Executive Summary of the Serious Case Review in respect of Child U

This report has been commissioned and prepared on behalf of Manchester Safeguarding Children Board and is available for publication on the 28th February 2013.

Until publication this report remains confidential and must not be shared with non-relevant parties in keeping with the MSCB Data Sharing Protocol.

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Mr I Rush

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1. Introduction

1.1 On the evening of 22nd September 2011, MU (mother of Child U) presented at the accident and emergency department of her local hospital with self inflicted injuries to her wrist and neck. MU was assessed at risk of further self harm, and was seen by an Emergency Medicine Registrar for assessment. MU informed medical staff that she had cut her wrists and ankle with a knife as she wanted to end her life; also that she had taken approximately ten paracetamol the previous night and drunk half a bottle of rum that day.
MU went on to say that she 'did what she did because it needed to be done', and that 'the system was corrupt; social workers were treating her badly and had taken her daughter'. When asked where her daughter was, MU informed medical staff that she was dead at home because she had suffocated her on Tuesday evening. The medical report noted that when disclosing her actions, MU showed no signs of regret and was very calm in her demeanour.

1.2 The police were contacted immediately and told of the information given by MU. The police attended the home address of Child U and MU urgently, and discovered the deceased body of a child, later confirmed to be Child U. Child U was four years and 9 months when she died.

1.3 Child U had been the subject of a multi agency Child Protection Plan at the point of her death.

1.4 MU was formally charged with the murder of Child U. She was detained in a secure mental health facility awaiting trial.

1.5 The Post mortem examination and investigations did not identify any natural conditions that could account for Child U's death; and it was noted that the circumstances described by MU provided a plausible account of how death occurred.

1.6 At Crown Court in November 2012, MU was deemed fit to enter a plea following a period of psychiatric treatment. MU pleaded not guilty to the murder of Child U, but guilty to manslaughter on the grounds of diminished responsibility. Both defence and prosecution Doctors were satisfied that MU was suffering from paranoid schizophrenia and had been at the time of the killing. MU was sentenced to a Hospital Order which is made when a person is convicted for a crime punishable by imprisonment and the Court is satisfied that the person is suffering from a mental disorder and, it is appropriate for them to be detained for medical treatment. In addition a Restriction Order was made for an indeterminate period of time which means that MU can only be released upon application to the Independent Mental Health Tribunal and application/ recommendation to the Ministry of Justice.

2. Methodology

2.1 A Serious Case Review Panel was established which comprised of the following people:
Independent SCR Chair, Mr David Hunter
Detective Sergeant, GMP Safeguarding Vulnerable Person Unit
Service Lead for Safeguarding, Manchester Children's Social Care (CSC)
Designated Nurse, NHS Manchester
Designated Doctor, NHS Manchester
Acting Business and Performance Manager, MSCB
Associate Director, Manchester Mental Health & Social Care Trust (MMHSCT)
Head of Operations, Sure Start and Early Years
Regional Director, Family Action
Group Chief Executive, Adactus Housing Association.

The Serious Case Review Panel met on nine occasions between January and October 2012.

2.2 An Independent Author Ms Colleen Murphy was appointed to write an Overview Report on the process and findings of the Serious Case Review.

2.3 The key lines of enquiry for the Serious Case Review were as follows:

The timeframe for the period of review is 3rd July 2008 and 22nd September 2011. This represents the period of time that statutory agencies became aware of a concern for Child U until the date of death.

1. How did agencies recognise and respond to sexually harmful behaviours and the potential impact on Child U and other children? Analysis to include adult & child's behaviour, comments, language & thoughts.
2. To what extent did assessment of mother's parenting take account of her behaviour towards Child U, other children, other adults, professionals and staff?
3. How did agencies concerns regarding mother's reported mental health issues inform the planning and safeguarding of Child U.
4. How holistic were agencies assessment of Child U's needs in relation to wider family and social isolation?
5. To what extent did agencies and services take account of issues such as: race and culture, language, age, disability, faith, gender, sexuality and economic status and how did this impact upon agencies assessment and service delivery?
6. What factors influenced the police decision to take Child U into police protection on 5th July 2009 and 13th October 2010?
7. To what extent were Child U's voice, wishes, feelings, behaviours and needs explored, understood and taken account of when making

decisions about the provision of services? Was this information recorded?

8. To what extent did agencies communicate effectively and work together to safeguard and promote the continued wellbeing of Child U?

2.4 The following agencies provided Individual Management Reports for consideration:

- Manchester Children's Social Care
- Manchester Early Years and Sure Start
- Greater Manchester Police
- Adactus Housing
- NHS Manchester
- Manchester Mental Health and Social Care Trust
- Central Manchester Foundation Trust.

Each IMR contained a chronology of agency contacts which was amalgamated to create a multi-agency chronology.

2.5 Alongside the SCR, there are two parallel processes that have occurred. Manchester Mental Health and Social Care Trust have conducted a Serious Untoward Incident Enquiry, the report from which was made available to the SCR panel. Additionally, the death of Child U has resulted in a murder charge against her mother, which was taken into account by the Serious Case Review Panel.

2.6 Each contributing agency has completed an Individual Management Review (IMR) with an understanding of the need to maximise independence and a desire to identify any learning opportunities. Authors engaged in the IMR process with rigour and critical honesty and for the purposes of the Serious Case Review this produced a good standard of draft reports. All IMR Authors attended a panel meeting to present their reports and the Serious Case Review Panel undertook constructive challenge of each IMR, in order to assist authors to reflect critically on the work undertaken by their agency and, where necessary, IMR authors redrafted their reports and recommendations. No panel members were involved in the writing of IMRs. This enabled an objective and challenging approach by the SCR panel.
The individual agency recommendations are attached as section six of this report.

2.7 Once all information was received, the SCR Panel considered that there was a need for specialist opinion from an Independent Psychiatrist to provide an informed and objective view of the possible contributory factors and mental health responses in relation to MU.
The panel posed the following questions for consideration and received a helpful and informative response.

- Review medical intervention and comment on whether the outcome of assessments were appropriate to the patient's history and presenting behaviours as reported by herself and others at that time?
- To what extent is it possible for a patient to mislead an assessment in this patient's circumstance?
- When the patient had a diagnosis in 2005: (1) what was the potential impact of her not receiving an ongoing service, (2) what was the likelihood of re-occurrence? (3) Should she have been reviewed during her period of medication?
- Given the patient's presentation, how can this behaviour be explained without the presence of mental illness? Can you give an indication whether cannabis use would offer explanation?
- What are the effects of ongoing cannabis use on mental health?
- Are there any indicators of the patient's behaviour that should have been seen as a risk to her child?

2.8 The Serious Case Review Panel (SCRP) gave careful consideration as to who should be consulted as part of the review from Child U's family. The SCRP was mindful that criminal charges were pending and the Acting MSCB Business and Performance Manager contacted the police in order to ascertain a view from the investigation officers and Crown Prosecution Service about the appropriateness of speaking with family members who could also be trial witnesses. The Panel was advised that it would not be appropriate to speak directly with trial witnesses, but that there were no objections to other family members. The Serious Case Review Panel had very limited information about the father of Child U (FU) and the Chair of the Panel made telephone contact with Child U's father who was living abroad. Child U's father considered that someone should have contacted him when Child U's mother needed help and he would have come to England and stated he did not know that there were problems which needed help. The panel intended if possible to speak with Child U's mother before any other family members, however, once the trial date was put back, and as she was a key witness, the SCR panel had to review the original intention to seek contribution from Child U's mother prior to any other family member. It was clear that there were significant gaps in understanding Child U's mother's personal life and relationships which would inhibit the analysis of trying to understand why she acted as she did. A decision was made to approach family members, who then helpfully contributed to the knowledge and understanding about Child U and her mother to assist the review.

3. Summary of Events

2008

3.1 Child U lived alone with her mother in a first floor flat. Up until the age of 18 months, Child U was known only to routine universal services. MU gave the impression that she was fairly isolated from her family. It is also known that she experienced some disharmony with her neighbours, and often reported incidents to Housing which she believed had been caused by a neighbour. Investigation of the incidents found no cause for concern.

3.2 In July 2008, a concerned member of MU's personal support network made contact with a community police officer to discuss concerns in relation to MU, and her view that she needed support. The concerns related to comments made by MU that her 18 month old daughter (Child U) wanted to have a sexual relationship with and that she (MU) was hearing voices.

3.3 The police made a referral to Children's Social Care. A strategy meeting and joint visit concluded that a mental health assessment should be arranged for MU. The pathway to achieving such an assessment proved problematic for the social worker to achieve, and ultimately MU was seen by an out of hours GP and assessed as not in need of an immediate mental health assessment, and that further medical input should be done through the routine GP. The social worker completed an Initial Assessment which recommended no further action, and the only subsequent medical follow up was by a health visitor. MU said she was more embarrassed than annoyed by the referral, stating that Child U was everything to her and she felt professional support groups had nothing to offer.

2009

3.4 In February MU began attending a local Sure Start Children's Centre. Records of her visits to the Centre indicate that she spoke a lot about God, and how God does not judge or punish. The Children's Centre contacted the Health Visitor as they were concerned about MU's behaviour to other parents which was experienced as rude, aggressive and on occasion prejudiced. The Health Visitor discussed the information with the GP and established that MU had not recently seen the GP but it was agreed that MU would be invited into the surgery to discuss a referral to psychiatry. When MU attended the surgery, Child U was reported as looking and interacting well with her mother. MU declined a referral to psychiatry but accepted that she had said inappropriate things to other mothers and would curb her tongue in future.

3.5 MU had expressed a desire to move home, and the Health Visitor wrote to her housing provider to support this. MU also asked the GP to send a letter to support this, but was recorded as abusive by the GP when discussing this

during a telephone conversation. However, when the Housing Association sent a medical assessment questionnaire to MU regarding application for medical priority, this was not completed and the application for medical priority was cancelled.

3.6 In July a maintenance operative undertaking routine housing repairs reported that MU had been aggressive towards him and that he was concerned about the way Child U was treated. This information was referred to Children's Social Care, stating concern for MU's mental state and a concern for how Child U was handled. There is no record of how this referral was responded to. Shortly after, MU attended a police station with Child U and said she was having arguments with her partner and no longer wanted to live with him. She told the officers that 'she began to hear the television laughing at her … FU became frustrated … and told her she was mad…' The Police Officers became concerned that MU said to Child U 'it's just me and you now; we will have to take each day as it comes and see how long we last. At least we know there is a place for us up there... .' The Police took MU to the hospital Emergency Department, and provided the history from the current and their previous involvement. MU was assessed by a Mental Health Liaison Nurse, it was concluded that there were no signs of mental illness, denial of auditory hallucinations or thoughts of suicide or self harm. During the episode police officers were concerned about aspects of MU's behaviour towards Child U, which was perceived as sexualised. Child U was placed in emergency foster care as the police exercised their powers of protection. During a joint visit between police and Children's Social Care the following day, MU denied saying 'there is a place up there for us' and it was agreed that Child U would return home whilst the Social Worker would conduct a core assessment. When Child U did return home, MU was concerned that she may have been sexually abused in foster care. A subsequent assessment by a Mental Health Social Worker and a Community Psychiatric Nurse (CPN) concluded that there was evidence of symptoms of mental disorder with overvalued ideation, delusions of reference and hypersensitivity to environmental dangers, however, that MU was not responding to hallucinations, thought blocking or formal thought disorder. MU declined any input from mental health services and it was agreed that as MU was not appropriate for services, therefore the referral was closed to mental health services. The Core Assessment was completed in August 2009, it did not fully explore family relationships, analyse need and risk yet on this basis the case was closed to Children's Social Care.

2010

3.7 Between May and July, the Children's Centre made three referrals to Children's Social Care (CSC). They each outlined similar concerns about MU's behaviour In April 2001; the Children's Centre were concerned by MU's presenting behaviour and comments she had made such as 'this is what people do they try to control you'. In May, a parent wrote a letter of

complaint to the Children's Centre outlining concerns about MU's behaviour towards her child. A referral was made to CSC which outlined the incidents and stating concerns for MU's mental health. Following consultation with the Health Visitor, no further action was taken. The Children's Centre made a further referral a week later following a meeting with MU. A decision was then made to allocate a Social Worker to undertake an Initial Assessment. The Initial Assessment was completed by early June, it lacked any detail about Child U's parenting and no further action was the agreed outcome. MU was resistant to the Children's Centre staff discussing any outstanding support needs.

3.8 In late July, the Children's Centre made a referral to Children's Social Care raising concerns on behalf of the management team who considered that a further assessment was needed. A decision was made to ask the Mental Health Team to further assess MU's mental health to establish whether her health was impacting upon her ability to parent. Consultation took place with MU's GP who advised that it was not thought that MU had mental health problems; however, the Mental Health Manager advised that MU had been assessed by a psychiatrist in 2005 and diagnosed with schizoid personality; significantly, this information had not been made available at previous assessment points. A plan was agreed that the GP would invite MU into the surgery for assessment. GP records indicated that MU was invited to attend the GP, but there was no follow up when she did not do so. No further action as taken by Children's Social Care or mental health services.

3.9 During September MU had several interactions with her Housing Association. On one occasion, an officer told her he would have to put the phone down because she was aggressive, and whilst visiting the home and hearing loud music she was told that enforcement action would have to be taken if it did not stop. In late September, two maintenance workers went to MU's home to complete repairs in the bathroom and kitchen. After the visit, the workers completed 'Concern Cards', raising concerns about what they experienced and saw. The workers reported that MU was abusive to them and used abusive language to Child U; they reported concerns about the welfare of Child U and state of mind of MU.

3.10 In October, the police responded to a call from a member of the public who witnessed MU hitting Child U hard. Child U was observed to have a bleeding scratch to the bottom of her neck, and when asked how this had happened, she said mummy had done it in an accident. The police invoked Police Protection Powers and MU was seen by a police surgeon who stated that she was fit to be detained. Child U was placed in emergency foster care. She told a Social Worker that MU slaps her when she doesn't listen. Following a strategy meeting, it was agreed that MU would receive a caution and Child U would return home. An agreement was made to convene an Initial Child Protection Conference which took place late November.

3.11 The Child Protection Conference was attended by key agencies, apart from the Children's Centre who had not been invited. Child U was made the subject of a Child Protection Plan under the grounds of neglect. The reason for neglect has no explainable rationale, when the focus of the Conference was risk in relation to physical and emotional abuse.

3.12 In December, a Housing Officer and Manager visited MU to discuss complaints from local residents. MU stated that she was being harassed but couldn't say who by or why. When asked what made her feel that she was being harassed she said that mud had been placed deliberately in her gutter to scare her and her daughter and that there was no grass growing on her lawn. MU was described as aggressive throughout the interview, shouting at both officers and not allowing them to speak. During this, Child U became more and more animated, and also shouted derogatory abuse at the officers.

2011

3.13 In January, two Housing Maintenance Workers attended MU's home. During the visit MU asked the men to marry her, but was also verbally abusive to them whilst they were cleaning up. As a result of this, MU was sent a written warning about her behaviour towards staff.

3.14 MU and Child U continued to attend a second Children's Centre, however, a number of incidents led other parents to be upset and offended by MU and they began to leave the sessions to avoid the situation. Parents reported that they felt intimidated by MU and unable to challenge her. The Children's Centre completed a referral form however, it would appear that they were not aware that Child U was the subject of a Child Protection Plan, but were aware of the concerns raised by the previous Centre.

3.15 The first Review Child Protection Conference was held in February 2011. The meeting was not attended by Police and the Children's Centre was invited but sent apologies. This meeting did not record any real progression of the issues of concern, there was no systematic evaluation of what had been achieved during the review period and no timescales were allocated to achieve further progress. Child U remained subject to a Child Protection Plan for neglect. The summary of the Conference is clearly at odds with the reality of the situation as it indicates that MU was now taking on board advice. The meeting confirmed the need for mental health assessment and a parenting approach.

3.16 In March, MU was referred to the Children and Parents Service (CAPS) for a parenting course; however, when she was contacted by the service she refused the parenting course.

3.17 In April, the Social Worker contacted MU's GP and requested an urgent assessment. The Social Worker was advised to ring back the following week as the GP would invite MU into surgery. The GP discussed the situation with a

Consultant Psychiatrist who felt that mental health assessment was advisable. The GP thought it would be difficult to make this referral as MU hadn't been seen since 2009, and agreed to discuss further with the Social Worker who was felt to be best placed to make the referral. The Social Worker contacted the GP again and was advised to send a referral to the Psychiatrist which was done that day. Once received by the Manchester Mental Health and Social Care Trust, the referral was quickly allocated and a plan was made for a Mental Health Social Worker to visit MU in May to conduct the assessment.

3.18 A Mental Health Social Worker conducted the assessment. Some abnormalities of mental state were noted but no symptoms of psychosis. The assessment could not be completed in full because Child U's presence was too disruptive, but MU had agreed to attend any outpatient psychiatry appointment. There are many recorded attempts by the Mental Health Social Worker to consult with the child's Social Worker prior to making arrangements directly with MU but no contact was established. An arrangement was made with MU for an appointment in July. MU was subsequently assessed at the outpatient clinic. The assessment concluded no abnormal findings, but notably did not have access to the records from 2005 which were handwritten on a different system to the one in operation.

3.19 The third Review Conference was in July. The Conference was not attended by the Police, or MU. Child U remained subject to a Child Protection Plan for neglect. MU was unhappy with the continued plan when she could see nothing wrong.

3.20 A Core Group meeting was held in August, attended by Social Worker, Health Visitor and MU. The focus of discussion was MU's decision to home educate Child U. The Health Visitor remained very concerned about the impact of MU's decision on Child U and discussed this issue with the Named Nurse who in turn raised the issue of concern with the Deputy District Manager (DDM) from Children's Social Care who agreed to review the case and perhaps seek legal advice. In September an Education Case Worker visited MU to discuss the issues relating to home schooling. MU advised she had researched home schooling on the internet and intended to pursue this. Child U was due to start school in January 2012, and the worker arranged to visit again in the New Year.

3.21 Throughout August and September, there are more positive recordings of Child U's behaviour and MU's interactions with her from the Children's Centre. A Core Group took place on 14th September where the focus was assessing home education, progressing the CAPS work and accessing activities that would promote social development for Child U. An appointment was made for CAPS on 23rd September; however, MU was still expressing reluctance to engage in parenting work. This was the last contact with MU and Child U prior to the death of Child U.

4. Lessons Learnt

Whilst the review identified individual failings across the system, this did not equate to systemic failings within the system. There were however a number of significant factors which impacted on the effectiveness of the operation of the child protection system and these are the areas from which key learning was drawn.

4.1 *The challenge of working with parents who are hostile or difficult to engage*
MU was perceived as having a difficult personality by all professionals who worked with her, she responded badly to any criticism or request for change, and this may be one reason why the Child Protection Plan and Core Group did not sufficiently focus on issues where change was required, and remained too occupied in attempting to achieving a partnership with MU, consequently lacking focus on Child U. There is a place for professionals only meetings, in particular this should be considered as necessary in situations where professionals may feel stuck with intractable problems.

4.2 *The need to listen to Children*
Children, however young or old, must be at the heart of a child protection process. This does not mean simply focussing on them as an object of concern, but allowing children to be heard through whatever means they can communicate and express themselves. This may be verbal, through behaviour and by observation. Child U was not afforded this opportunity.

4.3 *The Insufficiency of Assessments of Child U*
No sufficient assessment was achieved of Child U. Her father was unaware that she was the subject of a Child Protection Plan, and all information was taken from MU without corroboration. The insufficiency of Core Assessments is a central issue which results in a lack of recognition of risk. For Child U, the lack of understanding of the risks to which she was exposed resulted in a wrong categorisation of risk and this had detrimental consequences for the ongoing case management.

4.4 *The need for greater recognition of Key Risk Factors*
MU was known to have used cannabis from being a young teenager, yet the questions about usage, dependency and impact were never asked. MU alleged that she needed to leave her home when FU was present, citing domestic dispute as the reason, yet the facts were never asked or established.
The majority of professionals working with MU believed she experienced mental health problems, and whilst specialist assessment was sought, aspects of her behaviour remained problematic and not understood in the context of her health or personality.
National research confirms that domestic violence, mental health issues and substance misuse are common factors in parents whose children become the subject of SCRs and this is reflected in those conducted in Manchester. This

combination of factors should therefore been regarded as highly significant when assessing risk to children.

4.5 *The need for greater awareness of indicators of sexual harm*

There was continued evidence to suggest that MU was pre-occupied with sexualised behaviour and risk of sexual abuse to Child U. Despite this being a significant concern for the review and the Serious Case Review Group, this issue was only tacitly recognised within the contacts that MU and Child U had with professionals, and was not a feature of the Child Protection Plan.

4.6 *Professional Confidence to challenge medical assessments and outcomes*

The medical assessments of MU's mental health did not provide the answers that professionals were looking for to understand her presenting behaviour. The medical focus when assessing MU appeared to be to make a decision about eligibility for service rather than to undertake a more thorough assessment of mental health need. The lack of any challenge to the medical professions is often a combination of professional deference as well as a lack of technical knowledge from which to question the judgement of a medical practitioner. In this case the outcome of medical assessments served to create a diversion to health and social care services working together to better understand MU, rather than create a pathway to the joint approach that was even more necessary in the light of the not understanding why MU acted and thought as she did.

4.7 *Cutting time at key points of the Child Protection Process is false economy in achieving both good outcomes and effective use of resources*

All agencies and practitioners face high demand on their time, and can be tempted to focus on task rather than strategy. Trading time for competing demands is often given as a reason for not holding strategy meetings but the absence of one strategy meeting, as evidenced immediately following the assault on Child U, can have a profound impact upon the multi-agency response to child abuse and, therefore, on how well children are ultimately protected. Maximising both the protection of children and the criminal accountability of those who harm children, is best achieved through the practice of Strategy Meetings. This is written into procedure and statutory guidance and a failure to comply will compromise the welfare of children.

4.8 *The Child Protection system needs skilled professional judgement*

The Child Protection Conference is the epicentre of the child protection system, the significance and demands placed on Conference Chairs should not be underestimated. If the Child Protection Conference does not identify weaknesses in assessment, gaps in planning and hazards to good outcomes, practitioners will be falsely reassured that risk is reducing. Professional judgement is central to safeguarding work in all agencies. For staff to perform optimally, a degree of professional challenge is necessary as without this, any deficits in reasoning will go without notice. Generally a culture of challenge is a feature of all safe systems, and for staff with safeguarding responsibilities

this needs to be ever present as a method of professional support. This case highlights the autonomy of the Child Protection Conference Chair and how the lack of other sources of challenge such as safeguarding partners and robust line management can come together to create less safe systems.

4.9 The review identified that all agencies have safeguarding training and have the skills to identify causes for concern. However, it is less evident that staff have enough awareness and knowledge of mental health issues to work from a position of confidence.

4.10 Two issues that feature in this learning are present in so many Serious Case Reviews, that being the need for good assessment to underpin work with families and the need to listen to children. This suggests a need for greater guidance and challenge to staff from first line managers who are accountable for the quality of assessments completed within their span of management.

4.11 Although with the benefit of hindsight it is possible to reach a hypothesis about why MU acted as she did with some confidence, this should not imply that such a judgement was possible prior to the incident occurring. Based on what was known leading up to the death of Child U, her death could not have been predicted. By virtue of what was known to agencies the SCR Panel believed that MU, through her misguided actions, genuinely believed she was saving Child U from future harm.

5. Multi Agency Recommendations

Recommendation 1

That consideration is given to how multi agency services can draw upon an ongoing mental health input to assessment and case planning when a person is assessed as having no diagnosable mental illness, yet continues to present with what appears to be mental ill health.

Recommendation 2

The current multi agency escalation policy is amended to extend beyond disagreement and include those cases were professional(s) have concerns that a case is either ‘stuck’ or proving very difficult to progress.

Recommendation 3

That all agencies take responsibility for strict adherence to the requirement for Strategy discussions/meetings and that the MSCB requires evidence of expeditious progress with this.

Recommendation 4

That the findings of this Serious Case Review are used as an instructive case scenario against which to test out the developing guidance for single assessment. This should include the significance of building in:

- points of multi agency peer challenge;
- management oversight of multi agency child protection plans;
- the place for purposeful professionals only meeting.

Recommendation 5

That MSCB commission a deeper analysis of the reasons why Child Protection Plans focussing on risk of sexual abuse are lower than the national average and develop and action plan.

Recommendation 6

That the MSCB request an audit from the Safeguarding Improvement Unit that reports on the robustness of the child protection planning arrangements to include:

- Appropriate categorisation criteria;
- Robust child protection plan;
- Effective core group activity.

6. Individual Agency Recommendations

6.1 Manchester Children's Social Care

The report draws together what can be learnt and improved upon as a consequence of this review and makes the following recommendations:

1. Strengthen the existing quality assurance framework to improve the quality and consistency of assessments.
2. Embed the updated Quality Audit Framework and reporting to Senior Management.
3. Invitations to Initial Child Protection Conferences should reflect those Agencies with historical as well as current involvement.
4. Strengthen existing quality assurance work and management oversight in relation to S47 processes.

6.2 Manchester Early Years and Sure Start

The recommendation for action by Manchester Early Years and Sure Start are as follows:

1. Develop current policy and practice to ensure that managers escalate concerns when a parent is unwilling to engage in the Common Assessment Framework process.
2. Develop quality assurance practice within supervision to ensure that all recording is in line with standards outlined by MSCB and introduce guidance on recording timescales.
3. Introduce quality assurance practice in relation to the completion of a Safeguarding Children Referral.
4. Develop supervision practice and support for all staff dealing with complex needs including mental health issues to ensure that all staff including volunteers assess and sign post or refer as appropriate.

6.3 Greater Manchester Police

The recommendations by GMP are as follows:

1. That the Public Protection Division (PPD) produce an induction pack for all PPIU staff, including supervisors, specific to child protection. This pack should include guidance on role requirement, inter-agency working, strategy meetings and the completion of PPIU logs, drawing from the guidance in both WTSC 2010 and GMP's Safeguarding Children Policy and Manual of Guidance 2010.
2. That the PPD considers (and monitors) the provision of IT equipment to the PPIU on this division, to ensure that staff have sufficient computers to support them to complete their operational duties.

It is the Author's view that GMP should extend the learning from this review to ensure that all divisions, across other Local Authority areas have in place, and comply with, standardised procedures to accurately reflect the issues and decisions from strategy meetings.

6.4 Adactus Housing

The recommendations for actions are:

1. Disseminate good practice from this case and establish annual training programme for frontline maintenance staff to recognize signs of abuse and how to report any suspicion that abuse may be occurring.
2. In order to make it easier for staff to report concerns introduce use of pre-paid and addressed envelopes for onward transmission of "Concern Card" by maintenance operatives to the Tenancy Enforcement and Support Team.
3. All new starters to be made aware of the Group Safeguarding Policy as part of the Group induction programme.
4. When appropriate use this case as a case study to reinforce to staff in briefing sessions that where they are victims of abuse and inappropriate

behaviour by customers, any such incidents should be referred to the Tenancy Enforcement and Support Team for investigation, followed by appropriate action to challenge such behaviour. When appropriate use this case as a case study to show how significant their role in safeguarding is.

5. Introduce a system for auditing concern cards to ensure a record is kept of all Concern Cards completed and action taken. This should enable an analysis to be undertaken of the source and type of concern's being raised, which in turn may highlight areas for improvement or further training.

6.5 NHS Manchester

The recommendations for action by NHS Manchester are as follows:

1. There should be consolidation of the work begun on increasing GP contribution to Child Protection Case Conferences.
2. Flagging of children subject to a Child Protection Plan and their families should continue to be promoted with the aim that every child placed on a plan since March 2011 is correctly flagged on their GP record.
3. The GP Safeguarding Children Steering Group should consider a wider application of the use of Read Codes to flag vulnerable children and families and make recommendations on this to the LMC.

6.6 Manchester Mental Health and Social Care Trust

The recommendations for action from Manchester Mental Health and Social Care Trust are:

1. To ensure that the Trust's plans for a reorganisation of community services during the first half of 2012 result in clarity about eligibility for services, an appropriate allocation of patients to the right service, and training of staff in the operational policies of the service teams.
2. To ensure that decisions made in team meetings will be recorded in the patient's records and the referrer is informed of the outcome.
3. To establish a recognised procedure is developed for escalating referrals when there have been several referrals or significant events causing concern, and to ensure that a senior clinician undertake the assessment.
4. To ensure that where a joint assessment is undertaken then an integrated assessment is prepared with Children's Services.
5. To ensure that all significant paper record that would not be otherwise available are scanned into the AMIGOS record.

6. To develop a process for the review in supervision of decisions to discharge patients who are difficult to engage. The finding that a patient is difficult to engage with should prompt an assessment of what action could be taken to achieve engagement and lead to an exploration of access to alternative services.
7. There should be training in the identification and management of emergent psychotic symptoms so that in the management of younger people with possible symptoms of psychosis the EIP service should always be considered as a possible support.
8. There should be a summary opinion in the AMIGOS record following all outpatient clinic assessments which will be available to all MDT members prior to the typed letter being added to the records.
9. Clinicians undertake longitudinal history - taking as an integral part of all assessments and pay attention to the nature as the degree of presenting difficulties. They undertake a holistic assessment considering all needs of the service user, rather than focusing on eligibility criteria.
10. Clinicians comply with the Safeguarding Children Policy by sending discharge letters and letters following assessments to all agencies involved in the care of a parent.

6.7 Central Manchester Foundation Trust

The recommendations for action by CMFT are as follows:

1. CMFT will reinforce the existing safeguarding children basic awareness training package to include adult behaviours in the recognition of sexual abuse of children.
2. Health Visitor corporate case load practice standards are audited to ensure compliance and improved practice standards.
3. CMFT to develop an information pathway for adult A+E staff. To ensure information related to vulnerable adults seen in the department and who have child care responsibilities is shared with the appropriate health visitor or school nurse.

All of the above recommendations have been actioned.

6.8 NHS Manchester Commissioning Overview Report

The recommendations arising from this report are as follows:

1. Central Manchester Foundation Trust (CMFT) to ensure Health Visitors (HV) make contact directly with mental health staff who are involved with the family, so they can assess together, the impact of a parent's mental health needs on the child and that that HV's know how and when to make a direct referral.

2. CMFT to ensure that staff are contacting named nurses, who specialise in child protection, appropriately when there are child protection concerns and that significant event chronologies are being suitably analysed.
3. The primary care commissioning team and the 3 Clinical Commissioning Groups in Manchester to support the work to improve GPs participation in child protection processes.
4. NHS Manchester commissioners of health visiting services to ensure that the current review considers the findings in this case around: corporate caseload management and accountability, communication with adult services, case planning, training and escalation.
5. MMHSCT to assure commissioners that clinical supervision includes the impact on the child of mental health problems and that the audit programme includes analyzing a sample of case notes to ensure that the impact on a child has been assessed and appropriately managed.
6. MMHSCT to ensure a robust pathway to transfer care to another area is in place and quality assured.
7. NHS Manchester's mental health commissioners to seek assurance that all available historical information is now being accessed to inform clinical decision making.
8. NHS and LA commissioners to ensure that MMHSCT allow appropriate access to services where there are wider determinants of mental health including social circumstances; and that eligibility criteria are consistent with the section 75 partnership agreements re assessing parents who have dependent children.
9. Mental health commissioners to ensure the Early Intervention Service and referral criteria is reinforced to and understood by MMHSCT staff and service providers outside of mental health.
10. MMHSCT to revise its assessment tool and risk assessment protocols to include asking questions about any termination of pregnancy as well as feelings about a pregnancy and birth.
11. MMHSCT to add a risk flag to AMIGOS to highlight a woman with children who has had previous contact with mental health services.
12. The findings in this case to be shared with sexual health commissioners to inform a review of the assessment and support offered to women before and after a termination.
13. Manchester City Council and NHS Manchester commissioners to ensure the Dual Diagnosis Service and referral criteria is reinforced to and understood by service providers outside of mental health.
14. CMFT and MMHSCT to ensure that safeguarding supervision and training of HV's focuses on the voice and perspective of the child particularly when the toxic trio are present (mental health, substance misuse and domestic abuse).
15. Primary care commissioners to ensure safeguarding training to GPs is strengthened further to ensure that maintaining a focus on the child is a key message.

Appendix 1 - Multi Agency Action Plan

Child U SCR - Multi-agency Action Plan

Working Together to Safeguard Children in Manchester

No.	Recommendation	Lead	Key Actions	Evidence	Key Outcome	Date
1.	That consideration is given to how multi agency services can draw upon an ongoing mental health input to assessment and case planning when a person is assessed as having no diagnosable mental illness, yet continues to present with what appears to be mental ill health.	Safeguarding Practice and Improvement Group	1. Head of Safeguarding, CSC, and Head of Patient Safety, MMHSCT, design and undertake an audit of cases including mental health needs and Children's Social Care involvement, with the aim of producing a good practice guide. 2. Good practice guide is presented to and signed off by MSCB.	1. Audit tool. 2. Good practice guide. 3. Evidence of dissemination, implementation and use of guidance.	When there are concerns about mental health needs (with or without diagnosis), the focus on parenting capacity and the impact on children is maintained.	End of March 2013
2.	The current multi agency escalation policy is amended to extend beyond disagreement and include those cases where professional(s) have concerns that a case is either 'stuck' or proving very difficult to progress.	Policy and Procedures Subgroup	1. Convene a Task & Finish Group led by a manager from CSC and including representation from: Health, MMHSCT, Education, Police, Sure Start and Early Years. 2. Amended escalation policy is presented to	1. Terms of reference of the task and finish group. 2. Minutes or action notes from the meetings. 3. Evidence of dissemination, implementation and use.	Increased staff confidence by providing access to an area based network of professional expertise in supporting children's needs.	End of March 2013

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No.	Recommendation	Lead	Key Actions	Evidence	Key Outcome	Date
			and signed off by MSCB.			
3.	That all agencies take responsibility for strict adherence to the requirement for Strategy discussions/meetings and that MSCB requires evidence of expeditious progress with this.	MSCB Executive	1. MSCB to request a collective progress report from CSC (Area Safeguarding Manager) and GMP (DCI from PPD and DI nominated by the DCI from PPD) on the S47 process in Manchester to cover: a) Is sufficient priority and time being invested in S47 meetings? b) Are the right people invited? c) Do those who need to know receive the plan? E.g. GP, Examining Paediatrician, School, Health Visitor? d) Is every child	Reports to MSCB via Executive.	MSCB is assured that there is a consistent approach across the City to the convening and process of S47 strategy discussions in accordance with existing statutory guidance.	End of January 2013 & end of July 2013

No.	Recommendation	Lead	Key Actions	Evidence	Key Outcome	Date
			considered for an 'Achieving Best Evidence' Interview and the rationale for a decision recorded? 2. Initial report provided from the group to MSCB by the end of January 2013. 3. Group continue to monitor the situation and provide an update report to MSCB by the end of July 2013.			
4.	That the findings of this Serious Case Review are used as an instructive case scenario against which to test out the developing guidance for single assessment. This should include the significance of building in: • points of multi agency peer challenge;	MSCB Executive	1. The convening of a Task and Finish Group led by an Area Safeguarding Manager, CSC involving a Social Work Consultant and representatives from the Child in Need Service, MCAF team, Education/Schools and	1. ToR for Task and Finish group. 2. Minutes or action notes from meetings. 3. Revised guidance and framework in relation to assessment and integrated working.	Single high quality assessment process supported by peer challenge and clear management oversight.	End of March 2013

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No.	Recommendation	Lead	Key Actions	Evidence	Key Outcome	Date
	• management oversight of multi agency child protection plans; • the place for purposeful professionals only meeting.		Health. 2. The group should develop multi agency guidance and a framework relating to holistic single assessments. This should include decision making points in line with revised Working Together guidance and any proposals to integrate the First Response service.			
5.	That MSCB commission a deeper analysis of the reasons why Child Protection Plans focussing on risk of sexual abuse are lower than the national average and develop and action plan.	MSCB Chair & MSCB Business Manager	1. MSCB Chair, Business Manager and Head of Safeguarding, CSC meets in order to identify the most appropriate resource to undertake this piece of work. 2. The meeting should establish the Terms of	1. Document showing scope and terms of reference. 2. Report containing analysis, recommendations and actions.	MSCB are satisfied that children at risk of sexual abuse are being recognised and effectively protected.	End of March 2013

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Child U SCR - Multi-agency Action Plan **Working Together to Safeguard Children in Manchester**

No.	Recommendation	Lead	Key Actions	Evidence	Key Outcome	Date
			Reference and scope of the research. 3. Upon conclusion a report containing analysis, recommendations and an action plan should be produced to MSCB.			
6.	That MSCB request an audit from the Safeguarding Improvement Unit that reports on the robustness of the child protection planning arrangements to include: • Appropriate categorisation criteria; • Robust child protection plan; • Effective core group activity.	MSCB Executive via the Head of Safeguarding, CSC	1. Head of Safeguarding, CSC coordinates a case audit of a dip sample of cases over the last six months in relation to cases subject to CPP. 2. At the conclusion of the audit a report and action plan is presented to the MSCB Executive.	1. Audit tool. 2. Audit report.	MSCB are assured that the chairing of the case conference in this case was a deviation from standard practice.	End of March 2013