Manchester Safeguarding Children Board

Learning Report SCR - CHILD N1

August 2018

Learning Report

This report summarises the key learning points from the serious case review (SCR) of a child, referred to as CHILD N1, and has been written as a learning tool for agencies and practitioners.

A SCR is not an investigation intended to attribute blame, but rather to identify what went wrong in this case and how similar failures can be avoided by learning from this case.

Who is CHILD N1?

CHILD N1 was an only child and regularly attended nursery. CHILD N1 has been described as a very alert, happy, well-presented child who had met their milestones.

CHILD N1 was three years old at the time of death, and was found unresponsive in the bath. The cause of CHILD N1's death remains unascertained. The account given by mother is that CHILD N1 was left unsupervised in the bath.

The family frequently moved between different geographical areas. There were incidents of domestic abuse and mother's history of mental health was of concern.

Mother and father separated a number of times and mother stayed with her family, but felt under some pressure by her family to return to father.

Mother's cultural and ethnic heritage is Pakistani English and father is Pakistani. Parents are both Muslim faith.

In the previous year, before the death, CHILD N1 was taken to A&E after mother said that CHILD N1 had ingested some of her sleeping tablets. This incident was referred to Children's Social Care (CSC) in Manchester and an assessment was completed. The assessment concluded that this was an unfortunate accident and that mother had learnt from this. The case was then closed.

The week prior to CHILD N1's death, domestic abuse between mother and father was reported by mother and subsequently mother made an allegation of rape and threats to kill against father.

Why was the SCR carried out?

It was decided that the criteria for SCR - that abuse or neglect was suspected and serious harm to the child - were met and a commissioning meeting was held and the review got underway in October 2017.

The extent and quality of professional involvement and support given to CHILD N1 and their family over a four-year period, from May 2013 when mother became pregnant with CHILD N1, up until the death of CHILD N1 in March 2017, was considered by the review. During this period the main professional involvement came from universal services, such as midwifery, health visiting, education and GP.

The review agreed six key lines of enquiry for consideration in addition to analysing individual and organisational practice.

What did the SCR find?

The review identified five key practice episodes for analysis and found evidence of good practice and some success in working with the family, but also areas that the review felt could be improved upon.

The review identified examples of good practice, such as the identification of appropriate concerns and risk factors and some good responses to these. An assessment of mother's mental health by a consultant psychiatrist was thorough and identified appropriately the areas of concern and a plan was drawn up in response - however, this plan was never implemented.

Situations which involve people moving between areas, or expressing intention to move but not doing so, or moving without informing people (all of which were a feature in this case) can pose significant challenges to professional practice – particularly in respect of communication. Whilst there were examples of careful and thorough communication between professionals in different areas, it was found that there were also instances where communication was not so effective – with professionals not adequately passing information on or ensuring that communication had been received and was being acted on. These problems were compounded by delays in transfer of records (e.g. health records) from one area to another.

Whilst there were clear indications that mother was adopting a somewhat transient lifestyle, there was limited exploration of the reasons for this, and the implications. Little comment or assessment is made about the impact, or likely impact, on the routines and needs of a very young baby. Professionals were responding to, and accepting, mother's perspective without highlighting or assessing the daily lived experience of the child and the risks to CHILD N1.

There was some highlighting of concern around possible domestic abuse, as well as mother's mental health. It is apparent that mother gave inconsistent or contradictory information to different professionals, and whilst she showed some commitment to working with professionals, at other times she declined support or was less than open or complete in information she provided. She received no on-going support in relation to issues identified around domestic abuse or mental health problems.

There was evidence of some confusion around the respective roles and responsibilities of the different agencies. This was particularly evident in respect of referral pathways into mental health services.

There were opportunities for more thorough and co-ordinated multi-agency assessment; for example, a referral made to CSC whilst mother was pregnant with CHILD N1, however, a decision was made to take no further action at the time. Also an MCAF was carried out, but was not sufficiently thorough, and was effectively a single-agency task.

There were times when there could have been consideration by professionals of whether a referral needed to be made to CSC. A learning point from this review is that agency records do not adequately show that such consideration took place at key points. One such example was in July 2014 when a health professional was sufficiently concerned to make an application for urgent supported accommodation, correctly identifying risk factors. There

was evidence of domestic abuse and that this may well have been a reason or trigger behind the frequent moves. This was an opportunity to consider whether a referral to CSC was indicated. No such consideration is shown in the records.

An incident of Child N1 apparently ingesting mother's medication represents one occasion when there was clear reason for concern about the possibility of CHILD N1 having suffered neglectful parenting – in terms of being left unsupervised with dangerous medication, subsequent delay in mother seeking medical advice and her reluctance to follow that advice. The review has identified examples of difficulties and inadequacies in the professional response. There was some failure of communication between key professionals in the early stages of this incident. The ambulance crew were not informed of the fact that mother had delayed seeking medical advice for several hours, and that she had then exhibited 'indecisiveness' on the phone in relation to whether to follow the advice given. The ambulance crew were thus not in a position to inform A&E of these factors which could have been crucial in their clinical assessment and in deciding whether or not to make a safeguarding referral themselves. The review has questioned whether, on the information that was available to both ambulance service and to A&E at the time, these agencies could have decided to make safeguarding referrals.

There are some concerns over the response to the safeguarding referral that was made (by NHS 111) at this point – including recordings not showing explicit consideration of the immediate protection needs of CHILD N1. The strategy discussion that took place was not sufficiently multi-agency and relied on inadequate information, not least as there were deficiencies in the system used at the time for police checks that were carried out.

Following the strategy meeting, the attempts to complete an assessment were insufficiently robust – for example, not indicating consideration of different ways of responding to repeated failure to undertake home visits and see CHILD N1. There does appear to be some level of over-optimism, or at least lack of professional scepticism by some professionals – with mother's perspective being accepted at face value without sufficient attempts to seek information from other agencies (such as the nursery).

A theme throughout this review has been that there was never any concerted attempt to collate all of the information held by the different agencies and to put a co-ordinated plan in place. The week before CHILD N1s tragic death there was a referral to CSC following an incident of reported domestic abuse between the parents. A strategy meeting could have been another opportunity to bring together all the information that different agencies held. It is a cause for concern that the review has not been able to clarify why the decision was made not to convene such a meeting.

Conclusion of the review

The review did not bring any degree of certainty to the many questions around why the tragic outcome ultimately occurred or the factors that might have contributed to that outcome. Instead, the focus has been on whether there are lessons to be learned from the professional involvement in the case. Whilst there are undoubtedly some questions about professional actions (and what factors influenced these), which are not fully understood, there are some clear conclusions that have emerged as follows:-

There was a lack of involvement of CHILD N1's father in the work carried out. Professional contact with the family focused on mother, with little attempt to gain an understanding of father's role and perspective. It is not, therefore, fully understood how far father may have been a protective factor, or a cause for concern at various points.

Mother had a significant history of mental health problems. Mother stopped taking the anti-depressant medication prescribed by her GP due to becoming pregnant. During the timeline of the review, she did not receive any on-going support specifically for any mental health problems. It is not known whether such support was necessary, or whether it would have been useful. This is because there was little attempt made to assess mother's mental health. The one significant assessment of mother's mental health was undertaken by the consultant psychiatrist, which did highlight serious risks and highlighted the need for urgent allocation to a CMHT for close follow up during and following the pregnancy. However, this follow up did not happen as there were problems with delay, communication and some confusion around the pathways into secondary mental health services.

Professionals who worked with mother highlighted that she generally presented well and not in a way to cause concern about her mental health or her care of CHILD N1.

Families that are quite mobile pose particular problems for professionals trying to track movements and ensure communication between agencies and across areas is effective. This review highlighted some good examples of professionals responding appropriately to this challenge, anticipating the possibility of family moves and sharing information, but there were also some clear examples of deficiencies in communication and information sharing.

A clear understanding of some of the significant issues for the family has been difficult to achieve, such as:- the family's movements from one area to another, family dynamics, the pattern of separations within the relationship between mother and father, the extent to which domestic abuse (including psychological, physical, and sexual abuse) was a feature of their relationship, the role of the extended family – maternal and paternal - and the extent to which cultural factors might have been impacting on the family and on the care of CHILD N1.

The family that did not come to notice very regularly and there was no intensive or prolonged work undertaken with the family. There were instances of mother not being entirely open in her dealings with professionals, and of avoiding professionals. Mother was inconsistent with what she said at times and minimised problems. Father was even less seen or spoken with. The family was quite mobile, and mother and father did separate (and reunite) a number of times.

There were opportunities to recognise that the pattern of the family lifestyle, the nature of the parent's relationship, mother's mental health or mother's ambivalence towards the baby, might be of sufficient concern and risk to be further explored in more depth. The review identified points at which concern around these issues warranted a safeguarding referral to CSC, on the basis that there was reason to be concerned about the risks to CHILD N1. The involvement of the consultant psychiatrist and the safeguarding midwife was an example of a time when issues were identified as possibly posing risks for the care of CHILD N1, but the plan put in place did not include making a safeguarding referral to CSC.

Referrals were made to CSC, and there were opportunities within the interventions that did take place for co-ordinating detailed, multi-agency information sharing and assessment. It is perhaps the most significant point of learning from this review, that these opportunities were not taken. Professionals held different pieces of information. No attempts were made to get professionals together, or to complete a co-ordinated multi-agency assessment of parenting and of the care of CHILD N1.

The review has identified problems with the convening of strategy meetings. On one occasion a brief phone discussion between just two agencies and based on incomplete information, served as the strategy discussion. On another occasion no attempt was made to hold a strategy discussion.

The voice of the child, or the daily lived experience of the child is not well understood, and it appears that the perspective of the adults (particularly mother) was accepted rather than being sufficiently challenged.

Findings

1. **Referrals to Children's Social Care**

- There were a number of occasions, three of which were in Manchester, when different professionals were in possession of information indicating that there might be a risk of significant harm to CHILD N1.
- Inconsistency in the making of safeguarding referrals to Children's Social Care.
- Agency recordings do not routinely demonstrate that this course of action has been considered by professionals in such situations.

2. **Strategy Meetings**

- There are problems with the system of convening multi-agency strategy meetings in accordance with the procedure for enquiries undertaken following/in response to safeguarding referrals.

Issues for MSCB

1. Is the MSCB satisfied that there is an appropriate and consistent understanding across all agencies of the threshold for making a safeguarding referral to CSC?

2. Are professionals across all agencies familiar with when and how to make a safeguarding referral?

3. Are they adequately supported in this by reflective and challenging management oversight? Is there a practice of routinely considering whether a referral is indicated and of ensuring that such considerations are adequately recorded?

4. The MSCB needs to ensure that in all situations where enquiries are being made under section 47 of the Children Act 1989, that in line with the procedure, all

relevant agencies are involved in strategy meetings or discussions to share and evaluate information, and plan the work.

Subsidiary issues for further exploration:-

- Does training and management scrutiny sufficiently highlight that the voice of the child or the daily lived experience of the child is the primary focus of all agency considerations? Furthermore, do agency recordings routinely demonstrate that all new information received is considered in terms of the impact on the child?

- It is recommended that there is a piece of work done to ensure that pathways into secondary mental health services are clear to those who might need to refer people for assessments and interventions – particularly primary health services such as GPs.

- It is recommended that the board seeks reassurance that all professionals are using the Manchester Domestic Violence and Abuse Assessment and Referral form when there is a disclosure of Domestic Violence and Abuse. This can be included within the Safeguarding audit processes for Children's and Adult's.

- When police checks are being completed to inform child protection investigations are they now rigorous in checking with all available sources of information, such as the PNC and/or PND?

- It is recommended that work is undertaken to ensure that NHS 111 hand over all available safeguarding information to ambulance staff when they make referrals for ambulance service to become involved.

- It is recommended that knowledge and awareness of Forced Marriage/'so called' Honour Based Violence and Abuse is increased and the One Chance Policy is promoted. A seven minute briefing is one way that an increased awareness of the issues could be achieved.

Additional Resources:

Further resources are available from the resource hub of the MSB website: www.manchestersafeguardingboards.co.uk in particular resources on:

- Cross Boundary Cases
- Forced Marriage and Honour Based Violence and Abuse
- Domestic Violence and Abuse
- Hidden Men