# Overview Report 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.**

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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 (EMR) 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 EMR 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 Whilst at the hospital awaiting further specialist psychiatric assessment, MU was arrested on suspicion of the murder of Child U. After treatment for her physical injuries, MU was psychiatrically assessed as fit for discharge into criminal justice procedures, with advice of increased surveillance in police cells as she was distressed.

1.4 Further consultation took place between the hospital, the police and the Emergency Duty Children's Services where it was established that Child U was the current subject of a Child Protection Plan.

1.5 On 24th September 2011 MU was formally charged with the murder of Child U and detained in a secure mental health facility to await trial.

1.6 The Post mortem examination and investigations did not identify any natural disease 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.

## 2. Decision to Undertake a Serious Case Review

2.1 The death of Child U was considered at the Manchester Serious Case Review Sub Group (SCRSG) on 14th October 2011. A recommendation was made that the circumstances of Child U's death should be the subject of a Serious Case Review in accordance with Working Together 2010 given that a child had died and abuse or neglect was known or suspected to be a factor in the death. [Para 8.9 WT2010] Additionally, as Child U had been made the subject of a Child Protection Plan following a serious assault perpetrated by her mother, the case gave rise to questions about the way in which local professionals and services had worked together to safeguard and promote the welfare of the child.

2.2 The Chair of Manchester Safeguarding Children Board (MSCB) received the recommendation and the suggested terms of reference on 15th October 2011 and made the decision that a Serious Case Review should be held. Ofsted and the Department for Education were formally notified of the decision to hold a Serious Case Review that same day.

2.3 The MSCB appointed an Independent Chair and Independent Author and a commissioning meeting was held with both on 24th October 2011. This meeting reviewed and amended the draft terms of reference, following which the final terms of reference were agreed by the Chair of MSCB.

## 3. Membership and Conduct of the SCR Panel

3.1 The Independent Chair is Mr David Hunter. Mr Hunter is retired from Humberside Police in 2007 having served for 32 years; the last 16 years of which he was the Force Lead on Safeguarding. He has represented the police on 25 Child Serious Case Review Panels. Since retirement from the Force, he has acted as an Independent Author and Chair of Children's Serious Case Reviews, Multi Agency Public Protection Arrangement Serious Case Reviews, and Domestic Homicide Reviews. Mr Hunter holds a number of unpaid public appointments.

3.2 The Independent Author, Ms Colleen Murphy works as an Independent Social Worker undertaking a range of work specifically in children's services and quality assurance. Ms Murphy has been a qualified Social Worker for twenty-three years, and has previously worked in Social work and Social work management posts in the Local Authority and voluntary sector. Ms Murphy has undertaken previous Independent Chair and Authorship roles in Serious Case Reviews. Ms Murphy is not employed by any agency but is commissioned to undertake work that requires independence.

Neither Mr Hunter nor Ms Murphy has had any operational involvement with the case of Child U.

3.3 The Serious Case Review Panel met on nine occasions, on the following dates:

- 16th December 2011
- 16th January 2012
- 30th January 2012
- 20th February 2012
- 26th March 2012
- 12th June 2012
- 22nd August 2012
- 19th September 2012
- 23rd October 2012
- 3rd December 2012.

The Panel meetings have been between two and seven hours.

3.4 The Panel was comprised of the following people:

Independent SCR Chair
Detective Sergeant Greater Manchester Police Safeguarding Vulnerable Person Unit
Service Lead for Safeguarding, Manchester Children's Social Care
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.

Each meeting was attended by the MSCB Business Support Officer, who gave a high standard of support to the review process.
The Independent Author has been in attendance at all but one of the meetings.

3.5 The MSCB Acting Business and Performance Manager ensured liaison took place with the Coroner and the police overseeing the criminal processes.

3.6 Alongside the SCR, there are two parallel processes that have occurred. MMHSCT have conducted a Serious Untoward Incident Enquiry, the report from which has been made available to the SCR panel. Additionally, the death of Child U has resulted in a murder charge against her mother, a trial date was anticipated in May 2012, however in May 2012 this date was put back to November 2012 to allow for additional psychiatric assessment.

3.7 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.

3.8 A Commissioning PCT Overview Report has been completed by the Designated Nurse who was a Panel Member. The Designated Nurse has a high level of experience of producing such reports and this report presents a holistic overview of what can be learnt across the health economy.

3.9 The Serious Case Review Panel gave careful consideration to ensuring documents were suitably and consistently anonymised in order to protect as far as possible the privacy of Child U, family members and professionals.

# 4. Terms of Reference for the Review

The Terms of Reference for the Serious Case Review contextualise and fully set out the purpose and scope of the review. The Terms of Reference are summarised below:

4.1 The timeframe for the period of review is 3rd July 2008 to 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.

4.2 The Key lines of enquiry are as follows:

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?

## 5. Timescale for the Review

5.1 The original date for submission to Ofsted was agreed as 13th April 2012. Once the initial agency information was made available however, it became apparent how very important it was to seek a contribution ideally from MU herself, or as an alternative, close family members.

5.2 Initially it was anticipated that MU could be asked to contribute to the review following the criminal trial in May 2012. Following discussion between the panel and consultation with the Chair of the MSCB, it was agreed therefore that the completion date would be put back to 30th September 2012 to allow for this to take place with sensitive timing.

5.3 Once the trial date was rescheduled for 5th November 2012, the panel agreed that the second completion date would be adhered to. Very careful consideration was given as to whom in MU's family could be contacted to contribute a family perspective to the review. The panel preference would have been to consult with MU first, in particular given she had told people she had minimal family contact. Ultimately following contact with MU's sister, the Independent Author and Designated Nurse met with MU's sibling and mother on two occasions in August 2012.

5.4 At the SCR Panel on 22nd August 2012 it became clear that further consideration of the family contribution was desirable and to accommodate this, the final submission date was set at 30th October 2012. If appropriate MU could be seen after any trial and an addendum SCR prepared.

5.5 The Overview Report was considered by members of the Serious Case Review Sub Group on 7th September 2012 with an intention of submitting the report to the Board on 8th November 2012.

5.6 In early November 2012 however, the criminal trial in relation to MU concluded and it was felt appropriate to delay the presentation of the report as it was indicted that MU was willing to contribute directly to the review. Ultimately, MU made the decision not to contribute directly to the review and a final SCR panel meeting met on 3rd December to establish whether any additional information needed to be taken into account following MU accepting a plea of manslaughter.

## 6. Agency Contributions to the Review Information

6.1 The following agencies contributed Individual Management Reviews (IMR) to the Serious Case Review:

- Manchester Children's Social Care (CSC)
- Manchester Early Years and Sure Start
- Greater Manchester Police (GMP)
- Adactus Housing
- NHS Manchester
- Manchester Mental Health and Social Care Trust (MMHSCT
- Central Manchester Foundation Trust (CMFT).

6.2 The following agencies provided limited or specific information which has contributed to the combined chronology but where it was agreed by the panel that a full Individual Management Review was not required:

- Child's Dental Practice.

6.3 The following agencies were consulted and did not hold any information about Child U or MU:

- NSPCC
- Connexions
- CAFCASS
- Adult Social Care
- Education
- Youth Offending Service
- Manchester Youth Service
- Multi Agency Risk Assessment Conference (MARAC)
- Independent Domestic Violence Advisory Service (IDVA)
- Drug and Alcohol Strategy Team
- Greater Manchester Fire and Rescue Service
- Manchester Alliance for Community Care (MACC) – Voluntary Sector
- National Probation Service.

6.4 Once all information was received, the SCR Panel considered that that 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:

- 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?

## 7. The Family Contribution to the Review

7.1 At the first Panel meeting, 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 MSCB Acting 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.

7.2 The information received from the agencies suggested that MU was effectively estranged from her family and the SCR panel was mindful that MU may have made this decision herself for a particular reason. Bearing this in mind, the SCR panel made the decision that ideally MU should be offered the first opportunity to make a contribution, on the understanding that this could not happen until post trial.

7.3 The Serious Case Review Panel had very limited information about the father of Child U (FU) and it was agreed that the Chair of the Panel would make telephone contact with FU who was living abroad in order to inform him that the review was taking place and establish whether FU had information or questions he wished to contribute. FU stated that someone (unspecified) should have contacted him when Child U's mother needed help and he would have come to England. FU stated he did not know that there were problems which needed help. FU was asked for a postal or e-mail address which was not provided, however, in order to ensure he had contact should he wish to make further contribution to the review; he was given the mobile telephone number of the Independent Chair.

7.4 The Panel gave consideration as to who outside of the immediate kinship may be able to assist the review with information about Child U's life and insight into MU's thoughts and feelings. Two panel members met separately with two women who knew MU through a black women's support group. Both gave very helpful information which assisted the panel in developing an understanding of MU and her life.

7.5 Once the trial date was put back, the SCR panel had to review the original intention to seek contribution from MU prior to any other family member. It was clear that there were significant gaps in understanding MU's personal life and relationships which would inhibit the analysis of trying to understand why MU acted as she did. A decision was made to approach family members of MU who were very helpful.

## 8. Child U's Life

8.1 Child U was the only child of MU, and it is understood that she was born within a loving relationship between MU and FU. It is known that Child U is not the only child of FU. The majority of information in this section is provided by family members and has not been verified with either parent of Child U.

8.2 MU grew up with her mother, one full sibling and three half siblings. She is described as an intelligent woman but with significant mental health problems that impacted on her relationships with those around her. MU was also described as someone who had a resistance to authority through adolescence and adulthood, and that she would not compromise if she thought she was right.

8.3 Family members advised that MU had a strong sense of black identity, that she was knowledgeable about historical black political figures and would challenge racism and perceived racism. It is notable however, that when registering at a Sure Start Centre, MU refused to discuss her ethnicity and chose White British as her ethnicity. MU is described a very private by all who knew or worked with her, and many of the observations about her focus on negative aspects of her personality and behaviour because she put up barriers if people tried to get to know her.

8.4 Her family advised that MU experienced some turbulent issues during her adolescence, and with a group of friends she began smoking cannabis at the age of approximately 12 years.

8.5 It is the view of family members that MU has been mentally unwell since the age of about 20 years old. After leaving school and initially holding down a good job, MU began a relationship with a man that did not commit to her in the way she expected. She had hoped for motherhood, but did not receive the support she anticipated. MU found it very hard to accept the relationship ending and began harassing the ex-partner who had moved into another relationship.

8.6 Over this period, MU's relationship with her family became very strained. Family members described how MU was relentlessly hurtful to her mother until ultimately she had to be asked to leave home. After a brief period of time with her father, MU then went to live with an extended family member who was viewed as a type of godmother. In her mid 20s, MU was asked to leave her job as her bosses found her to be increasingly threatening and difficult.

8.7 Family members advised that whilst initially MU's cannabis smoking presented as recreational, over the years, her cannabis smoking became a greater need and possibly dependency.

8.8 The family advised that MU would wear down family members but would usually have a person to go to at any point in time. Prior to Child U's birth, family members stopped communicating directly with MU, as they found MU's behaviour towards their mother unacceptable. Family members described MU as unnecessarily challenging to all around her on very simple matters. This was consistent with professionals' experience.

8.9 Family members describe MU's relationship with FU as enduring to date, albeit that FU lives abroad. They understood Child U to be a wanted child, noting that FU was a nice man who was consistent with MU's ideal of a father for her child. They advised that MU and FU had made plans for Child U and MU to move to the country where FU lived, and that MU was getting impatient for this happen prior to Child U's death.

8.10 Following the incident, FU told police that he came to England in 2004 for his mother's funeral and was resident in Manchester from around November 2004 for a period of 12 months before returning to his home. FU then came back to Manchester after Christmas 2005 and was involved in a relationship with MU before he returned home in November 2006. MU gave birth to Child U in December 2006. FU first met Child U when she was one year old when MU visited his country of origin and remained for several months, leaving in March 2008. MU returned to visit FU with Child U on a number of further occasions, and he last saw them just before Child U's third birthday, in December 2009. FU stated he had never lived with MU although it is believed he was staying with her in July 2009.

8.11 A family member was present at the birth of Child U and helped MU prepare her home for the baby; for the first three years of her life, Child U and MU were regular visitors at MU's mother's home. However, when Child U was 3 years of age, MU accused a family member of inappropriately touching Child U whilst changing her. The family noted that MU's behaviour became increasingly watchful of Child U, and that she would 'inspect her' if she had been out of her sight. This behaviour led to a rift between MU and her family, and MU stopped visiting her mother's home although she did remain visiting the home of her mother's mother.

8.12 A family member commented that MU became 'paranoid in her own skin' , only leaving the home reluctantly for reasons do with Child U. Family members were not aware that Child U was known to Children's Services, but were aware that MU planned to home school Child U. Although one family member stated they were shocked by what had happened; another was not, and had always believed that MU was capable of something very extreme.

8.13 Family members described how MU could change in her presenting behaviour very quickly; one moment presenting as unwell and confused, but then shortly afterwards this would not be noticeable.

8.14 Through speaking with the family, a picture emerges of Child U as a cherished child, physically well cared for, whose primary attachment figure was MU. Child U's interactions with others were limited to a decreasing number of family members and professionals, and her world was very much shaped by MU. Given the description of MU's concerns about Child U's safety, particularly in a sexual context, it is likely that Child U experienced an anxious style of parenting, with a fluctuating over emphasis on her well being alongside an inability to focus on her immediate and long term emotional needs when MU was unwell.

8.15 MU registered with Sure Start in 2006 whilst pregnant with Child U, and they both accessed Early Years and Sure Start services Stay and Play sporadically from February 2009 until July 2011, mainly at two Sure Start Centres. The chronology of what was known to agencies indicates that MU was challenged about her personal behaviour towards others on a number of occasions, and each time this occurred, her attendance would reduce for a period. MU's engagement with others was considered to be limited, and it was felt that she sometimes isolated herself due to an aggressive style of communication with other adults and children. The Centre staff noted that MU would always keep Child U close to her, and speak to her about issues inappropriate to her age. Family members also noted that Child U found it difficult to socialise with children as she was much more used to adult interaction. Child U's behaviour was often described as demanding and aggressive, her language was not always appropriate for childhood. This type of behaviour was most likely a manifestation of what she had witnessed in her mother, who was not well able to provide the boundaries needed by a young child.

# 9. Overview of What Was Known and Agency Involvement With Child U

**2008**

9.1 In July 2008, Child U was living with her mother as a sole tenant in a first floor flat. At this point in time, Child U had received standard universal services for children which had not identified any concerns in respect of her health, development or safety. Records suggest that MU was fairly isolated from her family, and that she experienced some disharmony with her neighbours.

9.2 MU was involved in a women's support group which was established by a voluntary worker seeking to support vulnerable young black women in the community. On 3rd July 2008, the Volunteer Organiser (VO) made contact with a community police officer to discuss concerns in relation to MU, and her view that she needed support. The VO asked the Police Officer if someone sensitive to MU's needs could make contact. As a consequence of this conversation, the Police Officer contacted another Police Officer, who was a black officer based in the Public Protection Investigation Unit (PPIU) who seemed an ideal person with whom to discuss the information. The PPIU Officer made contact with the VO who sensed an urgent concern for welfare and consequently created a referral via a Force Wide Incident Number (FWIN). The Police Officer recollects that the VO reported concern for the welfare of MU, in particular that MU had said that her 18 month old daughter (Child U) wanted to have a sexual relationship with her and that she (MU) was hearing voices. The VO also said that she wanted the situation handled sensitively as there could be cultural issues. The use of the terminology 'cultural issues' was used to reflect that there was a perceived tendency within the black community to resist any engagement with the police and other agencies into family affairs.

9.3 Two Police Officers from the PPIU visited the home address that same day, MU was not home but a neighbour reported having seen MU and Child U safe and well the previous day.

9.4 Also that same day, the PPIU Police Officer made a referral to Children's Social Care. The referral detailed the information as above, but also stated that MU had said that the light bulbs were giving signals to her and causing her to approach her daughter in a sexual way. This referral was responded to by the Out of Hours Duty Social Worker (EDSSW) who contacted the VO directly. The VO was able to confirm that she had seen MU and considered her mood to be lighter. Child U had been seen safe and well and appeared very settled. Both the PPIU Police Officer and the EDSSW contacted MU by telephone, initially the Police Officer indicated a visit would need to be made that night, but after reviewing the information with a colleague, the EDSSW

concluded that the matter should not be dealt with as an emergency. MU agreed to a visit the following day, but it was clear that she felt betrayed by the VO for raising the concern.

9.5 The following morning, the referral was received and responded to by the day time social work team. A Social Worker was allocated who arranged for a strategy meeting to take place and made background checks with the health visiting service. The Social Worker also asked for attendance by a mental health Social Worker but this was not available. The Strategy meeting between Children's Social Care (CSC) and the PPIU concluded that an assessment of MU's mental health was needed that day and duly referred the matter directly to the Mental Health Team.

9.6 The PPIU and CSC Officers made a joint visit to MU and Child U. Social Care records indicate that home conditions were seen to be of a high standard and there was no evidence of presenting mental health issues for MU. Child U presented as healthy and attached to her mother. MU was described as visibly shocked when she was asked about the information of concern. Police records state that MU was feeling uncomfortable with Child U's behaviour towards her, that when breastfeeding she sometimes touched her breast and that she clings to her mothers legs, sometimes putting her head beneath them and smells. The Officers concluded that the best course of action remained for a mental health assessment and for the Social Worker to undertake an Initial Assessment.

9.7 That day, the Social Worker made a number of phone calls to try to progress the assessment of MU's mental health. The Mental Health Social Worker (MHSW) advised the Social Worker to make a referral to the Crisis Home Resolution Team (CHRT) however the Team advised it was outside of their policy to accept referrals from a Social Worker. The MHSW contacted MU's GP; however, the GP refused to make the referral and stated the Social Worker was in a better position to do so having recently seen MU.

9.8 MU was seen in the Out of Hours GP centre; she was assessed as calm and lucid and it was agreed she did not need an immediate assessment and should therefore contact her own GP after the weekend (it being a Friday evening). The GP recorded that there was no history of mental health problems and that MU was a single mother, isolated from her family and her partner was abroad. MU stated her intention to home school Child U as she was unhappy with the education system. There is no information that the matter was followed up after that weekend. The Initial Assessment was recorded as completed on 29th July 2008, some 25 days later.

9.9 On 16th July 2008, at the request of the GP, the Health Visitor made a home visit. 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. MU said that Child U was demanding, and she

did not always have much patience with her. It was recorded that Child U still had occasional breast feeds but an otherwise mixed diet, and was meeting all developmental milestones. MU also reported dispute with neighbours, and that she felt that a dead cat had been deliberately placed in her garden to intimidate her.

9.10 On 24th July 2008, MU contacted her Housing Officer and stated that her neighbour was tracking her movements room to room and that she would like to make a file note that he fancied her. The following day Child U was taken to the GP with nappy rash, however, the recent concerns regarding sexualised behaviour had not been recorded in Child U's notes so there was no further exploration of this issue.

9.11 MU contacted the police on 27th July, and stated that someone had dug a hole in her garden and allowed a dog to poo on the grass, possibly a neighbour was responsible. A uniformed Police Officer visited the following day, and observed the 'hole' to be a small pot of soil in the grass which was removed, and concluded that no crime had been committed.

9.12 On 20th August 2008, MU received a written warning from her GP practice as she was perceived as aggressive when trying to book an appointment to have a passport photograph signed.

9.13 On 2nd September 2008, MU contacted her Housing Officer and stated that her neighbour was 'looking at her in a strange way' and that he was starting to stalk her. MU agreed to mediation as did the neighbour when approached by the Housing Officer. The Mediation Service arranged to visit MU on 27th October; however MU cancelled this in writing stating that she would be away until the New Year. In the letter, MU stated that she was concerned about the interview taking place at her flat because the neighbour would be listening as when she was speaking to them on the telephone he had banged to confirm he was listening.

9.14 On 8th December 2008, a neighbour contacted the police and stated that MU and Child U had not been seen for several weeks; noting the previous intervention, the police responded by trying to contact MU unsuccessfully on her mobile. It was established following a discussion with a neighbour and contacting the Housing Office that MU and Child U were away until the New Year. The mother of MU confirmed to police that she had spoken to her daughter twice whilst she was away, but that she did not have contact details. MU contacted the police to let them know she was home safe and well at the end of December.

**2009**

9.15 At the beginning of January 2009, MU visited her GP and discussed her intent to cease breastfeeding Child U. As part of routine assessment, MU disclosed she was a cannabis user.

9.16 On 22nd January 2009, the Housing Office received a call from MU's neighbour complaining about loud music. MU was advised of the complaint and the neighbour confirmed there was no reoccurrence.

9.17 From February 2009, MU began attending a local Sure Start Children's Centre. It is recorded that she spoke a lot about God, and how God does not judge or punish, and was overheard saying to a Muslim parent that she was sure 'God would not judge you if you ate pork.' 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 regarding any mental health issues; however, the GP suggested that MU could be asked to attend for assessment. The Health Visitor and a Community Staff Nurse made a home visit on 10th March; MU was seen briefly as she was going out. The Health Visitor telephoned the GP the following day and the GP recorded that MU would be invited into the surgery to discuss a referral to psychiatry. The Health Visitor also sent a letter to Adactus Housing supporting MU's request for re-housing.

9.18 In early March MU's manner continued to be a concern to parents and staff at the Children's Centre, resulting in staff speaking to her about her language and behaviour.

9.19 On 24th March 2009, MU attended the GP surgery. Child U was reported as looking well and interacting with her mother. MU declined a referral to psychiatry but accepted that she had said inappropriate things to the Muslim mothers and would curb her tongue in future.

9.20 On 3rd April, the GP discussed with MU, who telephoned the surgery, a letter which had been sent some time ago by MU asking for the GP's support for re-housing on medical grounds. The GP explained there was no medical reason for writing to the housing department but she could write to say the neighbour was causing MU stress. MU then complained that the GP had failed to show her 'common decency' by waiting for MU to call before telling her this. The GP said she would not tolerate abuse and ended the conversation.

9.21 When the Housing Association sent a medical assessment questionnaire in May 2009 to MU regarding application for medical priority, this was not completed and the application for medical priority was cancelled. Also in

May, the Mediation Service advised the Housing Officer that agreement could not be reached following shuttle mediation between MU and the neighbour. On 27th May, MU contacted the Housing Officer and stated that the neighbour was trying to intimidate her by tapping and that she thought he fancied her.

9.22 On 1st July 2009 a maintenance operative reported to the Housing Officer 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.

9.23 On 5th July 2009, 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. A referral had also been made to EDSSW who confirmed that Child U was not currently an open case. After the assessment took place, EDSSW spoke with the Police Officers who stated that at the hospital they had observed MU tickling Child U between her legs, and then this action reciprocated. Police Protection powers were exercised and Child U was placed in emergency foster care. MU subsequently refused police assistance to seek a place of safety for herself.

9.24 On 6th July, a joint home visit was made by Police and Social Worker. Both MU and FU were present, and MU said that she had tickled Child U under her arms and between her inner thighs to make her laugh, not as a sexual gesture. Police records state that MU denied saying 'there is a place up there for us', but did mention that the television makes sexual innuendos. The visit concluded that there were no immediate concerns for Child U's safety and that she should return home and a Core Assessment would be completed. It is unclear what FU contributed to the discussion, as was the rationale for the decision to accept the explanation from MU and dismiss the witness testimony of two police officers. When Child U was returned home by a Family Support Worker, MU was considered to be agitated that Child U may have been sexually abused whilst in foster care. MU immediately stripped Child U and checked her for any signs of abuse.

Concerned about MU's reaction, the Family Support Worker contacted the Team Manger who advised that Child U should remain in MU's care but that further assessments would be needed. The Social Worker telephoned the

police to update and it was agreed to hold a multi agency meeting and for MU to have a mental health assessment. The Social Worker made a written referral to the Mental Health Team advising of the recent events and seeking a mental health assessment. The Mental Health records state that they were advised that FU was a stable influence but was due to depart for his home abroad imminently.

9.25 On 9th July, a home visit was made by the Mental Health Social Worker and a Community Psychiatric Nurse (CPN) and well as two Social Workers from CSC. The Mental Health workers concluded that there was evidence of symptoms of mental disorder with overvalued ideation, delusions of reference and hypersensitivity to environmental dangers. However, 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, the referral would be closed to CRHT. It was agreed however, that the CSC Social Worker would, over the following month, complete a Core Assessment.

9.26 A further visit was made by the health visitor and CSC on 22nd July. MU presented as calm and accepted that she has extreme views. Child U presented as having good interaction with her mother and meeting developmental milestones. MU advised that FU had been visiting from abroad and following the domestic abuse incident she is no longer going to accompany him back as planned.

9.27 The Core Assessment was completed on 17th August 2009. It is accepted that this assessment did not fully explore family relationships, analyse need and risk nor provide rationale for the recommendation of case closure. The Case was subsequently closed to CSC on 21st August.

9.28 In October 2009, a maintenance operator made a further complaint that MU was abusive to him whilst undertaking repairs at her property. Following this, a decision was made that visits would be made by two operators. The GP surgery recorded on 3rd November that MU was abusive in the surgery when no appointments were available for that day.

9.29 On 10th November, the health visiting team made a home visit. Child U was described as happy with no concerns about her development. MU's presentation was described as 'over active', constantly distracted and with quickened speech.

**2010**

9.30 The following year, on 23rd March, MU was nominated for a 2 bedroom flat but did not respond to the offer.

9.31 MU and Child U attended the Children's Centre on 30 April 2010. When a male staff member said hello, MU responded by saying 'don't look at me like that'. When asked what she meant, MU said that staff member was too tall and scaring Child U who did not present as upset. The staff member went on to explain the days activity to which MU replied 'this is what people do, they try to control you'. The visit continued with similar unusual comments, in particular about being controlled by men. The staff member spoke later with the health visitor, Children's Centre records indicate the outcome of the discussion was for them to monitor and observe without putting off MU from attending services, whereas the health records indicate that the Health Visitor advised a referral to CSC.

9.32 On 5th May, a parent wrote a letter of complaint to the Children's Centre outlining that MU had said to her 3 year old child who had eczema 'I hope its not contagious, don't look at me'. When the mother challenged MU she said 'he is only looking at me with astonishment and love and you know that love can kill and all children are drawn to me cause I'm a Pisces and in the bible'. A referral was made to CSC First Response Team on 13th May, outlining the incidents and stating concerns for MU's mental health, and, following consultation with the Health Visitor, no further action was taken. The Children's Centre made a further referral on 18th May, following a meeting with MU, discussions about their concerns about Child U and comments from other parents that were feeling intimidated by MU's behaviour. The Children's Centre Manager had also approached MU about the possibility of a nursery place for Child U, but MU stated she would never put Child U in a nursery and she would be home schooled, making comment about metal detectors and stabbings in schools. On 20th May, a decision was made to allocate a Social Worker to undertake an Initial Assessment.

9.33 The allocated Social Worker contacted the health visiting service and was advised that Child U would be seen on 24th May for a routine health and developmental check. This visit took place and identified no concerns although the outcome was not relayed to the Social Worker.

9.34 The Initial Assessment was completed by 1st June. The Initial Assessment document lacks any detail about Child U's parenting and although Child U was asleep at the time of the visit, no further action was the agreed outcome.

9.35 During May and June, information was collated through Housing regarding complaints about noise nuisance coming from MU's flat. MU subsequently expressed an interest in moving, and the Housing Association gave advice on this matter.

9.36 On 7th June, MU became challenging to the play worker at the Children's Centre. Her behaviour was considered rude and was observed by the other children and parents. When spoken to about her manner by a Centre Manager, MU became challenging her responses. She complained that no

one spoke with her, stating that women don't like other women, and that the staff enjoyed their power, 'like the police beating people up'. When MU was asked if she had any family support she commented 'I know where this is going' and left the meeting.

9.37 On 23rd 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. The referral listed the previous areas of concern as well as stating that there were no groups over the following six weeks so the family would not be seen at the centre. A decision was made to ask the Mental Health Team to assess MU's mental health to establish whether her health was impacting upon her ability to parent. The Mental Health Team Manager spoke with MU's GP, and asked that a referral was made to the Crisis Resolution Team who could provide a more urgent response. The information provided included the following issues:

- Examples of behaviour displayed by MU at the Sure Start Centre, including aggression to parents and staff;
- Concern for the safety of children and carers;
- That MU had commented that she felt isolated;
- That MU intended to home school Child U.

The GP reported that he did not think 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. A plan was agreed between health practitioners that the GP would invite MU into the surgery for assessment and feedback, and the Team Manager faxed a copy of a letter from 2005 when MU was seen in the Accident and Emergency Department. This letter indicated that MU had presented with her father and an Aunt, and that she had been ill for two weeks. She had presented as delusional, stating for instance that police were spiking her drinking water with cocaine and that her brother was in love with her. She had admitted to hearing voices and stated that she began smoking cannabis at the age of 13 years. Admission to hospital was discussed but her relatives preferred to care for her at home. She was started on treatment and was seen for follow up in 2006, but discharged once she moved to another borough. The GP records held no information about this.

9.38 On 28th July, prior to the GP appointment, Children's Social Care wrote to the Children's Centre and advised that no further action would be taken but they were awaiting the outcome of MU's mental health assessment.

9.39 The fax from the Mental Health Team to the GP requested feedback from the GP by 16th August, and stated that if MU had no serious and enduring mental illness, she would not meet the criteria for referral to the Mental Health Team and the case would be closed. On 16th August, the Mental Health Team established that the fax had been received by the GP, and as there was no

feedback from the GP, the case was closed to Mental Health services. GP records indicated that MU was invited to attend the GP, but there was no follow up when she did not do so. This action was not challenged by any other agency. In September the health visitor checked the status of the case with Children's Social Care and established it was closed on 24th July 2010.

9.40 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.

9.41 On 13th October, the police responded to a call from a member of the public who reported they had witnessed a mother hitting a child hard about 5 times near to a supermarket. The police attended the site and established that the child and mother had left in a taxi, and a second witness said they had observed the mother hide from the child and then scream and slap the child across the head for being missing. The police identified the child as Child U, and once located, arrested MU for common assault. 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 whilst waiting for a Social Worker to collect Child U, an officer noted a concern that she was touching her vaginal area and that of a toy.

9.42 At the police station, MU was seen by a police surgeon who stated that she was fit to be detained and was not exhibiting any mental health issues. In interview, MU stated that was tired as she had not slept and accepted that her actions had been excessive in relation to Child U misbehaving, and that she thought she may have ingested a dangerous domestic liquid. MU was bailed to return to the police station on 20th October, with a police bail condition that contact with Child U should be supervised.

9.43 Child U was placed in emergency foster care, and was taken by the Social Worker to the Children's Centre the following day. Children's Social Care intended to place Child U back with her mother that day, but were advised by MU that this would contravene the bail conditions and the police requested a strategy meeting as it was felt there were outstanding queries in relation to what had happened and whether or not a return home would be safe. At the Centre, contact took place between Child U and MU, and a record is noted in the Initial Assessment that MU stripped Child U during the contact to check

her. On the way to the second arranged placement, Child U told the Social Worker that MU slaps her when she doesn't listen.

9.44 A strategy meeting took place attended by Police and Children's Social Care on 18th October, the outcome of which was that MU would receive a caution, Child U would return home and an Initial Child Protection Conference would be convened. The caution and return home occurred that day. There was no consultation with health services, or reference to the ongoing concerns of the Children's Centre. The Health Visitor was contacted on 5th November. A high level of credence was given to the fact that MU had admitted to slapping Child U. The Child Protection Conference took place on 29th November.

9.45 On 3rd November, the Housing Association made a referral to Children's Social Care, outlining the concern of the workmen in September, along with reports from neighbours that Child U was running around the communal gardens naked and MU was unconcerned.

9.46 On 9th November, whilst playing at the Children's Centre, Child U called MU using very derogatory language. When the worker intervened and suggested an apology to MU, Child U said 'my mum hits me'. After consulting with senior staff, the worker completed a referral on the observations, the Centre reported that they did not receive any feedback regarding the referral and were not subsequently aware that Child U was made the subject of a child protection plan. MU and Child U did not attend this centre again.

9.47 The Child Protection Conference that took place on 29th November was attended by key agencies, and included Housing but not the Children's Centre. The Social Worker who attended was not the allocated Social Worker, was inexperienced, and did not know the case. MU attended the Conference and confirmed when asked that she was a cannabis user. 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. A first Core Group meeting was planned for 9th December; however, this was cancelled due to ill health of the Social Worker. A Core Group meeting subsequently took place on 20th December; again the allocated Social Worker was not present but was replaced by a Senior Practitioner.

9.48 On 15th 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. The officers explained that the season would dictate environmental factors such as mud and leaves gathering in gutters and the grass wasn't growing as it was under a shady tree. MU also pointed out that her neighbour downstairs had dirty net curtains and made disparaging

comments. 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 shouted derogatory abuse at the officers; notably MU did not flinch and carried on talking. At the end of the meeting MU was informed that the incident with Child U being abusive would be reported to her Social Worker. The main item of discussion at the Core Group the following week was the anti social behaviour. A referral had been made for a nursery placement for Child U.

**2011**

9.49 In January, MU refused a nursery placement for Child U, stating she wished for her to continue attending the playgroup together with MU three times weekly. In January the allocated Social Worker left, and the case was reallocated.

9.50 On 19th 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.

9.51 On 26th January, a visit was made to MU and Child U to introduce a new Health Visitor. Child U was observed to be mature for her age, with good speech, comprehension and vocabulary. She was also observed to be a little aggressive if she did not get her own way. MU reiterated her intention to home school Child U and stated that she does not require outside help.

9.52 During January, MU and Child U continued to attend the 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. The concerns identified included a lack of boundaries for Child U, inappropriate behaviour by MU and little interaction between Child U and MU.

9.53 On 1st February a further Core Group was cancelled as there was no attendance. Communication took place between the Health Visitor and Head of Centre and Social Worker about the concerns of the Centre. A Core Group Meeting took place on 3rd February, however; only Housing, Children's Social Care and MU appear to have been invited. In the event, the meeting was terminated because Child U was present.

9.54 On 15th February, a joint home visit was made by the Social Worker and Health Visitor to see Child U and discuss the forthcoming review Child

Protection Conference. During the meeting, MU agreed to attend a parenting class and partake in a mental health assessment.

9.55 The first Review Child Protection Conference was held on 17th February. The meeting was not attended by Police and the Children's Centre Head 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 Child U continues to be home schooled (which she was not, although this continued to be mother's intention at compulsory school age) and that MU was now taking on board advice. The meeting confirmed the need for mental health assessment, but there was no indication that the issue of cannabis was ever asked about or considered after the Initial Conference.

9.56 On 3rd March a Core Group meeting was cancelled because no child care had been arranged for Child U. It was further cancelled on 9th March, due to leave by the Social Worker. The Health Visitor contacted the Trust Safeguarding Team concerned that Core Groups were not meeting anticipated standards and made attempts to contact the Social Work Team manager.

9.57 On 11th March, the Social Worker made a home visit. MU reported the difficulties she was experiencing with neighbours and stated that she felt victimised by the Housing responses. It is apparent that 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.

9.58 On 4th April, the Social Worker contacted MU's GP who advised that MU had a past diagnosis of Schizophrenism. The Social Worker requested an urgent assessment, and was advised to ring back the following week as the GP would invite MU into the surgery. On 5th April, 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 best placed to make the referral. The Social Worker contacted the GP again on 19th April 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.

9.59 On 4th May the Social Worker made a home visit, and on 5th May a scheduled Core Group was again cancelled because a Support Worker was ill and there was nobody to look after Child U.

9.60 The Mental Health Social Worker conducted the assessment on 5th May. 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 an outpatient psychiatry appointment. There are many recorded attempts by the mental Health Social Worker to consult with the child Social Worker prior to making arrangements directly with MU but no contact was established. An arrangement was made with MU for an appointment on 5th July.

9.61 A Core Group Meeting was held on 9th May attended by Social Care, Health Visiting, Housing and the Children's Centre along with the Mental Health Social Worker who fed back the findings of the assessment and plans for follow up. On 19th June, the Social Worker contacted the CAPS service clinical psychologist outlining that MU needed parenting strategies. The CAPS service agreed to attend the forthcoming Child Protection review conference to ascertain if they could provide a service that MU would accept.

9.62 At the end of June, MU presented as agitated at the Children's Centre, focussing on minor complaints and struggling to respond to Child U's abusive language towards her. On 5th July, MU was assessed at the outpatient clinic as planned. 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.

9.63 On 7th July, A Core Group meeting was cancelled as the Social Worker was not in work.

9.64 The third Review Conference was held on 11th July. The Conference was not attended by the Police, or MU. Child U remained subject to a Child Protection Plan for neglect. The Social Worker visited MU on 13th July, MU was unhappy with the continued plan when she could see nothing wrong, and the Social Worker spoke to her about Child U's behaviour and proposed the work that could be offered by CAP.

9.65 On 4th August, the GP received a detailed letter outlining the outcome of the mental health assessment. It concluded that MU gave no impression of an enduring mental illness and she was discharged back to the care of the GP.

9.66 A Core Group meeting was held on 16th August, attended by Social Worker, Health Visitor and MU. The focus of discussion was home education. 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.

9.67 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.

## 10. Analysis Leading to the Lessons Learnt

The analysis is drawn from the individual Agency contributions to the Review, the discussion that has taken place in Serious Case Review Panel meetings and the author's independent contribution. This section of the report sets out to reach an understanding of how the sequence of events unfolded as it did for agencies working with Child U, and to try to gain an understanding of what factors influenced the tragic action taken by MU.

10.1 *How did agencies recognise and respond to reports of sexually harmful behaviours and the potential impact on Child U and other children? The analysis should include the adult and child's behaviour, comments, language and thoughts.*

10.1.1 The initial gathering of information on this child revealed some instantly concerning issues related to sexualised behaviour of Child U, but also an apparent preoccupation by MU to issues of potential sexual harm. The concerns were first highlighted in July 2008, at this time Child U was 18 months old. Information was given to the police by a community volunteer known to MU that she had expressed that her daughter wanted a sexual relationship with her. The police recognised the inherent concern in this statement and took a joint investigative approach with Children's Social Care. A joint visit to MU and Child U prompted a referral for a mental health assessment after MU expressed that Child U fondled her breasts when breast feeding, would also put her hands between her mothers legs and stated that light bulbs were giving her signals to approach her daughter in a sexual way. While such a medical assessment was clearly an important aspect of the response, what is surprising is that this became the only response, so that when the out of hours GP found no indicators of mental illness, no further exploration was made of the concerning statements made by MU. Somehow, the focus of concern in the Initial Assessment became whether or not MU was displaying signs of mental illness rather than considering the impact of her thoughts and behaviour on Child U. To some extent, this response set the tone for later interventions, and this caused agencies to overly focus on assessments of MU's health rather then a recognition of indicators of concern for Child U that should have led to further assessment.

10.1.2 In 2009, when MU presented at the police station stating she no longer wanted to live with FU, the police officers were concerned to hear MU say 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.. .' MU was taken to hospital for medical assessment, which again concluded that there were no signs of mental illness. However, whilst at the hospital, a police officer observed MU tickling Child U between her legs, and then this action reciprocated. So concerned were the police by the totality of what they observed that Police Protection powers were invoked and Child U was

placed in emergency foster care. The following day, during a visit from a social worker and police officer, MU denied saying what was overheard, rationalised the tickling incident but did agree that the television made sexual innuendos. A decision was made to return Child U home that day, on the basis that there were no immediate concerns for her welfare, but this time a Core Assessment would be completed. The Core Assessment was completed in August but was superficial. Whilst it noted that FU had returned to live abroad, it did not address the causes for concern in relation to Child U, or identify any of the strengths and weaknesses relating to MU. Significantly it only superficially considered the wider family and did not attempt therefore to draw on any sources of support potentially available to MU. The case was closed on the strength of a poorly constructed core assessment.

10.1.3 Child U was twice placed in emergency foster care having been made subject to Police Protection powers, in July 2009 and October 2010. On both occasions when Child U was returned to her mothers care, MU stripped Child U to check for signs of sexual abuse. Clearly MU had reasons why she was pre-occupied with the possible sexual abuse of Child U, but this was never discussed with her at any point despite this aspect concerning both social workers and police officers. An understanding of the effects of sexual harm would inevitably raise the antenna of a worker that this is a woman who could have been affected by traumatic experiences herself, and this hypothesis was confirmed by family members when asked. MU had a complex psychology, part of which is likely to be as a result of traumatic experience, but this recognition did not form part of an approach to working with MU. It would seem that MU's patterns of behaviour in relation to issues of sexual concern were only ever considered in the context of mental health issues rather than what could have been a more rational response to her own experiences; or a combination of both.

10.1.4 It is noticeable that the observations of sexualised concerns from MU are at points of high stress, for instance at the police station or when Child U had been removed from her care and in the family home when MU examined Child U for signs of sexual assault on her return from foster care. This type of behaviour was not seen at either Children Centre in a more routine environment.

10.1.5 Whilst suggesting that the issue of sexual behaviour was not fully considered from either the perspective of risk to Child U or as an area for exploration with MU by operational staff, it is also significant that the child protection conference lacked focus on indicators of sexually harmful behaviour and did not bring together the various comments and events which together presented as a much more concerning picture than in isolation.

10.1.6 This case causes into question whether there is sufficient recognition and understanding of the indicators and effects of sexual abuse. As of June 2012, 2% of children subject to Child Protection Plans in Manchester are for reason

of sexual abuse, against a national average of 5.4%. This could suggest that sexual abuse is under represented in Manchester and there is certainly a need to gain a wider understanding as to whether multi agency professionals feel sufficiently knowledgeable and equipped to identify and respond to indicators of sexual abuse. In this case, there is evidence that multi agency professionals recognise concern about sexualised behaviour, but there were limitations as to how those recognitions were used to reach a greater understanding of Child U and MU.

*10.2 To what extent did assessment of mother's parenting take account of her behaviour towards Child U, other children, other adults, professionals and staff?*

10.2.1 Between May and July 2010, the Children's Centre made three separate referrals to Children's Social Care. These referrals highlighted concerns about MU's behaviour, both in relation to Child U but also in relation to her interaction with other children and adults. There was reference to incidents at adult and toddler groups where other parents reported feeling intimidated by MU's aggressive behaviour and also examples of where she spoke to other children inappropriately. The first two referrals were five days apart, and both resulted in very limited response. The Social work visit made in response to the second referral did not explore the concerns in depth and allowed MU to minimise the concerns of the Children's Centre for Child U by diverting the focus by way of raising concerns about the health and safety standards in the Centre. When the case was closed twice, no advice was given to the Children's Centre about the ongoing management of their concerns or the need to initiate multi agency planning through the Common Assessment Framework (CAF). The third referral in July resulted in discussions with the adult mental health team however; the case was closed on the basis that a referral had been made for a mental health assessment.

10.2.2 Child U was subject to a Child Protection Plan from November 2010 until her death in September 2011, just short of one year. Within this ten month period, there were two review Conferences yet it remains hard to determine through available records what actual parenting assessment occurred during this time. The convening of the Initial Child Protection Conference fell short of the 15 day timescale from the Strategy meeting, and although there was multi agency representation from Children's Social Care, Police, Health Visiting Service and Housing, the absence of both Early Years and Adult Mental Health Services was significant and undoubtedly compromised the quality of information, decision making and planning. An example of this is the decision to effect a child protection plan for reasons of neglect when quite clearly the presenting issue of concern was physical and emotional abuse. The effect of applying the category of abuse wrongly was far reaching, firstly in a lack of appropriate focus to the child protection plan and secondly that throughout the child protection plan MU could not understand the reasons for the plan and this could not be adequately explained to her. The

Children's Social Care IMR recognises that the practice of the particular Conference Chair fell short of agency standards and could offer no rationale for the decision making. Significantly, only the Health Visiting Service raised the inappropriateness of the category of registration in the Conference, suggesting that emotional abuse was the greatest issue of concern, but this challenge did not result in the wider Conference reviewing the recommendation and this direction should have been provided by the Chair. The presence of representatives from the Early Years Service would have been influential in focussing on the areas of concern identified over a significant period of time.

10.2.3 The role of the multi agency core group is to develop and implement the child protection plan as a working tool and to take forward the plan that was agreed at the initial conference. In this case, while the primary reason for the intervention was the risk of physical and emotional harm, the core group and planning did not reflect this. The pattern of Core Group Meetings indicate a fairly chaotic approach to case planning, out of ten scheduled meetings, six were cancelled, and others were poorly represented. This represents a very poor service to MU, and Child U and would have served to re-enforce her view that the plan was not a meaningful issue. The lack of written assessments of parenting or risk alongside shortfalls in the planning structures should again have been identified by the Chair of the Conferences and were not. There was a great deal of information available about how MU conducted herself, much of which was not collated but could have been through a rigorous assessment, which once put together, presents a picture of a woman who others found intimidating. It is possible that the multi-agency meetings were limited in effectiveness because they did not focus on the primary reason for intervention but focussed instead on issues which were more comfortable to deal with. It is understandable that professionals become drawn to focussing on issues where resolutions appear achievable rather than dealing with complex issues which appear intractable. However, as in this case, this is more likely to happen when children have not been the subjects of comprehensive and written assessments which recognise their individual needs and unique positions in their families and communities. The consequence of the lack of focussed assessment is that the child protection plan is insufficiently bespoke to resolve the harm which children are suffering or to manage the risk to which they are exposed.

10.2.4 Notably, the reason for the convening of the Child Protection Conference and subsequent plan, namely, MU's physical abuse of Child U appeared to be almost forgotten. The description of the incident by three members of the public was one of a calculated and ferocious nature, and clearly indicated MU's ability to cause deliberate harm to Child U. In would appear that the focus of the work became on engaging MU, and because MU was considered to have a difficult and volatile personality, achieving any degree of engagement with her was seen a measure of success in itself. This is evidenced by the summary of the Review Conference in February 2011 which

stated that MU was now taking advice on board, when in reality no progress had been made. MU had ceased attending the Children's Centre that raised the original concerns however, the same issues were evident at the second centre she attended, and within weeks of this statement she refused to work with the parenting programme which was a central component to the child protection plan.

10.2.5 When MU was assessed in July 2011 at the psychiatric outpatient clinic, the Specialist Registrar spent almost an hour assessing MU. During this period, the Registrar was able to observe MU with Child U, and commented positively on the interaction between mother and daughter. The Registrar was attuned to MU as a parent and confirmed that MU did not voice any thoughts of harm to Child U, conversely describing her as a very talented child. MU accepted that that in the context of being a mother for the first time there may have been times that her behaviour was perceived by others to be inappropriate, and on this occasion stated that she was willing to engage in parenting work but not that she had refused it earlier.

*10.3 How did agencies concerns regarding mother's reported mental health issues inform the planning and safeguarding of Child U.*

10.3.1 Most professionals who worked with MU had questions and concerns about her mental health, this included police, social workers, health visitor and Children's Centre staff and several attempts were made to gain a better understanding of her mental health and the response to each of these referrals is analysed as part of the Independent Psychiatrists report.

10.3.2 Prior to the terms of reference for this review, a critical aspect of MU's medical history was the diagnosis of psychosis of schizophrenia in 2005 when treatment was commenced. This was the first known opportunity to establish a diagnosis, secure appropriate and effective treatment, understand the risk profile and ensure effective aftercare arrangements. However, MU's needs became lost through the fact that she was followed up by the Community Mental Health Team and discharged on the basis that she was changing GP and moving area when she should have remained in contact with Trust services until a referral to another mental health service had been achieved. This diagnosis and treatment did not form part of the history taking during the subsequent contacts which was a significant omission and was due to a manual recording system not having been transferred on to the electronic system when it changed over. No checks on the manual system were made until July 2010 when, responding to a referral from the Children's Centre, a mental health worker identified the 2005 history of schizoid personality.

10.3.3 The Independent Psychiatrist offered the following opinion in respect of each period of intervention:

- July 2008 when contact was made with the GP by the Social Worker requesting support to achieve a mental health assessment and no assessment occurred:
  That it was regrettable that an expert assessment was not undertaken at this stage as this might have been an occasion that would have afforded an assessment whilst MU was more floridly psychotic and reception into appropriate mental health services could have been facilitated.
- July 2009 when MU was taken to hospital by police after she had attended the station seeking help with regards to domestic violence. three days later, MU was assessed by a Community Psychiatric Nurse and the conclusion was that MU did not meet the criteria for service and the referral was closed:
  That the assessment and subsequent actions were unsatisfactory in many ways given the significant background of concerns regarding MU's behaviours, which had involved her child and had been witnessed. The assessment involved five clinicians, some of whom would have had access to the medical and other records which would have indicated a recurring pattern of emergency contact with the services, evidence of psychosis and subsequent denial of difficulties and disengagement. At the assessment, the community psychiatric nurse identified and documented evidence of psychosis and MU appeared to be completely indifferent to the concerns of the statutory services with regard to her daughter, and sought to normalise these behaviours, with some members of the assessing team appearing to be easily persuaded by MU's reassurance. The subsequent letter from this assessment sent to the general practitioner was wholly inadequate in terms of identifying fully the reasons for the assessment, the mental state examination at the time of the assessment and documenting much more clearly as to how they had reached their decision not to offer any services.
  The mental health services should have been significantly concerned about the evidence of psychosis they found, and this in combination with her apparent lack of insight, and the involvement of her vulnerable child in her delusional system should have rang alarm bells.
- April 2011 when a request was made for mental health assessment as part of the child protection plan:
  The assessment was unduly protracted and took over two months to conclude. However, when MU was seen by the psychiatrist who was a senior trainee, with many years' experience, a thorough assessment was undertaken. The psychiatrist did not elicit any symptoms indicative of serious mental illness and he subsequently wrote to the general practitioner providing a comprehensive report, summarising his findings and discharging MU from the service.

The IMR undertaken by MMHSCT had identified the issues raised by the Independent Psychiatrist. It was recognised by MMHSCT that in a number of respects the assessments and service response was inadequate. The IMR

analysis and action plan provide details of how the service response will be improved.

10.3.4 Whilst on occasions tenacious efforts were made by the Social Worker to achieve mental health assessments, there are two very significant issues for this review. Firstly, two months prior to the death of Child U, MU was assessed by an experienced psychiatrist as having no symptoms indicative of a serious mental illness following a comprehensive assessment. Secondly, each time medical opinion was sought, the outcome was similar, and MU was not considered to have any enduring mental health problems. This left professionals with a dilemma, if MU's behaviour was not influenced by compromised mental health, why did she act and communicate in an abnormal manner? This question does not appear to have been faced, as ultimately the conclusions could lead only to one of two outcomes, either the medical diagnoses was incorrect or MU had a personality profile that was damaging to those around her, in particular Child U. Either conclusion needed a challenging approach to either health professionals or MU herself. Instead what appeared to happen is that the absence of a formal mental health diagnosis became the arbitrar of the response to the concerns.

10.3.5 The concerns about MU's mental health therefore only informed the safeguarding planning process by establishing whether there was a medical explanation for MU's presentation. The fact that assessments concluded that no mental illness was present was treated as an outcome to the concerns rather than an indicator as part of a more holistic assessment. This approach suggests that there was a lack of confidence amongst practitioners in identifying and responding to what they believe to be mental health issues, and coupled with the difficulties they experienced in navigating access to assessment and mental health services, they appeared to remain simply puzzled by the lack of any formal diagnosis and how they could continue from that point.

10.3.6 MU confirmed at the Initial Child Protection Conference that she was a cannabis user and has told health professionals that she has smoked cannabis since she was approximately 13 years of age. It is notable that this issue never appeared to be explored with MU within the Child Protection Plan, and significant that her family have subsequently indicated that she had a growing dependency on cannabis. The Independent Psychiatrist was asked to comment about the effects of ongoing cannabis use on mental health and he comments that a small proportion of people appear to be significantly and adversely affected by it. Drawing on his 30 years experience for a significant minority of patients who have paranoid psychosis such as schizophrenia, he commented that cannabis use often coincides with an exacerbation of their psychosis and hinders recovery. It is possible therefore that continued and increasing cannabis use could have had a direct impact on MU's mental health.

10.3.7 The Central Manchester University Hospital Trust IMR author refers to a systematic review in 2009 and a link between early cannabis use as in MU's case, and later mental health problems in those with a general vulnerability. Cannabis use as a recreational drug is common in the geographical area and cultural surroundings of MU and this can result in an acceptance and normalisation without staff thinking of the impact particularly when there are dependents.

*10.4 How holistic were agencies assessment of Child U's needs in relation to wider family and social isolation?*

10.4.1 Whilst it is apparent that FU lived abroad for the majority of Child U's childhood, it is clear that he was staying with MU in July 2009, and MU presented at the police station because of arguments she was having with FU. The two Core Assessments completed do not sufficiently address FU's role in Child U's life, nor were any attempts made to speak with FU when Child U became the subject of a Child Protection Plan. The consequence of this denied FU the opportunity to take some responsibility for Child U's protection needs, and allowed MU to be the sole source of information about Child U's extended family.

10.4.2 MU indicated that she had little contact with her extended family, and the Child Protection Plan did not address this issue with any depth. Consultation with family members as part of this review has revealed that MU may have had more contact than she indicated, and also that members of the extended family may have been able to contribute to building a support network and resilience for Child U.

10.4.3 MU and Child U were recognised as isolated in both Children's Centre settings, partly because MU's behaviour intimidated other parents. It would seem she had little friendships and those she had were not enduring. There are many examples of Centre staff trying to talk with MU and encouraging her to modify her behaviour towards others to ease the resultant social isolation. It is positive that MU consistently used the two Children's Centres, and evidences that they are able to reach their target group. Clearly she got a lot from the Centres as she did continue to attend by choice despite putting herself in few other social situations.

10.4.4 MU did not want to let Child U out of her sight, and this included allowing Child U the freedom of attending school. MU was clear from early in Child U's life that she intended to home school her, and this caused a particular concern within the Child Protection Plan in addressing Child U's isolation. It is clear that the heath visitor saw this as a very important issue, as she took this as an issue of concern to the Named Nurse who in turn raised the issue of concern with senior management in Children's Social Care. This was a good example of a health visitor escalating concerns that she did not feel were being responded to with sufficient robustness.

10.4.5 The lack of robust assessment throughout the child protection planning process, although primary the function of Children's Social Care, is a matter that should concern all agencies. The Social Care IMR recognises weaknesses in management oversight, but it is apparent that other key agencies did not challenge this position and identify the need for a more comprehensive approach to the management of the Child Protection Plan.

*10.5 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.*

10.5.1 Whilst all agencies have in place systems for the collation of data relating to diversity, this case highlights that it was not scrupulously completed and therefore begs the question as to how significantly this data can be used to inform planning and service delivery. In the GP records, MU's ethnicity was recorded whilst Child U's was not. On occasions, MU refused to disclose her ethnicity. The majority of referral forms from other agencies into Children's Social Care failed to identify ethnicity, and there seemed to be no follow up system.

10.5.2 MU was recognised as vulnerable in a number of aspects, through concerns about her mental health, identification of her isolation, lone parenting status and limited economic means. How these issues impacted on MU are however not well understood, primarily because the Core Assessments are very limited in addressing these factors but also because MU appeared to operate privately and did not choose to share much about her life with professionals. Despite the ongoing involvement with MU, it does not feel that any professional got to know her, and she did not appear to seek out any particular person to confide in.

10.5.3 MU talked on occasions at the Children's Centre of wanting a man in her life, and family members said that MU was waiting for FU to make it financially possible for her and Child U to move abroad to live with FU. Family members indicated this was a frustrating wait for MU; however, she did not share this intention or her frustrations with any professionals.

10.5.4 Consultations with volunteer workers and her family as part of this review suggest that MU had an acute awareness of her black heritage. The extent to which her own ethnicity impacted on her own development and engagement with wider society did not appear to be addressed in any assessment of MU. It is possible that wanting to acknowledge cultural difference resulted in workers not being as concerned as they should have been about some of the bizarre presentations in MU's behaviour and in particular the effects of ongoing cannabis use on herself and Child U.

*10.6 What factors influenced the police decision to take Child U into police protection on 5th July 2009 and 13th October 2010.*

10.6.1 In 2009 the police attended the Accident & Emergency Department with MU who had gone to a police station reporting domestic abuse by FU. The police had a number of concerns:

- the alleged domestic abuse;
- the previous history from July 2008 where it had been alleged MU wanted a sexual relationship with Child U;
- MU had been overheard saying there were places for them in heaven;
- MU was observed to touch Child U in the genital area in a way similar to tickling, Child U then did the same back to MU whilst waiting at hospital.

As a direct consequence of their concerns, the police exercised Police Protection powers and informed the Emergency Duty Service in Children's Social Care of this and Child U was subsequently accommodated with emergency Foster Carers. What was surprising is that consultation with Children's Social Care did not occur prior to the issuing of the PPO, so as such the decision to remove Child U was made by police alone.

10.6.2 The following day a strategy meeting was held between a Social Worker and Detective Sergeant, it was not attended by either a Senior Practitioner or Team Manager from Children's Social Care as per practice standards. A joint visit with the police was undertaken and both agencies agreed the decision for Child U to return home with a Core Assessment to be completed and appropriate support provided. No other agency was consulted or invited to take part in the strategy and decision making. Although FU was present at the visit there is no record of his involvement (if any) in the discussion around the alleged incident of domestic abuse or the concerns over MU's mental health which had prompted MU to go to the police station resulting in the presentation at Hospital.

10.6.3 When Child U was returned home later that day, the accompanying Family Support Worker, was concerned that on arriving home Child U was immediately stripped by MU to check for signs of abuse whilst in foster care. This information was shared with the Line Manager and the police officer who had undertaken the joint visit and it is recorded that all agreed with the proposal to hold a multi-agency meeting and for MU to have a mental health assessment. No multi agency meeting took place, although this was significant in the rationale to support Child U's return home. A Core Assessment was completed and the case was closed to Children's Social Care. The factors that influenced the police to use emergency powers should also have influenced the ongoing progress of the case, and the failure to convene the multi agency planning meeting was an omission on the part of both Children's Social Care and the police.

10.6.4 In October 2010 the police used emergency powers following three separate members of the public reporting witnessing MU slapping Child U outside a local supermarket. Child U was noted to have a scratch on her neck and when asked said 'mummy did it'. Again the police informed Children's Social Care after the PPO was initiated and Child U was again placed in emergency foster care. The Initial Assessment was allocated to the Social Worker who had undertaken the Initial Assessment in June 2010 to provide consistency for the family. The following day, despite no strategy meeting involving the Police or other agencies taking place, the Social Worker visited MU and advised her that Child U could return home, this appears to have been a unilateral decision by Children's Social Care and it was MU that advised the Social Worker that her bail conditions precluded this course of action. Had a Strategy Meeting taken place as per procedure, then this would have been known and as a consequence, Child U had to move to a second foster placement as she was with an emergency carer. A Strategy Meeting took place the following day where it was agreed that MU would receive a caution and Child U would return home. No medical took place of Child U during this investigation, the rationale being that MU had admitted causing the injury; however, Child U could have had other undetected injuries. Given three people describing a sustained and severe assault, the decision not to have a medical was flawed and does not accord with good judgment.

10.6.5 This second use of police emergency powers led to an Initial Child Protection Conference being convened, as stated, outside of agreed timescales. It is worthy of note that Child U was not seen by a Social Worker until after the Child Protection Conference, and no home visit was made in the intervening period when MU had just been cautioned for assault. It is also unlikely that Child U's welfare was monitored through the Children's Centre as the Centre was unaware of the Conference taking place.

10.6.6 On both occasions, the police used emergency powers because of immediate concern for Child U's welfare. It is interesting that on both occasions Children's Social Care were informed rather than consulted about the need for emergency protection and this raises the question as to whether there is scope for improved working together arrangements at the point of crisis. Whilst the use of emergency powers implies immediacy and urgency, in reality there is likely to be the opportunity for consultation with safeguarding partners prior to implementation. Wherever possible, opportunity for joint decision making should be taken, as this will result in joint ownership of risk assessment and the implications for subsequent planning.

*10.7 To what extent was Child U's voice, wishes, feelings, behaviour and needs explored, understood and taken account of when making decisions about provision of services? Was this information recorded?*

10.7.1 Child U was an articulate child, she was noted to converse more on adult than child level. The extent to which Child U was consulted and heard is addressed

well by individual agencies in the relevant IMRs. The Police IMR questions whether in October 2010 Child U could have been interviewed by police and Children's Social Care under Achieving Best Evidence Conditions, however, what is important is that consideration did not appear to have been given at the time. Prior to any consultation with Children's Social Care, Child U was asked by attending police officers about her account of what happened outside of joint interview protocols. Child U was 3 years and 9 months at the time, and while MU admitted to the assault witnessed by members of the public, a considered interview may have enabled Child U to tell more information about her experiences of being cared for by MU. One can only assume that Child U was considered too young to be formally interviewed without fully considering her developmental stage. There are a number of records however of Child U's comments and presentations on this following this incident including:

- Child U telling police that 'mummy did it' – referring to the scratch on her neck;
- Information forwarded to the Social Worker by the police officer regarding her observations whilst caring for Child U at the police station that when reading a story about Princes and Princesses, Child U asked 'is he going to hit her'; Child U also kept shining the PC's torch into a teddy bears eyes and asked the officer to make the teddy cry;
- Child U told the foster carer that MU slaps her when she doesn't listen;
- Child U told the foster carer after wetting the bed that her mum smacks her when this happens at home.

10.7.2 Given what was witnessed, and what Child U said, the decision to return Child U to MU seems to have been made with undue haste. A further period of foster care would have allowed time for a deeper assessment of risk, and to work with both Child U and MU from a safe position. In the event, the comments of Child U were never discussed with MU and Child U was seen only twice alone during the period of the Child Protection Plan. The Children's Social Care IMR reflects that this represents poor judgement and a lack of robustness in managerial oversight.

10.7.3 There are a number of occasions where Child U should have been given the opportunity to speak with a Social Worker alone and this did not appear to happen. It is a requirement when undertaking Initial and Core Assessments that a child is seen as part of that assessment and good practice that where it is age appropriate that a child should be seen and spoken to without the parent present. The Initial Assessments in July 2009 and July 2010 record that Child U was seen but do not indicate that she was seen alone or spoken with. The Initial Assessment conducted in June 2010 refers to Child U being asleep at the time of the Social Worker's visit and therefore there were no observations or specific communications.

10.7.4 The IMR from Manchester Mental Health and Social Care Trust notes that although Child U was often seen during assessment of MU, her views and

comments are not recorded and the presentation of her behaviour was not seen as significant by practitioners and is critical that it assumed this is a task solely for Children's Social Care. The Health Visiting Service provides good observations of Child U during visits, but much less in the way of personal interaction.

*10.8 To what extent, if any, did agencies communicate effectively and work together to safeguard and promote the continued well being of Child U.*

10.8.1 This review does show some instances of good informal communications, for instance between the GP and Health Visitor, and the Children's Centre and Health Visitor.

10.8.2 A particular issue of concern was identified that when MU and Child U changed the Children's Centre they attended, the Children' Centre was not aware that Child U was subject to a Child Protection Plan for some time. The first Children's Centre was not aware that a Child Protection Conference had been held and so this information was never shared between Centres. The SCR Panel was surprised that Heads of Children's Centres did not have any access rights to the MICARE computerised record system used in Children's Social Care, and noted that access to simple factual information (level 1 access) would have alerted them immediately to the fact that a plan was in place. As a consequence of this finding, Heads of Centres are now being set up with Level 1 access to MICARE which will ensure they are able to note and follow up significant facts about the child.

10.8.3 From the point of the Initial Conference, multi agency working together arrangements were compromised for a number of reasons:

- Not all relevant agencies were invited to attend the Child Protection Conference;
- The Child Protection Plan was misguided by a lack of focus on the specific issues of concern;
- The Core Group arrangements did not work well both from an attendance perspective and a lack of common understanding of what needed to be the focus of change;
- The Review Child Protection Conferences did not systematically re-evaluate the causes for concern and what had or had not been achieved through the Child Protection Plan;
- The route into mental health assessment and services are not commonly understood or applied by professionals.

10.8.4 From speaking with MU's extended family, it is apparent that they may have provided a source of support and resilience for Child U had they known about her situation. MU's reported isolation from her family could have been further explored as part of a robust core assessment and attempts made to build up the strengths than can be provided by extended family and community.

10.8.5 The effectiveness of the Core Group was diminished by a lack of focus on the risk factors, and this would also have impacted on MU's understanding of what was expected of her. There is little about the Conference and Core Group experience that would have helped MU understand and accept what professionals were actually concerned about, and from this position any change was most unlikely. From this position, the potential to create change within a family is not viable.

10.8.6 Although it is crucial that family members participate as fully as is realisable in the child protection process, the responsibility for the Child Protection Plan and its implementation remains with professionals. When working with complex cases of child protection, as an integral part of the assessment and management of risk there needs to be scope for purposeful professionals only meetings, particularly where the plan is not moving forward and the practitioners feel stuck in achieving progress.

10.8.7 A most critical point in how agencies worked together to protect Child U was the actions taken following the assault on Child U by MU. This was an assault that alarmed bystanders so much that three members of the public called the police. When the police traced Child U she had a fresh scratch to her neck which was bleeding. This incident should have led to a joint Section 47 investigation from the outset, however, what occurred was the two agencies, police and Children's Social Care took an approach which worked in isolation. It is hard to comprehend why this happened, but clearly the absence of a Strategy meeting until two days after the incident did not help the common purpose of protecting Child U. The evidence does not support the decision for Child U to return home so quickly following a significant assault without any depth of understanding as to whether Child U would be safe. IMRs from both GMP and Children's Social Care acknowledge this to be a decision that cannot be easily understood, and the absence of any contemporaneous minutes from the strategy meeting further exacerbates the lack of explainable rationale. This is a critical error of judgement and the most important missed opportunity to better protect and robustly assess any ongoing risk to Child U.

# 11. Individual Agency Reports and Recommendations

## 11.1 Manchester Children's Social Care

11.1.1 Manchester Children's Social Care has completed an Individual Management Review for consideration as part of this review. The report has been completed by an Area Safeguarding Manager who has had no operational responsibility for the provision of services to Child U. The report is countersigned by the Assistant Director, Safeguarding Provision who has responsibility for the delivery of all Social Care services to children, young people and families in the City of Manchester.

11.1.2 Manchester Children's Social Care received the first referral for Child U in July 2008 when she was 18 months old. During the time period covered by this review, a total of 10 referrals were made; 3 from Children's Centre staff, 2 from Housing, 1 from the Mental Health Service to the Emergency Duty Service, 3 from police and 1 from hospital. The common thread in referrals related to concerns about MU's mental health and her management of Child U. All referrals made to Children's Social Care were screened by the First Response Team (FRT). This is a team of Social Workers and Family Support Workers who make initial enquiries to determine whether the referral should be passed to an Area Social Work Team for further work or an Initial Assessment.

11.1.3 The management review provides a thorough and critical examination of practice, and acknowledges shortfalls in expected practice standards in the following key areas:

- Lack of casework chronology;
- That insufficient consideration was given to the role of FU in Core Assessment;
- No evidence that alleged domestic abuse was explored;
- Lack of opportunities taken for engagement with wider family members;
- Poor considerations of Child U's expressed thoughts and feelings;
- The inappropriate categorisation of the reason for the Child Protection Plan and consequences of this;
- That there was a lack of robust management oversight of the case which could and should have identified the above issues at the time.

Additionally, the report states that there was an individual issue of poor performance by the Chair of Conference.

11.1.4 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.

11.1.5 Following completion of the IMR, all actions have been progressed with a particular focus on activity to strengthen the quality of assessments. The checklist used by team managers to quality assure and approve assessments has been amended and regular audits of cases have been undertaken. The outcomes from the audits are monitored via a monthly performance meeting and improvements in the quality and consistency of Core Assessments have been reported. Practice guidance in relation to Core Assessments has been revised and briefings by Social work Consultants have been completed to improve the recording and analysis in assessments. The existing audit processes is strengthened with a revised audit framework implemented in September 2012 which includes audit of cases, observation of practice and completion of a self assessment audit tool prior to supervision. This is designed to provide depth and more detailed analysis on the quality of assessments.
To strengthen Section 47 strategy meetings a standard template has been introduced which enables attendees to receive the minutes of the meeting on the day. Work is currently in progress to ensure GP's are included in strategy discussions along with agreement for a Police Officer from the PPIU to be co located at an area social work office to maximise working together in Section 47 activity.

## 11.2 Manchester Early Years and Sure Start

11.2.1 Manchester Early Years and Sure Start have completed an Individual Management Review for consideration as part of this review. The report has been completed by a District Head of Centre who had had no operational responsibility for the provision of services to Child U. The report is countersigned by the Assistant Director, Safeguarding Provision.

11.2.2 MU and Child U mainly accessed Early Years and Sure Start services from February 2009 until July 2011. MU used two Sure Start Children's Centres during this period, predominantly using Stay and Play Events sporadically. Their attendance indicates that MU had a pattern of staying away from a service for a period after being challenged about aspects of her behaviour, and indeed, MU did not attend one of the Centre's again after referrals were made to Children's Social Care.

11.2.3 The review notes that concerns were noted throughout about aspects of MU's parenting and behaviour to Child U, ultimately this resulted in referrals

to Children's Social Care. The report acknowledges that whilst appropriate referrals were made, the Centre's knowledge and in depth observations and assessment of MU's parenting skills were well reflected in the referral documentation. In addition the early impact of information known to Children's Centres was lost when they were not invited to attend the Initial Child Protection Conference or Core Group.

11.2.4 The report draws what can be learnt whilst noting that staff across the Sure Start Children's Centres did recognise and attempt to address safeguarding concerns, as well as refer to Children's Social Care where appropriate. Learning is identified in areas of communication across Centres, enhanced recording practice, and opportunities for reflection within a supervisory process.

11.2.5 Understanding this case scenario has enhanced and strengthened practice in relation to the completion of comprehensive safeguarding referrals whilst access to clinical supervision and support to all staff and volunteers is recognised as a priority area to build into the current redesign of the service.

11.2.6 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.

## 11.3 Greater Manchester Police

11.3.1 Greater Manchester Police has completed an Individual Management Review for consideration as part of this review. The report has been completed by a Detective Inspector from the Investigative Review Section who has had no operational involvement in the provision of services to Child U. The report is countersigned by the Force Review Officer.

11.3.2 Child U was first brought to the attention of GMP in July 2008, when concern was raised about MU and Child U by a community volunteer. Subsequently, they were contacted on two further occasions by members of the public expressing concern (once when MU and Child U had not been seen in the

neighbourhood as they were abroad for a lengthy period, and also in relation to MU assaulting Child U), on one occasion MU presented at the police station with Child U and the last occasion was the contact from the hospital after MU had stated that Child U was deceased. The immediate response to each individual event was timely and focussed on the immediate welfare of Child U. On two occasions the police used powers of protection to secure Child U's welfare. It is evident that whilst focussing on the protection needs of Child U, police practice has also focussed on the welfare needs of MU.

11.3.3 The IMR provides a very detailed analysis of the actions taken by police, and critically appraises whether there were any opportunities for improved practice. The report identifies specifically that there was no definitive records/minutes of interagency strategy meetings, and noted that the agency recording logs did not compensate for this deficit. No specific recommendation is made in this respect as this was not considered to be a single agency issue. Paragraph 10.1.5 notes that this issue has been addressed by police and Social Care together however, the police IMR suggests this remains a force wide issue across the Greater Manchester Authorities. In discussing the role of the PPIU with officers, the IMR Author was made aware that officers have limited preparation and prior training in working with children when moving into a specialist unit for vulnerable persons. In order to address this concern, a recommendation is made to address how officers can be assisted when making this transition.

11.3.4 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.

## 11.4 Adactus Housing

11.4.1 Adactus Housing has completed an Individual Management Review for consideration as part of this review. The report has been completed by the Head of Internal Affairs who has had no operational involvement in the

provision of services to MU or Child U. The report is countersigned by the Director for Corporate Services.

11.4.2 MU had a tenancy with Adactus Housing from 2005 initially as a single person. During the period of review, MU had many contacts with Adactus Housing in relations to property improvements and repairs and also in relation to neighbour dispute and anti social behaviour. The agency had shown a strong awareness of safeguarding issues, and clearly identifies themselves as an agency with safeguarding responsibilities. The reporting of concerns about Child U on two occasions by maintenance staff evidences that safeguarding training has been effective and resulted in appropriate concerns being raised.

11.4.3 The IMR provides a detailed summary of the contacts between the agency and MU, and comments on what the agency knew about Child U. The agency has taken from this review how significant a role that housing agencies can play in safeguarding children and as a consequence focussed on strengthening the training programme processes for all staff as well as streamlining reporting processes. All actions have been planned or implemented.

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.

## 11.5 NHS Manchester

11.5.1 NHS Manchester has completed an Individual Management Review for consideration as part of this review. The report has been written by a Consultant Paediatrician in Community Child Health who is the named doctor for Child Protection. The report is countersigned by the Locality Medical Advisor for the Trust.

11.5.2 NHS Manchester provided GP services for both MU and Child U. During the time period of this review MU was seen by a GP on six occasions and Child U seen on five. There were also seven occasions when other professionals rang to speak with the GP in order to share concerns or request assistance in relation to MU's mental health/behaviour.

11.5.3 The report is thorough and reviews in detail each contact with GP services as well as the role of the GP within the multi agency identification and response to concerns. The report notes that the bulk of the information in the GP records related to MU, and that although Child U was seen on several occasions very little was written about her therefore it was difficult to form an impression of Child U and what life was like for her. The Author commented that Child U seemed to become lost in the mass of information and high level of concern about MU's mental health noting that from the beginning, the focus was shifted away from safeguarding which became a recurring theme. The report also identified that no information about Child U was recorded in her own records when it had been received in relation to MU contrary to expected practice and concluded that if practitioners had been alerted to past and ongoing concerns each time MU and Child U were seen or new information was received, it would have allowed for this to be seen in perspective and may have altered the management of the case.

The report also reviews the system of 'flagging' patient records, noting that since 2001, general practice in Manchester is that when a child is subject to a Child Protection Plan a flag should be placed on the record of parent and child so practitioners are alerted each time the patient is seen or information is received. The report concludes however, that it could be helpful to place an alert on patient records whenever there are safeguarding or parental mental health concerns and not just when a child becomes subject to a Child Protection Plan as if there had been a flag on MU's and Child U's record it would have facilitated a more holistic and longer term view of the issues, rather than reacting to each event in isolation.

11.5.4 The report outlines that improving GP involvement in Child Protection Conferences is a priority for the GP Safeguarding Children Steering Group. 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.

11.5.5 Progress has been made on each recommendation and systems have been strengthened to ensure timely notification and targeted support is being offered to GP practices who have been invited to Child Protection Conferences whilst the issue of coding is currently being explored.

## 11.6 Manchester Mental Health and Social Care Trust

11.6.1 Manchester Mental Health and Social Care Trust have completed an Individual Management Review for consideration as part of this review. The report has been written by a Medical Director who is also the medical lead for Safeguarding and has had no operational involvement with Child U. The report is countersigned by the Chief Executive of the Trust.

11.6.2 Manchester Mental Health and Social Care Trust provide mental health and well being services for people aged above 18 years in Manchester. The Trust's Involvement with MU began in July 2008, when a request was made for an emergency service which did not result in a mental health assessment. In July 2009, MU was assessed twice, one at hospital and once in the community. In July 2011 MU was seen by a psychiatrist as an out patient and on none of the above occasions was MU considered to have a mental illness.

11.6.3 The review provides a critical and honest appraisal of the services provided to MU as well as reviewing the appropriateness of the occasions when a service was not directly offered. The report concludes that in 2008 the Crisis Resolution Home Treatment Team had a poor understanding of their operational policy and as a result did not accept a referral. The report further states that on the occasions that an assessment occurred, the focus appeared to be to make a decision about eligibility for service rather than to undertake a more thorough assessment of mental health need, with the consequence that MU's significant symptoms and recurrent presentation was not taken into account in deciding on appropriate care. Additionally, the reasons for decisions being made regarding referrals were not recorded and the outcomes of referrals were not reliably communicated to the referrer.

11.6.4 The report further concludes that the practice was below expected practice standards in the quality of response to concerns about potential sexually harmful behaviour towards Child U, a lack of integrated assessments which resulted in Child U's needs not being adequately considered by mental health staff, and referrers not being informed of the outcome of an assessment as a

matter of routine. Additionally, the report identified that the Trust's electronic record system does not easily allow previous handwritten records to be incorporated into the main patient record resulting in previous records that were available and contained important information not being fully conveyed to professionals.

11.6.5 As a consequence of the review, the Trust is currently piloting a Gateway Project (commenced 1st July 2012) to improve referral pathways into the service. The purpose is to ensure that all referrals both internally and from external agencies are properly reviewed and that the most appropriate services are allocated. This includes the completion of urgent assessments and feedback on outcomes to the referrer. Additionally a senior Social Worker has been appointed to the project team who will provide immediate advice regarding any safeguarding issues. The pilot will be evaluated and rolled out across the Trust later this year.
An internal audit of the frequency of longitudinal history taking has been completed, and as a result of this further instruction has been issued to the workforce and a re- audit is scheduled later in the year to track improvement. The Trust clinical risk assessment training has been revised to ensure that staff are clear that risk histories are correctly taken and recorded, in addition a mandatory Safeguarding training day for Consultant Psychiatrists has taken place specifically focusing on the learning from this SCR.

11.6.6 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.

## 11.7 Central Manchester Foundation Trust

11.7.1 Central Manchester Foundation Trust have completed an Individual Management Review for consideration as part of this review. The report has been written by the Named Nurse for Safeguarding. The report is countersigned by the Medical Director.

11.7.2 Central Manchester University Hospitals NHS Foundation Trust provides regional and local primary, secondary and tertiary medical and maternity services with four hospitals on one site. In April 2011 CMFT became responsible for Children's Community Services, which includes Health Visiting and School Nursing provision for the City of Manchester.

11.7.3 The services provided to MU and Child U within the timeframe of this review included Emergency Department treatment, health visitor, community staff nurses and community nursery nurses as part of the health visiting team, and Children and Parent Service (CAPS) to assist with parenting. This included three attendances at hospital emergency department (one in relation to a minor injury to Child U, two in relation to MU); eight home visits by the Health Visiting Team; and a referral to CAPS which resulted in a plan to assess MU the day after Child U's death was discovered.

11.7.4 The report systematically evaluates the practice of staff and comments that the Health Visiting establishment in Manchester is recognised as being below the number required to deliver a full service is an issue that is currently being addressed. As a consequence, service delivery is targeted and prioritised for children under the age of eight months, children with additional needs and children at risk of significant harm.

11.7.5 The report identifies that the health visiting service was overlooked as a key multi agency partner in both strategy meetings and core assessment as well as stating that practice standards fell short through a lack of challenge or analysis to MU in 2008 and 2009 regarding the potential impact of her

behaviour and sexually inappropriate language on Child U. The report noted that the health visiting team found MU to be an ' articulate, knowledgeable and well informed parent with extreme views' and this may place in context a professional mindset that meant that her behaviour was not seen as the cause for concern that it should have been.

11.7.6 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.

## 11.8 NHS Manchester Commissioning Overview Report

11.8.1 A commissioning PCT health overview report of NHS Manchester has been completed in accordance with the requirements of Working Together to Safeguard Children 2010. The purpose of this report is to add value to the learning from health services and it reviews and evaluates the practice of all involved health professionals, including GPs and providers commissioned by the Primary Care Trust (PCT). This report provides a focus on how effectively health organisations interacted together and makes additional recommendations.

11.8.2 The report looks at particular issues that may be relevant to MU, in particular that she has smoked cannabis since the age of 13 years. The report notes that although MU's use of cannabis was referred to by service providers, the issue and its contextual significance did not feature in assessments. The author of the report believes commissioners of drug services should consider the potential impact of cannabis on parenting to inform future commissioning.

11.8.3 The report provides a very comprehensive overview of health services and makes significant links to ensure the learning from individual health agencies is shared across the health economy of services. 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 HVs 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 HVs 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.

## 12. Concluding Comments and Multi Agency Recommendations

12.1 This Serious Case Review was convened by the Manchester Safeguarding Children Board in order to critically examine the circumstances leading up to the untimely death of Child U. Each participating agency entered this process with a spirit of openness and genuine desire to undertake a critical review for the purposes of learning lessons, and in doing so they have openly identified where there have been shortfalls in expected standards of practice and acknowledged the impact of this.

Child U was solely dependent on her mother for her care and protection, yet whilst it is evident that MU wanted to be a good parent to her daughter, it is also clear that she struggled to achieve this over a period of at least two years, this very sadly resulted in MU taking the life of her daughter Child U. The injuries that MU inflicted upon herself would suggest that she also had some intention to take her own life. In circumstances where a parent intends to take their own life as well as that of their child (filicide-suicide), there are five potential motivations, (1) altruistic (2) acutely psychotic (3) accidental (4) unwanted child (neonaticide) (5) spousal revenge. A study paper by Phillip Resnick (*Journal of the American Academy of Psychiatry and Law in 2005*) hypothesised that motives for filicide-suicide would most likely be altruistic, revenge or acutely psychotic. Altruistic killings are characterised by the parent believing that the child will be relieved of real or imagined suffering and is often followed by the suicide or attempted suicide of the parent; revenge killings are related to the breakdown of the parental relationship whereby the child becomes the instrument of revenge by the perpetrator against their partner, and acutely psychotic accounts for the mental state of the parent at the point of the incident. The forensic examinations following Child U's death do not suggest any struggle, leaving the impression therefore of mother who did not kill her child in an act of rage.

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.

The SCR Panel believe that MU genuinely believed she was saving Child U from future harm.

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.

12.2 Family functioning and how it impacts on the capacity of a parent to protect their child is highly significant, but the route to understanding how families work has many pitfalls, and many have been evident in this review. First and foremost, a comprehensive and robust assessment of Child U and her family was never achieved, and as such this compromised the ability of professionals to understand the strengths and vulnerabilities of the family in order to direct the services at increasing strength and decreasing vulnerability. When children are the subject of a Child Protection Plan, fundamental to working with the family is a holistic assessment of need and risk, because without this, a Child Protection Plan can only ever be superficial.

12.3 Child Protection Systems are very sophisticated, and designed to promote and support best practice. Implemented effectively, the multi agency child protection systems in Manchester are robust and protect the vast majority of children. Whilst therefore there were individual failings across the system, this does not equate to systemic failings within the system. There 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 needs to be drawn. The Factors include the following:

*12.3.1 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.

*12.3.2 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.

*12.3.3 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.

*12.3.4 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.

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

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.

*12.3.6 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 MMHSCT IMR states that the 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.
**Recommendation 1**

*12.3.7 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. The Board needs to be satisfied that this guidance is wholly embedded in practice and that the management of joint Section 47 investigations is always compliant with the requirement for a Strategy Meeting.
**Recommendation 2**

*12.3.8 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.
Historically, and at the time during this review, Child Protection Conferences in Manchester have been chaired by Independent Reviewing Officers with a dual purpose caseload. Very recently, Manchester has reviewed the position of Chairs of Conference and there is now a team of seven Chairs, dedicated solely to Child Protection Conferences. It is intended that this will increase skill, consistency and offer peer challenge.

12.4 The review has identified that all agencies have safeguarding training and have had 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. In order to address this a recommendation is made that as part of multi agency training, staff are equipped with sufficient knowledge to respond to the toxic trio of safeguarding concerns – mental health, substance abuse and domestic abuse.
**Recommendation 3**

12.5 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. Both have been findings in previous Manchester Serious Case reviews, yet despite disseminating this need and equipping staff with training, both issues remain problematic in practice. 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. Currently, in line with recommendations from the Munro Review of Child Protection, Manchester is reviewing its approach to assessment, with a view to creating a single assessment framework; this creates an opportunity for single agency assessments to come together in a more seamless approach for children subject to a child protection plan.
**Recommendation 4**

12.6 In conducting this review, the panel and Author had been concerned about the indicators of sexual harm that were not identified as part of the Protection Plan. The questions as to why sexual abuse is such a low percentage of children subject to a Child Protection Plan is important to establish, particularly as this indicates that this type of harm is becoming less recognised and therefore responded to.
**Recommendation 5**

12.7 The messages from this review are not new, and it for this reason that there is a challenge in not simply repeating previous recommendations. Each agency has made individual recommendations, and has covered all areas where this learning has supported improvement. There is however, a need for agencies to dig deeper still to get to the heart of how the above findings can be embedded into future practice.
The dissemination of learning from this Serious Case Review is already taking place across agencies. It is intended to hold a dissemination event with key professionals in to encourage reflective learning to begin the process of embedding changes to culture and practice.

## Multi Agency Recommendations (reference Action Plan in Appendix 1)

**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.

## 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.<br>2. Good practice guide is presented to and signed off by MSCB. | 1. Audit tool.<br>2. Good practice guide.<br>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.<br>2. Amended escalation policy is presented to and signed off by MSCB. | 1. Terms of reference of the task and finish group.<br>2. Minutes or action notes from the meetings.<br>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 |

## 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 |
|---|---|---|---|---|---|---|
| **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:<br>a) Is sufficient priority and time being invested in S47 meetings?<br>b) Are the right people invited?<br>c) Do those who need to know receive the plan? E.g. GP, Examining Paediatrician, School, Health Visitor?<br>d) Is every child considered for an 'Achieving Best Evidence' Interview and the rationale for a decision recorded? | 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 |

**Child U SCR - Multi-agency Action Plan**

**Working Together to Safeguard Children in Manchester**

| No. | Recommendation | Lead | Key Actions | Evidence | Key Outcome | Date |
|---|---|---|---|---|---|---|
| | | | 2. Initial report provided from the group to MSCB by the end of January 2013.<br><br>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:<br>• points of multi agency peer challenge;<br>• management oversight of multi agency child protection plans;<br>• the place for purposeful professionals only meeting. | 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 Health.<br><br>2. The group should develop multi agency guidance and a framework relating to holistic single assessments. This | 1. ToR for Task and Finish group.<br>2. Minutes or action notes from meetings.<br>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 |

**Child U SCR - Multi-agency Action Plan**

**Working Together to Safeguard Children in Manchester**

| No. | Recommendation | Lead | Key Actions | Evidence | Key Outcome | Date |
|---|---|---|---|---|---|---|
| | | | 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.<br>2. The meeting should establish the Terms of Reference and scope of the research.<br>3. Upon conclusion a report containing analysis, recommendations and an action plan should be produced to MSCB. | 1. Document showing scope and terms of reference.<br>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 |

**Child U SCR - Multi-agency Action Plan**

**Working Together to Safeguard Children in Manchester**

| No. | Recommendation | Lead | Key Actions | Evidence | Key Outcome | Date |
|---|---|---|---|---|---|---|
| **6.** | That MSCB request an audit from the Safeguarding Improvement Unit that reports on the robustness of the child protection planning arrangements to include:<br>• Appropriate categorisation criteria;<br>• Robust child protection plan;<br>• 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.<br>2. At the conclusion of the audit a report and action plan is presented to the MSCB Executive. | 1. Audit tool.<br>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 |