Case Review 3:
Child T

Salford Safeguarding Children Board

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Review Methodology

1) MACR panel with an independent Chair
2) Appointment of independent reviewers
3) 10 Lines of Enquiry
4) Integrated chronology
5) Single Agency Analysis Reports (SAARs)- agreed timeline from 18th Feb 2015- 22nd Dec 2016
6) Professional perspectives obtained by SAAR authors
7) Consideration of significant others in Child T's life
8) Presentation of report at SSCB on 21st May 2018

Multi-agency Concise Review Criteria

A child is *harmed* through abuse/neglect or other cause and the case gives rise to concerns about the way in which local professionals and services work together to safeguard the child/children in such circumstances.

The review should lead to significant and new learning that improves multi-agency communication, procedures, policy and/or practice’.

A Portrait of Child T

- Born in January 2014- mother's 6th and father's first child. Prior to the incident- abduction from UK while subject to a full Care Order Child T was:
- Observed to be securely attached to both parents- care provided by both parents assessed to be good;
- Observed to be a contented child in parents' care- plenty of toys and home conditions satisfactory;
- Noted to be a *'confident and happy little girl'* by the IRO;
- Always well presented;
- Settled in Nursery after a difficult start and making friends with peers;
- Developing well aside from a slight delay in speech- due to multiple languages used at home (Polish, Farsi and Greek) and English in Nursery.

Chronology (1)

1) **May 2013-** Concerns about mother's parenting capacity led to 2 of her children being placed in LA foster care in another Local Authority which also took action to safeguard Child T.
2) **September 2013-** Child T made subject to a pre-birth Child Protection Plan (Neglect).
3) **January 2014-** Child T made subject to an Interim Care Order after birth with LAC placed at home status.
4) **18th February 2015-** Care Proceedings concluded- Child T made subject to a Full Care Order remaining placed at home with Salford City Council becoming the responsible Authority. Father deemed the '*primary and protective*' parent by the Court.
5) **19th February 2015 to 4th December 2016-** Child T progressing well and no concerns noted about parental care or adherence to the Care Plan and first written agreement. Application to discharge the Care Order had been made.

Chronology (2)

1) **March 2016-** Home Office Criminal and Financial Investigation (CFI) Officers began investigating both parents for suspected facilitation and money laundering offences- involved agencies unaware.
2) **5th December 2016-** both parents arrested by CFI and Greater Manchester Police (GMP) Officers. Child T made subject to a Police Protection Order (PPO) after the arrests.
3) **6th December-** parents released with Police bail conditions. Child T returned to their care. Second written agreement put in place.
4) **9th December-** parents attempted to travel to Belfast- opportunistic stop check by a Merseyside Police Special Branch Ports Unit Officer prevented travel.
5) **12th December-** ***Trigger incident-*** parents and Child T left the UK. They flew to Iran via Munich from the Republic of Ireland.

1st Key Point in timeline-planning of the arrests by the Home Office CFI Team

Systems and Practice Issues:

- Nationally no flags for LAC on any Police systems.
- CFI Team reliant on local Force information for safeguarding checks- this is not a robust process. Children's Services are the lead agency for safeguarding children.
- CFI Officers unaware of Child T's LAC status.
- CFI Officers unaware of any safeguarding concerns for Child T and parental criminal activity not deemed to pose a serious risk to her- decision made by CFI Team not to contact Children's Services prior to the arrests.
- Children's Services were unaware of the parental involvement in serious crime.

What could have helped? ***Had Child T's LAC status been known, there would have been contact made with Children's Services at this point by CFI Officers prompting multi-agency assessment and planning prior to the arrests.***

Children's Services Care Planning would have been informed by a good understanding of the parental involvement in serious crime.

2nd Key Point in timeline- arrest of parents on Dec 5th & Child T being made subject to a PPO

Systems and Practice Issues:

- Arresting Officers (CFI & GMP) unaware of Child T's LAC status and mother said there was no suitable adult to care for her. PPO deemed necessary which had to be secured by GMP as the investigating CFI Team did not have the necessary Police powers.
- Children's Services became aware of parents' arrests on the day and were informed the PPO had already been secured.
- Safeguarding decisions had to be made quickly at the point of the arrests.
- GMP took the lead role in safeguarding communications but was not leading the investigation and Officers were unaware of detailed information.

What could have helped? ***Had Children's Services been made aware prior to the arrests, there would have been multi-agency decision making and planning.***
The PPO was not necessary given Child T's LAC status and alternative plans could have been made for her care.
Decisions would have been made by all the key professionals in a timely and coordinated manner.
Children's Services Care Planning would have been informed by a good understanding of the parental involvement in serious crime.

3rd Key Point in timeline- return of Child T to parents' care on Dec 6th

Systems and Practice Issues:

- GMP PPIU Officer had discussions with Children's Services due to GMP having established communication processes in place.
- Information held on the GMP log did not include any safeguarding concerns for Child T in relation to parents' arrests and detail of the CFI led investigation was not on the GMP systems.
- Children's Services made a decision to return Child T to parents' care in light of the positive progress in the case and being unaware of key information.
- The requirement for a Strategy Meeting or Discussion to always be held prior to a child being released from a PPO was not met.

What could have helped? ***A multi-agency Strategy Meeting involving both CFI and GMP Officers at this point would have enabled multi-agency decision making and ensured correct procedures were followed for a child made subject to a PPO. The meeting would have facilitated multi-agency discussions about the risks to Child T of both parents being involved in serious criminal activities, the nature of the activities and father's lead role, flight risk, the need to seize travel documents, the Police bail conditions and the implications of these being breached. A multi-agency plan would have been agreed and may have included Section 47 enquiries once all known information had been shared.***

4th Key Point in timeline- the first attempt to leave the UK on Dec 9th

Systems and Practice Issues:

- Ports Officer unable to contact the CFI Investigating Officer due to the Police National Computer containing only the details of a GMP Officer involved in the arrests.
- Ports Officer identified the CFI Team was leading the investigation on December 12th by which point the family had already left the UK.

What could have helped? ***Had the Ports Officer been able to inform the Investigating Officer of the family attempting to leave the UK on December 9th, there would have been prompt information sharing and multi-agency planning in light of the significant, new information.***

Good Practice

There were 9 instances of good practice identified including:

- Provision of the first written agreement in Farsi by Children's Services.
- Arrest planning by the CFI Team included consideration of a young child being present.
- Nursery staff and involved Social Worker were proactive in doing everything possible to support Child T's unexpected placement into foster care on the day of parents' arrest.
- Very prompt multi-agency response as soon as it was known Child T was missing.
- The review identified a number of instances of robust and effective multi-agency communication and information sharing throughout the timeline.

Learning - Professionals

- Effective information sharing and communication are vital in safeguarding children when parents are involved in serious crime- robust risk assessment and planning can only take place once all relevant information is known and understood. The possibility of flight risk should be actively considered.
- Professionals working with LAC placed at home should be alert to their vulnerability and ensure they understand their responsibilities towards safeguarding these children and meeting their needs.
- Whilst parental written agreements are initiated by Children's Services, involved multi-agency professionals need to ensure they are: clear about their content, document this within agency records and understand their responsibilities towards written agreements.
- Always be alert to the possibility of disguised compliance even when parents present as fully engaged and working well with agencies.

Learning – Managers / Organisations

The Home Office should consider actions to be taken to address the identified systems issues namely;

- No system for flagging children subject to Care Orders on Police systems.
- CFI Officers obtain safeguarding information from the relevant local Police Force systems to inform safeguarding decisions. In this case, checks could not identify Child T was subject to a Care Order. Whilst local Force systems would identify children subject to Child Protection Plans, they would not identify all vulnerable children known to Children's Services.
- Differing Police powers- although leading the investigation, the CFI Team did not have the required powers to secure the PPO.
- The Police National Computer system did not include contact details for the Investigating Officer. This case has identified the importance of information held on the Police National Computer containing sufficient detail to enable timely contact with Investigating Officers including outside of standard office hours.

Learning – Managers / Organisations

All agencies to ensure that the learning from this review is cascaded.

All agencies to ensure that safeguarding systems and processes including training and supervision incorporate the learning from this review, namely:

- Safeguarding children where parents are involved in serious crime is complex and requires effective communication between involved agencies to ensure robust risk assessment and decision making.
- The vulnerability of LAC placed at home and the importance of effective multi-agency safeguarding practice in securing good outcomes.
- The use of written agreements in multi-agency safeguarding practice.
- The possibility of disguised compliance should always be considered, even where cases are apparently progressing well. Evidence of parental compliance should be obtained where possible.

SSCB Recommendations

1. Children's Services (CS) to provide assurance to the SSCB to ensure the **policy on written agreements** reflects the learning from this case. Including evidence of review, compliance and expectations for partner agencies.
2. **Information sharing arrangements** between CS and GMP regarding LAC to be formally agreed and reflected in the updating of the Salford CS internal notification procedures. All agencies will need to confirm how they record if a child is LAC.
3. The SSCB Training Coordinator to review relevant SSCB courses to include reference to the **different Care Orders** and what they mean.
4. GMP and CS should assure the SSCB that **Strategy Meetings or Discussions are always held** when a child has been subject to a PPO.
5. Home Office to provide assurance to the SSCB that the systems issues, relevant to the organisation, have been considered, **systems strengthened and the learning has been disseminated** to relevant departments.

Further information

- Child T MACR Executive Summary Report
- Child T MACR 7 Minute Briefing
- Working Agreements and Safety Plans in Child in Need, Child Protection and Looked After Child Cases, November 2018
- Legal Framework for Safeguarding Children in Individual Cases, December 2018
- Disguised Compliance Briefing