieving assessment practice that reflects the needs and circumstances of children living in families that face a wide range of persistent challenges and difficulties. It is a recurring conundrum that assessment is often distracted by the problems and needs of adults and is therefore unable to analyse the implications for parenting of very young children in particular. Analysis is also compromised by insufficient discussion between different professionals. A consistent theme in this and other serious case reviews is the degree to which the information held by GPs in particular is not accessed.

290. PO1 identified a need to have a parenting assessment completed at an early stage in the first pregnancy. No assessment was completed in response to that referral. CSC were not persuaded that a pre-birth assessment was necessary based on the information they received; that judgment relied on partial information that did not achieve direct conversation with other relevant services and did not identify the history about the childhood abuse of both parents.

291. The historical checks were impeded by difficulties in the functionality of the electronic information systems to identify historical information from as late as 2008 and accessing archived records. FN1 was also influential in how CSC managed aspects of the referral and assessment.

292. The involvement of the family nurse in this case involved a degree of assessment with the focus on a structured strengths based and motivational model of engagement with MZ through a structured visiting programme. Clinical record keeping includes supervision documentation and focuses on both strengths and risks within the household across a number of domains, especially in relation to safeguarding the child. FNP is a behaviour change programme identifying strengths in order to build positive, sustainable behaviour change. The programme also has an expectation that practitioners will assess for and identify risks, agree actions with clients and continually monitor progress ,so that risks are addressed, including ensuring protective factors are in place to keep a child safe.

293. Local implementation of the FNP model is supported by a detailed management manual, which informs and guides local areas in what they need to do to set up, sustain and continually improve the FNP programme locally. The guidance in the manual is then backed up by a range of national clinical guidance documents, which are continually reviewed and updated in light of national and local learning. All local areas are advised to implement the clinical guidance within the requirements of their local frameworks and to ensure that the national guidance is understood locally.

294. The model has been validated through research evidence to produce improved outcomes for maternal health and child development. Not unreasonably, the use of such validated approaches can infer a high level of confidence that good outcomes will follow in all circumstances; this is not a comment intended to be restricted to FNP and certainly does not argue against the implementation of validated and structured approaches that are supported with good research evidence such as FNP. This is an area of refection and challenge in the final chapter of this report.

295. FN1 had assessed that MZ had been happy about both pregnancies and there was good attachment with both children. As will be clear from the previous sections, there was evidence that suggested that attachment practice was not as positive as had been inferred. What is clear is that FN1 had secured MZ's confidence and that MZ re-established the contact after six weeks when she had withdrawn from midwifery services.

296. The other assessment that was undertaken was the initial assessment in June 2012 that followed the referral from the hospital Emergency Department Nurse after FZ had presented Sibling 1 with a history of three days vomiting. The presence of a bruise and Siblings 1's dirty and dishevelled condition combined with FZ's 'odd' answers had caused the nurse to make a referral. This was the clearest opportunity for an s47 enquiry and assessment to have been completed and should have been. If the information had been correctly defined as a child protection referral there would have been a medical examination of the children and a multi-agency strategy discussion that may have moved on to a core assessment. This does not mean that the tragic death of Child Z would have necessarily been prevented but it would have created the conditions for a much clearer level of insight and understanding about what the children's circumstances were.

297. The CSC IMR explains the system of referrals as requiring an initial response from FRT but the assessment was then allocated to a neighbourhood social work team. In this case there was an important loss of detail in information between the hospital and the area. For example the information about Sibling 1's physical presentation at hospital was not included. There was no discussion between the emergency department nurse and the Social Worker who had responsibility for the home visit and completion of the assessment. The system also has implications for how the team manager was able to quality assure a response to contacts and referrals; in being able to assess the rigour and appropriateness of decision making the manager has to have a sufficiently detailed knowledge about what the originating issues and concerns were.

298. A home visit took place involving FN1 and the Social Worker; FN1 had discouraged an assessment following the referral from the ambulance service because it would upset MZ and FN1 clearly still felt that MZ was capable of parenting her children adequately. The mindset that was carried into the process of assessment is an influence that is increasingly understood in a range of different settings; how to ensure that the person making the enquiry is not just looking for evidence and information that they expect to find to reinforce their pre-existing judgement about

the person or situation. It is especially important in this type of assessment that involves children who have yet to develop sufficient language and other skills to convey their own feelings; it is also important when trying to identify underlying patterns of neglect that do not usually involve one defining act of abuse or maltreatment but rather represents an accumulation of inappropriate emotional and physical care that has a negative cumulative impact on the child's development and possible safety.

299. The Munro Review was very critical of the national assessment frameworks and practice in place until April 2013 and this has informed the revised national guidance for how local areas develop their own assessment frameworks. In a well-intentioned effort to create greater consistency and thoroughness, the system of national standards had largely created the conditions for assessment to be treated as an essentially administrative task of completing forms.

300. These forms have inherent weaknesses such as providing little scope for developing the narrative story of a child and how they are affected by the behaviour or lifestyle of parents or other adults as well as being weak on identifying risk or understanding need. However, there are parts of the form that should be useful that include for example capturing information about family and some of their history. This was not completed in this case. If the history had been known, it is more likely that a different inference would have been given to the current information reported in relation to the children of MZ and FZ.

301. By the time the initial assessment was completed there had already been prior referrals from probation and midwifery services that included concerns about domestic violence and use of drugs. Additionally, if historical checks had been completed there was a relevant history of childhood abuse and trauma in both parents' childhoods available in archived paper records rather than stored in the current electronic systems, and aspects of their current lifestyle that also deserved more detailed, reflective and sceptical exploration. It was the second strategy meeting after the death of Child Z that identified learning difficulties, the history of self-harm by both parents and the level of offending by FZ both historically and recently.

302. The records were not checked and the consequence was that FN1 (who was already convinced MZ could parent) and the social worker (who considered this was a case that did not involve an identifiable risk of injury and significant harm because the main presenting issue in the information passed through focussed on the delay in seeking medical attention for Sibling 1) were more reliant on what MZ wanted them to hear or discover through the assessment.

303. MZ was motivated to minimise any reason for concern and therefore continuing involvement by a service such as CSC. Therefore she was allowed to offer reassurance for example on why the house was in the condition it was because she had been ill and 'was a bit behind'. MZ had the motivation to divert attention and the professional mindset was such that it lacked enough sceptical curiosity and challenge

to see behind the information being presented in words and behaviour. FN1 was also clearly working hard to maintain a relationship with MZ and in retrospect this probably deserved more exploration in professional supervision.

304. The CSC IMR identifies a number of learning points from their examination of the assessment for the serious case review. This included the absence of historical checks, not recognising the indicators of inappropriate care such MZ's reference to allowing Sibling 1 to go up and down stairs and playing on their own in their bedroom and the physical conditions throughout the house.

305. There is a phrase that is often used in multi-agency discussion that centres on trying to understand what is 'good enough parenting'. Consideration has also been given to the fact that MZ and FZ lived in a community where some aspects of their lifestyle were not unusual in matters such as a toleration of substance use. Difficult judgements also need to distinguish between people trying to overcome poverty and the contrast with behaviour that is neglectful and abusive to children.

306. In this case it is known that FN1 believed that MZ was capable of providing good enough parenting and had been influential in how an earlier referral had been managed and persuading CSC that an initial assessment would be unhelpful. It seems clear that a great deal of this judgement was a reflection as to how MZ responded to the FNP structure which was not risk based.

307. FZ was not present for the assessment interview; no tools were used to explore issues such as the use of drugs or the quality of emotional care and attachment process with the children. The result of the assessment was that no further action was required; the reasoning was that there had been no previous CSC involvement (which was not correct as far as historical childhood contact with MZ and FZ was concerned); that other services such as the FNP were already involved and reassurance had been taken from the way MZ had responded during the single visit. MZ did not want further help and involvement and both professionals identified no reason to take a more assertive approach. There was little recorded about the interaction between MZ and her children although tellingly one of the children was only dressed in a nappy during the visit.

308. Although there are clear and validated reasons about why early years, health and social care professionals in particular should give sufficient attention to historical information about families where pregnancy and young children are concerned, this continues to be an area of practice that is highlighted frequently in child deaths and serious case reviews as requiring more development.

309. The serious injury and killing of children is rarely a predictable event. There are factors that can indicate a child might be more vulnerable to neglect or significant harm through the interplay of underlying and often overlooked factors that have their origins in personal and family history. This does not mean that where such factors are recognised it should lead to parents being suspected or accused of harming their children but rather should alert and provoke a higher level of informed

and sceptical curiosity that is respectful and persistent. This is difficult when individual professionals are managing complex workloads and need to prioritise according to what they see to be the more urgent situations.

310. The factors that are identified in research as being likely to be found in the maltreatment of children rely on sufficient attention being paid to history rather than waiting for a defining event to occur such as an injury to the child. The factors relevant to this case include the following:

a) Isolated parents who have little or no extended family capable of providing good emotional and practical support or have other forms of support available for example from a community or faith based group; in this case FZ had very limited family support which was characterised by violence and some professionals may have been over optimistic about the quality of family support that was available to MZ;

b) A history of being abused or rejected as children or having multiple changes of carers; FZ's history is especially relevant and there are gaps in regard to MZ; there is a dearth of family and social history although the initial assessment established that neither parent was close to their respective families despite living nearby and appeared to be socially isolated;

c) Mental illness, personality disorder and/or a learning disability/difficulties; these are often not recognised or diagnosed and in this case there was no evidence of information being sought from the parents or elsewhere; the education history in respect of both being young parents (and therefore had left school relatively recently) was not sought to establish if there was any evidence of special educational needs when they were at school;

d) Particular vulnerability if there is no other parent or extended family member available to share parenting (that becomes exacerbated if a child is hard to parent which does not appear to been the case for Child Z or Sibling 1); it was unclear to what extent FZ was a member of the household for several months; MZ had the sole tenancy on properties and after Child Z had died FZ was said to be still living at a different address (Address 5);

e) There is reliance on alcohol or drugs and the parents do not accept they need to control it; FZ had a historical and problematic use of alcohol and drugs and continued to use skunk cannabis; there is no evidence of enquiry about his use of substances except by PO1 and similarly no enquiry regarding MZ; this is an area of practice that is frequently not managed well by any professional group outside of specialist services and was a theme in recent serious cases in other areas;

f) There is a history of aggressive outbursts and a record of violence including intimate partner violence; FZ's record of violence was known to PO1 and was included in the first referral to CSC; no inquiries were made with the police who had information about violence in the relationship between FZ and MZ which had not been shared with CSC in spite of it occurring when MZ was pregnant;

g) There is a history of obsession/very controlling personalities often associated with low self-esteem; FZ's history and his childhood trauma of maternal death were all factors that were not looked at and the implications for his sense of identity and self-worth;

h) There is fear of stigma or suspicion about statutory services; this is a frequent and unrecognised factor in interaction between professionals and families and in this case there was clear evidence for example in the response from FN1 to the first referral to CSC and her expressed concerns of involving services such as CSC; it has implications for how parents will seek to present themselves and want to manage information that minimises the motivation and reasons for key professionals to become more curious and further involved when it is not welcomed.

311. It is apparent that these factors to varying degrees were present in this case but either went unrecognised or individual practitioners were misdirected by a false sense of reassurance. On two occasions MZ had scored towards the higher end of the Hospital Anxiety and Depression Scale (HADS) but this was not followed up. The injury to FZ's hand in March 2011 required specialist plastic surgery indicating a significant injury that was also not enquired into. A similar lack of curiosity applied in respect of evidence of cannabis use and domestic abuse.

312. In addition to these factors that are indicators for enhanced historical curiosity, there are specific areas that a competent parenting assessment would give attention to and requires sufficient historical inquiry; this includes for example the style of attachment experience that parents had as a child and therefore bring to their own parenting. In services that were busy and professionals have busy and challenging workloads, there was insufficient attention to challenging an over reliance on observed behaviour to make important judgments and decisions.

TOR 3 Multi-agency recognition and response to neglect

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.

313. The HOR comments that there was evidence of potential neglect from the first pregnancy when there were several missed appointments for antenatal care. The

author of the HOR and of this overview report was struck by how the IMRs give an impression of key professionals 'treading softly' in trying to encourage a better level of engagement by a young parent and were cautious about adopting a more assertive strategy that focussed on the implications for the unborn child.

314. This is a theme explored in the final chapter of this report; it is an area of practice that represents a challenge for most professionals who will be mindful that the greatest potential for effective help is developing a relationship that encourages trust and openness. In this particular case there was an improved level of engagement after the birth of Sibling 1 which was regarded as progress particularly by FNP1.

315. It is not apparent that the health and social care professionals anticipated that neglect might be a factor in this family. The absence of such anticipation or hypothesis means that the patterns of cumulative concerns are less likely to be identified. The family were regarded as having money problems and clearly there was a toleration of dirty and chaotic domestic conditions. Neglect is a pattern of behaviour which by its nature may not look significant unless underlying patterns are identified and there is sufficient focus and understanding about how severe neglect has adverse effects on for example children's ability to form attachments and can significantly impair physical growth and intellectual development.

316. The impact of physical and emotional neglect has only recently become much more understood especially in relation to preschool children. Physical and emotional neglect has profound risk for issues such as brain development, physical growth and health and the development of cognitive and language skills of children. These have short and longer term implications for children.

317. The recognition and assessment of neglect has been problematic for professional practice across all disciplines and is one of the single greatest challenges for single and multi-agency work. There are problems in arriving at working frameworks of definition that can help professionals from different backgrounds to communicate meaningfully. For example, a health professional may have a very clear theoretical and clinical understanding about the future implications of neglectful care that is not as well understood by other professionals or it may be that professionals have different views about what constitutes harmful neglect.

318. There are profound ethical dilemmas and conflicts that confront professionals; for example wanting to avoid discriminatory practice that penalises a family living in poverty especially in communities that are dealing with widespread deprivation and social challenges. Distinction has to made between material poverty and disadvantage for example, and evidence of emotional neglect. Additionally, neglect relies on being able to discover the patterns associated with neglectful parenting behaviour and giving proper inference to issues of lifestyle.

319. It is also about understanding the significance of adult behaviour for the well-being of the children. The HOR highlights for example how MZ's decision to take her own discharge from hospital after the birth of Sibling 1 was an example of putting her own

needs ahead of her baby's. There were other examples of similar behaviour in regard to missed appointments and waiting for treatment.

320. The fact that the regional ambulance service made one of the referrals about the evidence of neglect when they went to the house in June 2011 prompted particular reflection by the panel. It is relatively unusual for the ambulance service to make a referral and by inference suggested there was a significant set of issues to be explored.

321. There were specific challenges facing this family for example in regard to their housing. It remained unclear when and whether FZ and MZ were sharing a household. MZ lived in two properties that had problems. In the last but one property that was privately owned the property was in a state of considerable disrepair and from evidence in the police records MZ had difficulties with the landlord.

322. The identification of neglect requires a good deal of self-confidence on the part of practitioners working with families living in very challenging circumstances who have the capacity and time to spend with parents and children. They also need to have access to and an understanding of relevant tools and analytical techniques or frameworks that can give greater confidence in distinguishing between what might be isolated patterns of inadequate emotional or physical care and the more damaging and persistent underlying patterns associated with neglect. It requires a clear and consistent focus on what is happening to the child in terms of their emotional and physical development and can also develop an understanding about the particular resilience of specific children and their families. Working with neglect is not about the application of a restrictive template of standards although it has to recognise that children have essential rights to a minimum level of care and nurturing.

323. The barriers that confront effective interaction between professionals and parents and their children are becoming better understood. It is not good enough to rely on the observed behaviour of a parent during short interviews or other activity or on their asserted intentions of behaving differently when confronted over individual episodes of inappropriate behaviour. In this case, FZ was never interviewed in regard to his role as a parent or the risks that his history and lifestyle represented to his children. That risk came from his capacity for violence as well as the implied violence to be inferred from the reports of attempted break in to the property and the discovery of weapons in the house.

324. None of the IMR authors described any recognisable tools or frameworks for collating information about neglect or arrangements for inferring and analysing the significance for the children. The only tool or framework that is described related to FNP that had a distinct and different purpose in motivating and reinforcing the strengths based approach to working with parents. In this case, it was unable to recognise emerging patterns that required consideration as to whether the approach was sufficient.

325. Care is needed in being overly critical, recent national studies describe the problems of developing such material and ascribing too much reliability. It is not the tools that can produce the right judgments; it is the training and emotional intelligence and aptitude of the practitioners applying themselves to more structured and analytical supervision and multi-agency discussion that is more likely to minimise the reliance on simply trying to guess what might be important. It also creates the conditions in which the resolve, motivation and capability of an adult to parents is more likely to occur; asking and exploring for example what the significance of the children were to both MZ and to FZ.

TOR 4 Quality of communication and working in partnership

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.

326. This section of the report invites reflection as to whether communication was good enough to encourage the well-being of both children and the extent to which assumptions were made about the role of different services. Comment has already been made about the influence of mind-set and relying on what MZ in particular was saying rather than paying more attention and inference to other evidence contained in referrals, historical records if they had been checked as well as the observation of physical standards and care.

327. The quality of information sharing and communication are frequently an area of particular difficulty identified in serious case reviews, it would therefore be surprising if there was not learning to be examined in this case about how different people processed information as it was transferred between different services and work locations.

328. The importance of early identification of vulnerability in relation to new parents in particular has been commented upon in previous sections. There will be opportunities for discrete professional groups such as GPs and midwifery services to revisit the expectations and accepted practice that applies for example in the very early stages of pregnancy to gather enough information at the outset about the circumstances of the pregnancy and the parents.

329. In this particular case, very little information was gathered about FZ at the outset and he remained largely invisible throughout the time period examined by this review. It is significant that the GP practice was not aware of the involvement of the FNP. The practice had been sent a letter when MZ first enrolled on the programme. This information was lost when she changed GP and there was no further attempt to communicate with the GP.

330. The HOR comments that that it was notable that there was a lack of important information sharing within the health community as well as between health and other services. In particular, the GP had significant information, historical and current, that was not accessed by other services during enquiries and assessment, and FN1 generally worked in isolation from other services that included the GP.

331. PO1 was the first professional to query whether there were risks associated with FZ in particular. PO1 appropriately checked with FRT to establish whether there was any current CSC involvement with the family. When it was established there was none, the response was to make a referral for a pre-birth assessment. The request for a pre-birth assessment has to be placed within some organisational context; in Manchester the FRT are dealing with in excess of 16,000 contacts each year. Inevitably, the service will be applying a risk assessed approach to that volume of enquiry and this will be reliant on the information provided from the person making the referral as well as completing sufficient checks to each individual contact.

332. A further important distinction is that for FRT and CSC generally, the decision as to whether information coming into the service is a contact (providing information for example) or a referral rests with FRT. It is FRT who decide that the information is being managed as a referral and therefore requires further enquiry and assessment.

333. For the probation service there are two main areas for learning identified. The first is that a CAF could have strengthened the range of information that could have been included in a referral to FRT if efforts to deliver support had proved insufficient. It would have been a vehicle for sharing information from the criminal justice system and primary and midwifery services and given a more informed picture of the range of need and risk associated with the family.

334. Secondly, the fact that PO1 was not yet qualified and there was a lack of supervisory oversight are other contributory factors identified by the IMR rather than a lack of capacity or will for the service to engage with the CAF process. When a decision to compete a CAF in late 2010 was made, the opportunity was lost when MZ effectively withdrew from contact with services. When contact was re-established, the plan was not followed through possibly arising through a concern that it would discourage MZ from engaging with the FNP In particular.

335. The fact that PO1 did not follow up with any challenge to the absence of further assessment by FRT was probably a reflection that reassurance was taken by both PO1 and FRT that the midwifery service would alert CSC if there were any cause for additional concern. This is not an unusual approach in cases that do not have a compelling and visible level of risk needing to be addressed.

336. The referral in June 2011 from the North West Ambulance Service(NWAS) to FRT raised concerns about the physical conditions in the home and the emotional care of Sibling 1. The discussion with FN1 provided reassurance that MZ was engaging with the FNP and her concerns if CSC visited reflected a range of assumptions on the part of both services; that FN1 was in a position to objectively comment about evidence

of neglect and the assumption that CSC did not have the capacity to respond to MZ's anxieties and concerns.

337. The response in June 2012 following the referral from the EDN following FZ's presentation in the hospital emergency service with Sibling 1 resulted in the initial assessment that recommended no further action by CSC. It is explicitly recorded that one of the reasons for no further action was the involvement of other services although this relied on MZ both continuing to allow contact by FN1 in particular and that the contact was addressing the indicators of neglect and risk. This was not happening and because of the manner in which the assessment was completed these factors were not identified and therefore recognised.

338. The family faced considerable practical difficulties in regard to their housing and in particular the issue in respect of the malfunctioning shower. There was a considerable level of communication by phone, letter and email from different professionals about this although it was some months before the matter was resolved.

339. Although the housing provider accurately describes the legal position whereby MZ took on a tenancy knowing for example about the absence of a bath, there appeared to be reluctance to acknowledge her desperation at the time to secure a home and that her circumstances had changed with the birth of Child Z and practical problems that confronted MZ in bathing her two very young children; this did not help a situation where the standards of cleanliness in the house were clearly an issue. The matter was only resolved when the surveyor condemned the condition of the shower as being uneconomic to repair.

TOR 5 Quality of inter-agency response to specific incidents or information of concern

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.

340. The episodes of concern that were identified during the timeframe for the review were never considered within the framework of the child protection procedures. The reasons for this have been described and analysed in other sections of the report.

341. PO1 had thought a pre-birth assessment was required when MZ was pregnant with Sibling 1 but this was not seen to be necessary by other services. When MZ told Connexions that she had become homeless when her family told her to leave when she was three months pregnant this did not result in contact or referral to CSC or the completion of a Connexions assessment. This was a departure from agency standards and practice.

342. Referrals from the ambulance service and the hospital emergency department were not escalated and the police did not make any referral to CSC in regard to the

domestic violence. The single most significant consequence is that information was never collated in any form of multi-agency discussion and analysis.

343. Although it is correct to assert that keeping children safe does not just rely on the application of the specific protocols developed by the MSCB and in current national guidance and standards, the significance of framing concerns as having the potential to cause significant harm for children provides a focus on identifying the significance of different information and ensuring that all services contribute and share information.

344. The single largest gap in the case is that it was not until the death of Child Z and the convening of a strategy meeting under the MSCB protocols that there had been any multi agency meeting to share and consider the significance of different information. Until that point, although information was being shared, the outcomes were largely reliant upon the decision making within single agencies and often relied on the inference and interpretation given by professionals working within the silos of their own discipline in too much isolation from each other's sources of information and analytical perspective.

345. The consequence was that any gaps or misdirection in the information was not identified until this review began collating information and subjecting it to analysis by the review panel.

346. Although the serious injury and killing of children is rarely a predictable event, there are factors that can indicate a child might be vulnerable to neglect or significant harm through the interplay of underlying and often overlooked factors that have their origins in personal and family history.

347. This does not mean that where such factors are recognised it should lead to parents being suspected or accused of harming their children but rather should alert and provoke a higher level of informed and sceptical curiosity that is appropriately persistent. This is more likely to occur if there has been an opportunity to share information and to provide respectful and informed challenge. It is especially important when services and people feel under pressure and are having to manage difficult workload demands.

TOR 6 How information about the family's more general circumstances was considered

The extent to which 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 the impact upon agencies assessment and service delivery

348. The IMRs generally acknowledge that although individual professionals were appropriately sensitive and respectful to MZ who was the main point of contact, there was less attention given to the fact that MZ and FZ were relatively isolated from their families and within their community.

349. It has become more apparent that learning difficulties were a factor; the police recognised this at an early stage in the criminal investigation by arranging for appropriate adults to be part of the interviews with both parents. Only PO1 identified any degree of difficulty when FZ's dyslexia was recognised and had implications for FZ's self-confidence and willingness to commit to support from other services trying to help him gain employment and to address his difficulties in relation to his use of alcohol and drugs.

350. The risk factors associated with aspects of FZ's lifestyle in particular did not attract sufficient attention; the continuing evidence of cannabis use, his capacity for violence in and outside the household and the implications of his criminal activity on the safety of the household were not sufficiently recognised at the time.

351. Issues such as illicit substance misuse can present ethical and professional dilemmas for individual practitioners. An implied tolerance of issues such as cannabis use can reflect an individual professional feeling empathetic to the difficulties facing an adult and a misunderstanding about the potential risks for example to the care of very young children. There will also be additional concerns for example in wanting to establish and sustain relationship with adults who have shown a reluctance to maintain contact. A health or social care professional will know that establishing the trust and confidence of a parent is the foundation for developing a more open line of communication where the adult is willing to disclose and talk about the real concerns and troubles that they want to keep hidden.

3 Analysis of key themes for learning from the case and recommendations

352. This report begins with an acknowledgment of the imminent changes that will take place over the forthcoming months in the conduct of serious case reviews throughout England. These changes are driven by the recognition that for any meaningful analysis of the complex human interactions and decision making processes that are involved in multiagency work with vulnerable families has to understand why things happen and the extent to which the local systems (people, processes, organisations) help or hinder effective work within 'the tunnel'[23].

353. In this chapter the panel set out key findings that are designed to offer challenge and reflection for the LSCB and partners. The emphasis is not on the more traditional articulation of SMART recommendations. The key findings are framed using a systems based typology developed by SCIE. Although this serious case review has not used systems learning to collate evidence there is value in using the following framework to identify some of the underlying patterns that appear to be significant for local practice in Manchester whilst accepting there are some limitations and mismatch between how the evidence has been collated and this form of presenting the key findings:

a) Innate human biases (cognitive and emotional)
b) Family-professional interaction
c) Responses to incidents
d) Longer term work
e) Tools
f) Management systems.

354. The remainder of this report aims to use this particular case, and to reflect on what this reveals about gaps and inadequacies in the local child protection system and use it as a limited window into the local systems.

355. In providing the reflections and challenges to the LSCB there is an expectation that the Board will provide a response to each of the key findings as well as to the recommendations and action plans that are described in the IMRs. As far as the key findings described in the remainder of this chapter it is anticipated that the Board will take the following action:

LSCB response:

a) Does the Board accept the finding?

b) How is the Board to take this forward? If not, please explain why.

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

c) Who is best placed to do this?

d) What are the timescales for response?

e) How and when will it be reported?

356. The LSCB will determine how this information is managed and communicated to relevant stakeholders. This report recommends that the LSCB discuss the key findings and make a formal response that is also published.

3.1 Learning from Previous Serious Case Reviews

357. The LSCB in Manchester had undertaken ten serious case reviews between 2007 and 2010.

358. Reference to the evidence from serious case reviews has been made throughout the IMRs, the Health Overview Report (HOR) and this Overview Report.

3.2 Innate Human Biases (cognitive and emotional)

Human 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.

359. The circumstances of MZ in particular provoked an empathetic response in the professionals working with her and were most evident for the individuals who had very extensive contact and personal commitment to helping the family. The importance of making an emotional connection between the people needing help and the person providing support is very well understood as a foundation for developing a relationship of trust and was in evidence for example in how FN1 worked with the family and MZ especially.

360. It is part of the emotional foundation described by Ferguson[24] for exercising good authority. He describes the complexity of cognitive influences, systems and processes and understanding the significance of the factors that are linked to increased harm; recognising the families who through their history as well as immediate circumstances, are likely to have less resilience to face events that can derail them; how this relies on professionals having the capacity and aptitude to develop appropriate relationships with the family that goes beyond relying on empathetic support.

361. There were several examples of individual professionals wanting to help MZ and FZ translate their stated intentions to create better childhoods for their children than

[24] *Child Protection Practice*; Palgrave Macmillan; 2011.

had been possible for them although they faced considerable difficulty in seeing the intention translated into tangible outcomes.

362. A common thread through this case is that none of the individual professionals had an entirely satisfactory knowledge of either parent's history. This inevitably made the professionals more reliant on processing information from their direct observation and contact on the basis of what either parent told them. The report has highlighted in previous sections how information was minimised, omitted or simply not factually correct on regular occasions with the apparent intent to redirect professional attention. This is behaviour that is identified very often in reviews such as this.

363. The only professional who had a better level of historical information as it related to FZ was PO1 who initially asked for a pre-birth assessment to be completed. This did not happen and neither did a CAF take place. Contributory factors to that particular aspect of the case included the fact that PO1 was in training and therefore did not have the status and confidence that could be expected from a fully qualified practitioner. The case coincided with a period when the probation service was under significant local organisational stress and the availability of supervision and management oversight was not as clear as would more normally be achieved.

364. The most significant professional involved with the family was FN1 who clearly worked with great persistence and dedication to develop a relationship and implement a validated programme of support and parent training that had the potential to secure improved outcomes for Child Z and Sibling 1.

365. In developing that relationship and implementing that programme it appears that a prevailing mind-set had developed that believed MZ and FZ had the capacity to parent their children to a good enough standard. Influential in that judgment was how MZ in particular interacted with FN1. For example, FN1 did not contradict concerns directly on the occasions that were raised, for example in regard to the referral from the hospital, but instead were subjected to an acknowledgment of the issue, an explanation about why standards had not been achieved for example in regard to aspects of cleaning and a commitment to do better and to get on top of things. FN1 believed that MZ and FZ could make their parenting better than they had experienced as children.

366. With hindsight it is possible to query the foundation of evidence that was available to the professionals who had the most influential roles in the case. This is not to personalise around single professionals but was a general theme.

367. There is evidence that professionals for a variety of reasons tolerated or overlooked aspects of lifestyle and behaviour. The FN1 was influential in how other services such as CSC conducted their enquiries; for example expressing concerns about the impact on MZ of involvement by CSC; both services missed evidence of neglectful parenting and did not provide enough challenge about the chaos and dirt in the house. Some of the practitioners were shown copies of the photographs that were taken in the house on the day that Child Z had died; some dispute that the

conditions were as poor during their visits to the home although the panel retain a more sceptical view that the conditions were representative of longer term difficulties.

368. Some professionals knew that FZ was a habitual user of cannabis although with some exceptions, very little enquiry or challenge was made regarding his use. Some of that probably reflects the fact that in some areas the use of substances such as cannabis is part of the routine background to daily life.

Issues for consideration by the LSCB

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?

3.3 Responses to incidents or information

Effective enquiries and management of information have to identify the relevant underlying patterns of behaviour, inconsistencies and inherent factors of vulnerability of risk.

369. The first chapter of this report identified five episodes that the panel have examined in particular for the purpose of looking for learning opportunities from this case; four episodes concern referrals that could have been opportunities for more effective enquiry that could have included the use of CAF.

370. The first was a request for a pre-birth assessment that was diverted to the midwifery service as a case for the Vulnerable Babies Service; it did not address the underlying reasons for the concerns being raised. The report has also highlighted that a CAF could have provided an opportunity for enquiry and sharing of information. The report has highlighted that a combination of factors had an impact on that first occasion that included the inability of the FRT electronic system at the time to identify historical archived information, through to the relative inexperience of PO1 who was working with reduced levels of supervision support and oversight due to organisational problems at the time.

371. The second episode that involved the police having a disclosure of domestic abuse over several months and involving a pregnant teenager was not referred to CSC. There was a mistaken belief that information just went to health and at the time was transmitted via a fax that left no audit trail of who actually received the information or what was done with it. The incident represented a safeguarding concern for both MZ and the unborn child and about which CSC remained unaware until this SCR. The Police Officer who dealt with the incident displayed an appropriate concern and focus on offering protection to MZ who declined to make a formal criminal complaint against her partner. As on the first occasion an opportunity to identify significant underlying patterns of concerns was missed by systems of information sharing not working effectively. Matters were compounded by incomplete checks and enquiries with other services.

372. In June 2011 when the ambulance service made a referral in relation to neglect was a third opportunity to make formal enquiries. Although this did result in a home visit taking place it did not involve CSC who were persuaded perhaps too readily that FN1 could follow this up. Analysis in regard to the cognitive and mindset influences has identified the conditions within which the information provided by the ambulance crew was downgraded rather than being seen as an unusual source of referral.

373. The fourth occasion was the referral from the hospital emergency department that was also indicating neglect as well as for the time describing a physical injury to one of the children. Although the referral was followed up through a joint visit to the home, the visit lacked sufficient focus on the information provided. Again this was for a number of different reasons that included some aspects of the referral not being made clear in the transfer of information from FRT to the neighbourhood team; assumptions being made that the child had been subject of a medical examination and by implication in the absence of any diagnosis of abuse there was a lower level of concern; and the interaction between MZ and a more trusted professional who had confidence and belief in the capacity of the parents to look after their children.

374. The influence of hindsight that can have an impact on a review such as this can make this sequence of opportunities look more obvious than they were in reality at the time for the people dealing with information and events. Although PO1 had felt there was a degree of concern to justify a pre-birth assessment this was on the basis of wanting to discover more information rather than being certain and definite about the degree of risk or otherwise to the unborn baby.

375. This could have been addressed through a CAF and would have been the basis of more information for further contact with services such as CSC. The involvement of services such as the FNP apparently provided a good deal of reassurance to several people. The ambulance referral was not regarded as being a significant concern.

376. All of this reflects the lessons that come through often, that it is not individual incidents or events that are significant but rather the ability to place them within a context. That context has to include sufficient knowledge about the history of parents or significant adults as well as linking current and recent events in a

meaningful chronology and narrative that focuses on what the implications are for the child.

377. It requires triangulation of direct observation of attitude, behaviour and lifestyle, checking for relevant historical information within which to place current information and analysis, together with appropriate and proportionate discussion with third party professionals in respect of information and perspectives they may have.

Issues for consideration by the LSCB

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?

3.4 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.

378. The influence of empathy that is highlighted in regard to the emotional response to MZ and FZ's circumstances have implications for longer term work with parents with longstanding challenges that arise from health, lifestyle and social circumstances.

379. For the professionals working with families facing high levels of complex needs and difficulty it can be the case that the problems of the family overwhelm everybody. This can be a reason why families can believe there is no point reopening a discussion about particular problems such as anger management or domestic abuse for example, as much as the professionals wanting to believe optimistic statements that previous interventions have addressed problems. In this case, there was reference to FZ having done work in relation to anger management although little detail was sought in regard to what had actually been achieved or to meaningfully understand whether it had been successful.

380. There were several longer term issues that were apparently given cursory attention. This included the evidence of very poor home conditions; the panel were generally dismayed by the photographic evidence of the house on the day that Child Z died and had difficulty reconciling this with the information provided through IMRs that acknowledged clutter and some lack of cleanliness but did not resonate with the evidence of long term squalor and neglect represented in the photographic evidence.

381. Because of the current methodology of reviews there is some limitation on how far a report such as this can truly understand the systemic influences operating on

practitioners and families such as Child Z. It is possible to say that evidence from this and other reviews do identify how long term and chronic problems and needs represent a challenge to the professionals achieving and sustaining an effective role and influence.

382. Other factors such as the long term substance misuse, offending and the evidence of weapons in the home were not identified as factors to be addressed. In this particular case, there was the additional factor of a specific model of intervention through the FNP and the perception that other services had of this, that probably had an influence in how these aspects of case management were handled.

Issue for consideration by the LSCB

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?

3.5 Tools

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.

383. An important aspect of this particular review is the use of the FNP and some of the possibly unintended consequences that have applied. The FNP and probation service used tools to underpin their ongoing work and were primarily focussed on current circumstances. In Probation there was an assessment of risk presented by FZ which supported the initial referral to CSC. The FNP deployed a framework designed to strengthen the parenting capacity and capability of MZ in particular but was not rooted in any knowledge about the history and experience of either parent.

384. The FNP is an important aspect of the local frameworks of services that are being implemented across health and social care services in Manchester and England more generally.

385. The report has described some of the incorrect inferences that were applied to the FNP and to other programmes such as the Vulnerable Babies Service. There has been a degree of reassurance taken from the fact that the FNP had been apparently accepted by the family and that it was going to be addressing the issues being highlighted in referrals and contacts with services such as CSC.

386. In reality there was some doubt about the extent to which the FNP was accepted by the family in spite of the very considerable effort by FN1 to achieve this. The panel have noted that FN1 showed persistence in keeping contact with MZ in particular. FN1 was successful in being allowed to resume contact with MZ after she moved although may have developed a misplaced confidence that the parents were accepting of the contact. Much of this appears to have relied on the parents (MZ in

particular) expressing a commitment to follow up advice such as improving the standards of hygiene. In reality, there is evidence that very little of the advice appeared to be effective in changing conditions.

387. The FNP follows a structured programme which did not appear to be sufficiently adapted in this instance to a family that was experiencing high levels of disruption and chaos. The insecurity of the family's housing, the difficulties of the broken shower in addition to the other problems discussed in previous sections were not directly inquired into and assessed in terms of risk for the children.

388. The clarification through the review that the allocation of FNP had never reflected a particular assessment of level of need within this family, over and above the fact that MZ was a first time teenage mother at the time of referral, provided a stark contrast to the assumptions that had apparently been made by various professionals.

389. A lesson from this review is that the use of a strengths based approach to increasing the quality and capacity of parenting skills in particular families has to give some cognisance to the circumstances, motivation and ability of the family to use such an approach. It also has to ensure that the effectiveness of the programme is being examined in respect of benefits and outcomes for the child.

390. In regard to the statutory assessment it is not apparent that any other tools or frameworks were used to analyse issues such as the parenting capacity of MZ and FZ (possibly because it was assumed this was being done by the FNP), there was no recognition and therefore analysis about the quality of emotional as well physical care of the children. There was no evidence of any common framework or tool such as the graded care profile to help collate and analyse information about neglect.

Issues for consideration by the LSCB

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?

3.6 Management systems

The implementation of new or revised working arrangements and information systems can represent additional barriers to effective information searches, collation and analysis.

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

392. The response by FRT in respect of contacts from PO1, the ambulance service and the hospital emergency department were all unable to identify that there had been relevant historical involvement. Access to supervision and oversight for PO1 had been affected by organisational workforce problems and the sharing of information by the Police in regard to the domestic abuse was hindered by working practices that have since been changed.

393. A significant part of this final chapter of the report has reflected upon the challenge of implementing new programmes and ensuring that they do not misdirect practitioners and their purpose is sufficiently well understood by the relevant services. False assumptions were made about the FNP and the Vulnerable Babies Service.

Issue for consideration by the LSCB

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?

Supervision and semi-structured peer discussion does not yet provide sufficient opportunity to deal with the ethical and legal complexities associated with more marginal lifestyles.

394. The panel were concerned that this case appears to indicate a degree of tolerance being exhibited in issues such as the use of cannabis and the degree of cleanliness.

395. The reality for many of the professionals in this case is that they will be working with families in some of the most challenging of social and economic circumstances. Listening to adults who want to overcome their problems can invoke a mindset that is less challenging of contradictory evidence or aspects of lifestyle such as the use of cannabis and alcohol.

396. For practitioners who are trying to work on the longer term achievement of change with families, they face the juxtaposition of trying to gain the engagement and confidence of adults who through their personal history and circumstances are mistrustful and at the same time have to confront behaviours and lifestyles that are detrimental to children.

397. Knowing when and how to respond comes with experience and professional self-confidence. It is less developed in professionals who are not so established in their professional roles.

398. Practitioners have access to and be required to participate in supervision and discussion that can offer the degree of critical challenge and purposeful reflection that goes beyond compliance with protocol and develops greater resilience and resistance to the dangers of normalising or minimising evidence and information.

Issue for consideration by the LSCB

1) 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?

3.7 Issues for national policy

399. The development of the Family Nurse Partnership is an important aspect of national policy. On the 4th April 2013 the Health Minister announced that 16,000 of the most disadvantaged new parents in the country will be offered tailored help and support from a specialist nurse by 2015. This means many more vulnerable children across the country will get early support for a better start in life. Initial research in England has found that mothers who receive support from family nurses show positive results.

400. This review has highlighted the importance of local areas developing a robust understanding of FNP and giving clear consideration, through the recommended FNP Advisory Boards, of the ways in which they will integrate national implementation and clinical guidance within local policy and practice. This includes initiatives such as the FNP being linked effectively with other local services and ensuring that practitioners have a clear understanding about when to consult and make referrals to other services.

401. The review also raises a challenge in how the methodology and evaluation of such programmes is understood. A simplistic, deterministic belief in the veracity of a proven framework can encourage misdirection away from evidence of need or an inadequate assessment of the extent to which risk factors are being addressed through change or improvements in the family. This has implications for the level of information that is exchanged between agencies in regard to issues such as personal and family history, the continual development of a supervision model within the programme which encourages critical reflections and an implementation context which ensures that local processes support expert practice. This should ensure that practitioners are able to continue to have an approach of respectful curiosity in regard to all aspects of the family's life and keep the child at the centre of their work.

Peter Maddocks, CQSW, MA.
Independent author
August 2013

Signed

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

20th August 2013

4 APPENDICES

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 Record Keeping Guidance (2011) with regards to father's health needs and other household 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.

Appendix 1 - Procedures and guidance relevant to this Serious Case Review

Legislation

The Children Act 1989

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

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

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

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

The Children Act 2004

Section 10 requires each local authority to make arrangements to promote co-operation between it, each of its relevant partners and such other persons or bodies, working with children in the authority's area, as the authority consider appropriate. The arrangements are to be made with a view to improving the wellbeing of children in the authority's area – which includes protection from harm or neglect alongside other outcomes. This section is the legislative basis for children's trusts arrangements.

Section 11 of the Children Act 2004 places a duty on the key people and bodies described in the Act[26] to make arrangements to ensure that their functions are discharged with regard to

---

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

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

the need to safeguard and promote the welfare of children. The application of this duty varies according to the nature of each agency and its particular functions. The Section 11 duty means that these key people and bodies must make arrangements to ensure that their functions are discharged having regard to the need to safeguard and promote the welfare of children and this includes any services that they contract out to others.

Safeguarding Procedures

The local safeguarding children procedures

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

Other local procedures relevant to this serious case review

National guidance[27]

Working Together to Safeguard Children 2013

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

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

The guidance in respect of *the Framework for the Assessment of Children in Need and their Families* is issued under section 7 of the Local Authority Social Services Act 1970 and is therefore mandatory.

The framework sets out the framework for ensuring a timely response and effective provision of services to children in need. It makes clear the importance of achieving improved outcomes for children through effective collaboration between practitioners and agencies. The framework sets out clear timescales for key activities. This includes making decisions on referrals within one working day, completing initial assessments within seven

[27] The election of a coalition government in May 2010 may result in changes to guidance and policy developed by the previous government.

working days and core assessments within 35 working days. As part of an initial assessment children should be seen and spoken with to ensure their feelings and wishes contribute to understanding how they are affected. If concerns regarding significant harm are identified they must be subject of a strategy discussion to co-ordinate information and plan enquiries. Child protection procedures must be followed.

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

Common Assessment Framework (CAF)

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

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

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

Glossary

A&E	Accident and Emergency
ADS	Addiction Dependency Solutions
CAF	Common Assessment Framework
CIN	Child in Need
CSC	Children's Social Care
CPP	Child Protection Plan
CPR	Cardiopulmonary Resuscitation
CMFT	Central Manchester Foundation Trust
CPC	Child Protection Conference
DVU	Domestic Violence Unit
EDN	Emergency Department Nurse
EDS / T	Emergency Duty Service / Team
FNP	Family Nurse Partnership
FRT	First Response Team (part of CSC)
GP	General Practitioner
GMWHMT	Greater Manchester West Mental Health Trust
HADQ/S	Hospital anxiety and depression questionnaire/Scale
HCPC	Health Care Profession Council
HOR	Health Overview Report
ICO	Interim Care Order
IMR	Individual Management Review (report)
LSCB	Local Safeguarding Children Board
MARAC	Multi Agency Risk Assessment Checklist
MSCB	Manchester Safeguarding Children Board
NFA	No further Action
NHS	National Health Service
NSPCC	National Society of the Prevention of Cruelty to Children
NWAS	North West Ambulance Service
OASys	Offender Assessment System (Probation)
PPOP	Police powers of protection
PPU	Police Protection Unit
PIPE	Partners In Parenting Education
SCIE	Social Care Institute for Excellence
SNF/SCF	Special Needs or Circumstances Form
SMART	Specific, Measurable, Achievable, Realistic, Timely
SUDC	Sudden Unexpected Death of Children
TPM	Teenage Pregnancy Midwife
UHSM	University Hospital South Manchester
VBS	Vulnerable Babies Service
WIC	Walk in Centre