

BABY MD

SERIOUS CASE REVIEW

4th February 2020

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SECTION 1: EXECUTIVE SUMMARY.

1. **Introduction:** This SCR (the review) followed the sudden, unexpected death in August 2018 of 5-week old Baby MD who was subject, along with siblings, to a Child Protection (CP) Plan under the category of neglect. Baby MD had been placed by mother in the parental bed to sleep during the night and was found lifeless and unresponsive by her at 8am. Both parents had drunk alcohol the previous evening and there had been a domestic abuse incident. The overarching aim of the review was to '*establish understanding regarding this case and consider if professionals could have taken any other steps to support the family*' and the 4 Key Lines of Enquiry included a focus on the Children's Social Care (CSC) transfer of complex cases across Greater Manchester Local Authority (GMLA) boundaries. The case was transferred from GMLA 1 to GMLA 2 CSC in August 2014 and from GMLA 2 to Salford CSC in January 2018. The timeline of the review was from the 21st April 2011 up to the date of the incident. The review identified 8 instances of good practice and it was apparent practitioners did their utmost to support the family. Sixteen learning points were identified and 3 recommendations were made.
2. **Case summary:** Mother's own childhood had been difficult and she had experienced Adverse Childhood Experiences (ACEs). She had a history of alcohol misuse and mental health challenges. The parental relationship commenced in 2011, at which point mother was heavily pregnant with her fourth child and was not caring for her 3 previous children. Domestic abuse was an ongoing feature in the parental relationship and had been an issue in parental previous relationships. Father had significant alcohol misuse issues and had received convictions related to domestic abuse incidents against mother and other violent offences. It was understood by practitioners within GMLA 2 the parental relationship had ended towards the end of 2017 and it was hoped the move to Salford would support mother in having no further contact with father. The review identified however that the relationship always continued and father was found at the home on the date of the incident.
3. Mother's fourth child was also not in her care early in 2014 when she became pregnant with her fifth child, her first child by father. GMLA 1 CSC had undertaken a pre-birth assessment which was provided to GMLA 2 after mother moved from GMLA 1 to GMLA 2. The CSC case transfer was not robust due to all the significant information held by GMLA 1 not being shared with GMLA 2 including that related to mother's difficult childhood. Both parents complied with further assessments undertaken in GMLA 2 and with a subsequent 8-month period of CP/Child in Need (CIN) planning. Unborn Poppy became subject to a CP Plan under the category of neglect in September and then subject to CIN planning in December. GMLA 2 CSC closed the case in May 2015 in light of positive progress seen and no concerns about parents' care of Poppy. After this period of positive engagement by father, he subsequently became a '*hidden male*' and agencies had very limited contact with him.
4. In June 2015, mother's eldest child, Adam, and her fourth child who had both been in maternal grandmother's care following private law arrangements in 2012 returned to live with mother and Poppy's father. The decision for this to happen was made by mother and grandmother. Concerns were raised with GMLA 2 CSC by partner agencies about their return resulting in a further brief period of CIN intervention after which the case was closed to CSC in August 2015. In December 2015, a first reported domestic abuse incident in GMLA 2 (a verbal incident) occurred which led to a period of Early Help (EH) planning. A second significant incident occurred in March 2016 resulting in father being convicted of Common Assault and Criminal Damage for which he received a 12-month Suspended Sentence Order. Both parents were intoxicated at the time. The incident was subject to prompt multi-agency discussion with actions agreed however the case was not escalated to CIN or CP planning at this point. The EH Plan continued until June 2016 at which point it was felt its outcomes had been largely achieved.
5. Mother initially told practitioners the relationship had ended after the March incident, however it resumed and a further child, Luke, was born early in 2017. In March 2017, the previous education EH Plan lead

contacted GMLA 2 CSC raising concerns about mother's fourth child and was advised to provide further EH support. Mother did not engage with this and the case was escalated to CSC in June 2017 due to concerns for all the children which included ongoing domestic abuse and parents not engaging with the support offered. Around this time, mother's fourth child returned to grandmother's care at grandmother's request.

6. A further period of CIN intervention was attempted but was not successful and concerns escalated including 2 further domestic abuse incidents in August and September 2017. At an Initial Child Protection Case Conference (ICPC) at the end of October Adam, Poppy and Luke were made subject to CP Plans under the category of neglect (failure to protect from domestic abuse). Mother said the relationship had ended and she and the 3 children moved to Salford after temporary accommodation was secured. Mother was pregnant with Baby MD at this point. Concern has been raised about use of the term of failure to protect in domestic abuse cases as it puts the onus on a mother who is herself a victim of abuse to protect her children.
7. The case transfer from GMLA 2 to Salford CSC in early January 2018 was very robust. Positive factors in the transfer process included all information known to GMLA 2 being effectively shared and attendance by involved GMLA 2 practitioners at the Transfer-in Conference. Poppy and Luke continued to be subject to CP Plans under the neglect category and Adam became subject to a Vulnerable Young Person's Plan. After the move to Salford, no concerns were identified until early in May when a neighbour reported a domestic abuse incident. Mother advised attending Police Officers father had just turned up at the home. A Strategy Meeting was held due to this incident. Early in June, mother contacted the Police reporting Adam as missing. Attending Officers found an intoxicated man in the house who they identified as father after the incident.
8. Prompt action was taken by Salford CSC after the second incident with a Legal Planning meeting being held after which Pre-proceedings under the Public Law Outline commenced prior to Baby MD's birth towards the end of June. Baby MD progressed well and no concerns were raised about mother's care of her baby prior to the incident. Safe Sleep advice was given and a safe sleep assessment undertaken in accordance with practice expectations.
9. Written/working agreements were used within each of the GMLAs with 3 of these requiring mother not to allow father to have contact with the children. Mother's feedback to the independent reviewer was that she '*couldn't not sign them*' despite knowing her relationship with father hadn't ended because she feared the consequences including fear of her children being removed from her care.
10. Valuable information about the risks posed by father was held by the Community Rehabilitation Company (CRC) i.e. Probation. This service was involved during the review timeline from May 2014- February 2015 after father had been convicted of Shop Theft and Common Assault (against a third party) and sentenced to a 9-month Community Order. The CRC practitioner during this time period had involvement in the multi-agency interventions for Poppy enabling relevant information to inform case planning.
11. This service was next involved from April 2016 to April 2017 after father's conviction for the March 2016 significant domestic abuse incident. The second CRC practitioner involved made 2 referrals to GMLA 2 CSC in May 2016 and in March 2017. A CSC Children and Families assessment was completed after the first referral was made after which CSC closed the case. The CRC practitioner was advised that an EH Plan was in place after the second referral. Had the March 2016 incident resulted in the case being escalated to CIN or CP planning, the valuable information held by the CRC practitioner could have informed multi-agency decision making. Father was deemed to pose a medium risk of serious harm by this agency and he did not comply with his Suspended Sentence Order resulting in breach proceedings and a warrant for his arrest being issued.

12. The 2 key areas of learning from this review are as follows:
13. ***The importance of trauma informed practice-*** the review identified information about mother's difficult childhood including her ACEs was not shared effectively during the transfer from GMLA 1 to GMLA 2. It is important multi-agency practitioners are aware that trauma in childhood is common and of its negative impacts in an adult's life including on their ability to form positive relationships, parenting capacity and their capacity to change. Trauma informed practice can support service users in forming effective working relationships with practitioners, increasing their resilience and in making the changes required to achieve a positive outcome- **see Recommendation 1.**
14. ***The importance of effective transfers of complex cases by CSC Services across Local Authority Boundaries-*** This review has demonstrated the contributing factors to and outcomes of an ineffective case transfer from GMLA 1 to GMLA 2 followed by a very effective case transfer from GMLA 2 to Salford. The importance of ensuring all relevant information including about significant historical risk factors and parental ACEs follows a family when their case is transferred has been highlighted. Without a good understanding of the history, a '*start again*' approach is likely as seen in this case following the first transfer. The review has also demonstrated that expected practice has since evolved to ensure consistently effective case transfers and the available regional guidance requires review and update to reflect current good practice and ensure its consistency across the region. All involved partner agencies also require effective systems and processes which support timely and robust case transfers for complex cases - **see Recommendation 2.**
15. Further areas of learning from this review include the following:
16. **The provision of safe sleep advice to vulnerable families-** Recent research findings have clarified that sudden, unexpected deaths in infancy (SUDI) now occur largely in association with social deprivation and modifiable risk factors and that more consideration is needed on how best to support such vulnerable families. It is important that Child Death Overview Panels (CDOP) and Public Health maintain a strategic focus on this issue which includes the exploration of more effective interventions to support this challenging area of practice.
17. **The management of domestic abuse cases-** Prompt multi-agency planning to agree actions after a significant domestic abuse incident is good practice. Decision making including the most appropriate level of intervention should be informed by a good understanding of the history of the parental relationship and previous incidents including whether these led to convictions.
18. A key intervention in these cases is safety planning with the victim. Direct communication with children to understand their perspectives is important and the development of a separate safety plan with a child once this is age appropriate can further support them in keeping themselves safe.
19. This case has highlighted the following practice issues which should inform agency processes including risk assessments, care planning and supervision:
- the absence of current evidence of previous significant risk factors should not provide assurance these risks have been resolved. Evidence should also be sought which proves these risk factors are no longer an issue such as positive changes made by parents which are sustained over time;
 - whilst a victim of domestic abuse may say the relationship has ended, there is a need to consider the likelihood of that given the history of the relationship including coercive control, evidence of it continuing over time such as further pregnancies, support mechanisms available to the victim and the fact that a victim may fear the consequences of admitting it hasn't ended;

- including requirements for a victim of domestic abuse to have no contact with the perpetrator within a written/working agreement is inappropriate;
- the possibility of manipulation by parents and disguised compliance which, in domestic abuse cases, might occur for a number of reasons including a victim's fear of the perpetrator or of the consequences of not complying.

20. The understanding of risk in complex cases- Obtaining relevant information from previously involved key adult services including Probation supports the understanding of risk in complex cases. In this case, the CRC Case Manager held both valuable risk information in respect of father and also information about his lack of compliance during 2 periods of intervention including with domestic abuse and alcohol abuse interventions. The Joint Targeted Area Inspection in Salford (October 2016) report highlighted the important role of Probation Services (CRC and NPS) and that this is not well understood by partner agencies.

21. The understanding of children returning to parental care following private law arrangements and of children not in their parents' care- It is not uncommon for children who have lived with relatives under private law arrangements to return to their parent/s' care. If concerns about such a move are raised with CSC by an agency or involved relatives, careful consideration on a case by case basis is required particularly when there are current or have been recent safeguarding concerns relating to the parent/s. Determining the action required by CSC should be informed by a good understanding of Orders previously issued and their current legal status. This is particularly important if CSC interventions were being provided and the Orders issued informed CSC decision making. Access to the private law papers would support a good understanding of the concerns about parental difficulties and assessment of a parent's capacity to change. It is important the risk and protective factors for the returning children and any children already in parents' care are identified including whether vulnerable parents are likely to be able to effectively meet the needs of all the children. All agencies should have systems and processes in place to ensure the circumstances of such children returning to parental care are understood and correctly recorded to inform effective care planning.

22. This review has also highlighted the challenges posed by the circumstances of siblings not in parental care being poorly understood including important historical information about parenting capacity and capacity to change becoming 'lost'.

23. Decision making in relation to the category of abuse for CP Plans- When a child becomes subject to a CP Plan, the category of abuse should be determined by the evidence presented to the ICPC and the views of practitioners in attendance. The category should reflect the primary area of concern identified at the Conference. For the duration of the CP Plan, the category of abuse should be formally reviewed within each Review Conference.

24. The review has made 3 recommendations:

Recommendation 1: SSCP to consider escalating the trauma informed practice learning to the GM Standards Board in order for that Board to consider implementing actions aimed at supporting the development of trauma informed approaches to practice across GM.

Recommendation 2: The North West ADCS Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure and the GM Pre-Birth Assessment guidance should be reviewed and updated in light of the learning from this review. SSCP to:
-endorse the recommendation and request the Greater Manchester Policy & Procedures Group considers this and determines the actions required to meet it;

-be assured the North West ADCS Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure and the GM Pre-Birth Assessment guidance have been reviewed and updated and that they concur in relation to the management of case transfers for unborn babies.

Recommendation 3: The SSCP to be assured its multi-agency partners have considered the relevant learning points and developed implementation plans in order to support safeguarding practice when working with complex families with multiple risk factors.

- 25. Conclusion:** This was a complex family in which there had been long-standing domestic abuse within the parental relationship, histories of alcohol misuse for both parents and a maternal history of mental health difficulties. Case management was complicated further by 2 moves across GMLA boundaries which resulted in key information becoming 'lost' during the first transfer. Practitioners strove to support mother and the children. The review has been informed by the valuable participation of mother, maternal grandmother and mother's eldest child, Adam.
- 26.** Practitioners endeavoured to work in partnership with mother who, from March 2016 onwards, said on a number of occasions father wasn't living at the home or that they were no longer in a relationship. Practitioners wanted her to succeed and supported her in the belief she had made positive changes. The review has identified evidence of the relationship not ever having ended and that the risks posed by father's alcohol misuse and violent behaviours continued. With the benefit of hindsight, the review has identified practitioners were attempting to work in partnership with parents who were non-compliant and deliberately manipulative. It may well have been the case that mother's fear of father resulted in these behaviours on her part and that the impacts of the ACEs she had experienced impacted on her ability to make required changes including ending the relationship. However, the overall impact of the non-compliance and manipulation was that practitioners were unaware of the reality of life in the family home.

SECTION 2: AN INTRODUCTION TO THE REVIEW.

2.1 FOREWORD.

- 27. Copyright:** This Serious Case Review (SCR) has been authored and produced by Melanie Hartley, independent reviewer. The review was commissioned by Salford Safeguarding Children Board (SSCB). From 1st April 2019, SSCB was replaced by the new partnership arrangements and this SCR transitioned to the Salford Safeguarding Children Partnership (SSCP). The review's content has been quality assured by the SCR Panel and by the SSCP. It is owned by and copyright remains with the SSCP. Permission should be gained from the SSCP prior to sharing the content of this review either in paper form or electronically with any organisation or individual.
- 28. Anonymity:** The review has been written in a way to protect the identity of Baby MD, the family and involved practitioners. The agreed key lines of enquiry (KLOE), significant events and emerging themes are discussed in a style which minimises the risk of either Baby MD or the family's identity being unintentionally revealed. Multi-agency employees are described in respect to their job role to protect their anonymity. This approach is taken to encourage open and honest reflection of safeguarding practice.
- 29. Thanks:** The independent reviewer would like to thank:
- Baby MD's mother, maternal grandmother and eldest half-sibling, Adam, for their willingness to participate in the review and for their valuable contributions;
 - Practitioners, managers, multi-agency organisations and independent providers who openly and honestly reflected on and shared their experiences whilst working on the case. Their contributions

were extremely advantageous, enabling enhanced learning and the identification of good practice. The motivation and passion of frontline practitioners to make a difference to the life of Baby MD and the family was always evident throughout the process.

30. **Abbreviations:**

Abbreviation/Term	Description
ACE	Adverse Childhood Experience
ACPO	Association of Chief Police Officers
ADCS	Association of Directors of Children's Services
A&E	Accident and Emergency
CAF	Common Assessment Framework
Cafcass	Children and Family Court Advisory and Support Service
CCG	Clinical Commissioning Group
CDOP	Child Death Overview Panel
CGM CRC	Cheshire and Greater Manchester Community Rehabilitation Company
CIN	Child In Need
CP Plan	Child Protection Plan
CPS	Crown Prosecution Service
CR&ASG	Case Review and Audit Sub-Group
CRC	Community Rehabilitation Company
CSC	Children's Social Care
DASH	Domestic Abuse, Stalking and Harassment
DfE	Department for Education
EH	Early Help
FSW	Family Support Worker
FW	Family Worker
GM	Greater Manchester
GMLA	Greater Manchester Local Authority
GMP	Greater Manchester Police
GP	General Practitioner
HV	Health Visitor
IA	Initial Assessment
ICPC	Initial Child Protection Conference
KLOE	Key Line of Enquiry
MARAC	Multi-agency Risk Assessment Conference
MASS	Multi-agency Screening Service
MFT	Manchester University NHS Foundation Trust
NHS FT	National Health Service Foundation Trust
Ofsted	Office for Standards in Education, Children's Services and Skills
PPIU	Public Protection Investigation Unit
RPE	Reflective Practitioner Event
SCR	Serious Case Review
SRFT	Salford Royal NHS Foundation Trust
SSCB	Salford Safeguarding Children Board
SSCP	Salford Safeguarding Children Partnership
SIDASS	Salford Independent Domestic Abuse Support Service
STEIS	Strategic Executive Information System
SQAU	Safeguarding Children and Quality Assurance

SUDC	Sudden Unexpected Death in Childhood
SW	Social Worker
VCSE	Voluntary, Community and Social Enterprise
VYPP	Vulnerable Young Person's Plan
YPP	Young Person's Plan

2.2 **THE INCIDENT, SERIOUS CASE REVIEW DECISION AND METHODOLOGY.**

31. **The Incident:** Baby MD, who was subject to a Child Protection Plan (CP Plan) under the category of neglect, died at the age of 5 weeks one day early in August 2018. At 08:25 hours Greater Manchester Police (GMP) were contacted and a disturbance at the home reported. Attending Officers identified an unresponsive baby was in the process of being transferred to hospital by the North West Ambulance Service. After a period of attempted resuscitation, Baby MD's death was confirmed at 08.55 hours by medical staff and the Sudden Unexpected Death in Childhood (SUDC) process was instigated.
32. Domestic abuse was a key risk factor in the case with mother understood by involved agencies not to be having any contact with father. Attending Officers found Baby MD's father to be present at the address. As a result of reports by neighbours of a domestic incident during the night and mother being observed to have a 'slight' black eye, father was arrested for assault. Baby MD's siblings were placed with family members with parental agreement. Toxicology results for Baby MD did not identify the presence of alcohol or other substances.
33. During a subsequent GMP investigation, father disclosed he had been living at the property. Both parents disclosed having drunk a significant amount of alcohol the previous evening. Mother stated she had put Baby MD into bed next to her at around 3am after a feed and then woke at 8am to find her baby lifeless and unresponsive. It was clarified that mother and father had both been sleeping in the bed lying with their heads at opposite ends of the bed at the time of the incident.
34. **The Decision:** GMP referred the incident to the SSCB Case Review and Audit Sub-Group (CR&ASG) 3 days after the incident. Salford Children's Social Care (CSC) Services notified Ofsted¹ and the Department for Education (DfE) of the serious childcare incident in line with expected practice. The referral and agency summary reports were considered by a Rapid Review Panel within 15 working days in accordance with the interim Rapid Review pathway (Working Together, 2018²). The outcome was the criteria for a local practice review had been met, this recommendation was endorsed by the SSCB Independent Chair and the Child Safeguarding Practice Review Panel, DfE and Ofsted were notified of the decision. Following communications between the Child Safeguarding Practice Review Panel and the SSCB Independent Chair, agreement was reached that an SCR under the Working Together, 2015³ criteria would be commissioned. This would be proportionate to the scale and complexity of the issues of concern, using the methodology already agreed and led by an independent reviewer.

¹Ofsted is the Office for Standards in Education, Children's Services and Skills. Working Together to Safeguard Children guidance states that Local Authorities should notify Ofsted of serious childcare incidents. Notifiable incidents are those involving death or serious harm to a child where abuse or neglect is known or suspected, and also deaths of Looked After Children or children placed in regulated settings.

² HM Govt (2018) Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf (Accessed 24.07.19)

³ HM Govt (2015) Working together to safeguard children. A guide to inter-agency working to safeguard and promote the welfare of children. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf (Accessed: 21.07.19)

35. *The Methodology:* The methodology was determined by members of the Rapid Review Panel and confirmed at the first SCR Panel meeting at the end of February 2019. The SCR has been undertaken in accordance with the North West Learning and Improvement Framework (2013) and the Greater Manchester (GM) Serious Case Review Systems Approach. The review methodology has included the following:

- SCR Panel with an Independent Chair- independent reviewer
- Single Agency Summary Reports
- Terms of Reference and specific KLOE
- Reflective Practitioner and Practitioner Feedback Events
- Integrated chronology-developed by independent reviewer
- Overview Report- developed by the independent reviewer
- Consideration of significant others in Baby MD's life
- Consideration of parallel proceedings.

36. The timeline of the SCR was agreed as the 21st April 2011 (date of a referral to GMLA 1 CSC) up to the date of the incident. The subjects of the SCR have been all the children and adults living in the family home at the time of the incident.

37. *The SCR Panel Membership:*

The following agencies were represented:

Organisation	Role
GMP	Detective Sergeant, SCR Team
Salford CSC Services: Safeguarding & Quality Assurance	Head of Safeguarding
Salford CSC Services	CP/CIN Practice Manager
GMLA 2 CSC Services	Head of Service: Child Protection and Care Proceedings
GMLA 1 CSC Services	Service Manager
Salford Clinical Commissioning Group (CCG)	Deputy Designated Nurse Safeguarding Children and Looked After Children
Salford Royal NHS Foundation Trust (SRFT)	Named Nurse Safeguarding Children
Manchester University NHS Foundation Trust (MFT)	Specialist Midwife
Pennine Care NHS Foundation Trust (NHSFT)	Named Nurse for Safeguarding Children and Adults
Cheshire and Greater Manchester Community Rehabilitation Company (CGM CRC)	Community Director
Humankind Family Support Service	Area Manager
Independent Reviewer	SCR Panel Chair and report author
GMLA 1 LSCB	Board Coordinator
Children and Families (Legal) Group	Solicitor
SSCP	Business Manager
SSCP	Senior Business Support Officer (Minutes)

38. At the first SCR Panel (panel), actions were agreed including appropriate representation at the Reflective Practitioner Event (RPE). Following the first panel, agency leads were requested to review and update their initial summary reports in light of the developed integrated chronology, the terms of reference and

the KLOE. Further required agency summary reports (Nursery, Education, Cafcass, Humankind Family Support Service) and information were also requested. The integrated chronology comprised of summary information from the 21st April 2011 and a detailed chronology for the 12-month period which preceded the date of the incident.

39. Discussions at the first panel considered the criminal investigation in progress at that time and agreement was reached that the joint Association of Chief Police Officers and the Crown Prosecution Service (ACPO/CPS) guidance⁴ would be utilised to support the SCR process as necessary. A key aspect of the case was the fact that mother moved across Greater Manchester Local Authority (GMLA) boundaries on 2 occasions during the timeline whilst CSC interventions were ongoing. Mother was pregnant at both these transition points. The panel membership included key partner agencies from GMLA 1 and GMLA 2.
40. The overarching aim of the SCR was to '*establish understanding regarding this case and consider if professionals could have taken any other steps to support the family*' and the KLOE included a focus on the transfer of cases across GMLA boundaries.
41. **Key Lines of Enquiry:** the following KLOE were agreed:

KLOE	
KLOE 1	Evidence base of decision making throughout multi-agency involvement, including the way in which historical information was understood to inform capacity to change or ability to meet the children's needs in the long term.
KLOE 2	Impact of moving into another geographical area (GMLA 1 to GMLA 2 and GMLA 2 to Salford) upon assessment, planning and decision making. Include consideration of current GM transfer in policies and procedures.
KLOE 3	Impact of changes of social worker/professional and change of Local Authority.
KLOE 4	Role of agencies in risk assessment, planning and decision making.

42. **Practitioner Participation:** the following practitioners and managers attended the RPE:

Organisation	Role
SRFT	Named Nurse Safeguarding Children
GMP	SCR Team
GMP	SCR Team
Salford CCG	General Practitioner (GP)
Salford CSC	Social Worker
Salford CSC	Safeguarding Service Manager
Salford CSC	CP Coordinator
Salford CSC	Practice Manager
Salford CSC	Early Help Locality Manager
GMLA 1 Education	Education Caseworker
GMLA 2 CSC	Social Worker
GMLA 2 CSC	Head of Practice Improvement

⁴ ACPO and CPS (2014) Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews. Available at:

https://www.cps.gov.uk/sites/default/files/documents/publications/liaison_and_information_exchange.pdf (Accessed: 21.07.19)

Pennine Care NHSFT	Health Visitor
Pennine Care NHSFT	Health Visitor Team Leader
Pennine Care NHSFT	Named Nurse for Safeguarding Children and Adults
CGM CRC	Probation Officer
Humankind Family Support Service	Family Support Worker
Humankind Family Support Service	Service Manager
Independent Reviewers	Lead and Support Reviewers

43. The RPE was held in May and was attended by 6 practitioners and 12 managers. Whilst there is a risk in such instances of the event becoming management focused, this event was well evaluated with all attendees participating fully and with attending practitioners being effectively supported. The lead reviewer was supported by a second independent reviewer- Jane Carwardine- in facilitating this event.
44. Towards the conclusion of the review a practitioner feedback event was held to share the learning with practitioners and managers involved in the RPE. This was well attended and positive feedback was received regarding practitioner involvement in the review process, the learning being shared directly and on the opportunity the events had provided for multi-agency reflection and discussion.
45. **Additional Information:** Further information was sought as gaps in information appeared. Legal advice was obtained in anticipation of the RPE being held whilst a criminal investigation or criminal proceedings were underway. However, the criminal investigation was concluded prior to the date of the RPE.
46. **Parallel Review Processes:** Baby MD's death was notified to the Child Death Overview Panel (CDOP) with expected practice being that child deaths would be discussed within that forum once all other parallel processes had been concluded. The CCG reported the incident to the NHS Strategic Executive Information System (STEIS) as a serious incident in accordance with expected practice. None of the involved agencies instigated single-agency reviews in respect of the incident.
47. **SCR Report Format:** The report has been written for publication without redactions in line with Working Together 2015 expectations⁵. Panel members agreed the format including an executive summary, a portrait of Baby MD and family members and an analysis of events linked to the KLOE with learning points, good practice and recommendations included as identified throughout the report. The learning points and good practice have also been collated (Appendix 1). Identified key single-agency learning has been included within the body of the report. Each agency was required to develop an action plan and provide assurance that their recommendations have been implemented and embedded into practice. The biographies of the independent reviewers have been included (Appendix 2).

2.3 **BABY MD's SIBLINGS- OUTCOME OF CARE PROCEEDINGS.**

48. The Care Proceedings related to Poppy and Luke and were concluded in February 2019. They became subject to Full Care Orders⁶, placed together with a maternal auntie and uncle with continued CSC

⁵ Working Together (2015)- All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report may be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

⁶ A care order places a child in the care of a Local Authority. Under s31 of the Children Act 1989 a court may only make a care order or supervision order if it is satisfied that the child concerned is suffering, or is likely to suffer, significant harm and that such harm is as a result of the care given to the child by their parent.

involvement. Adam was not subject to these proceedings and, on completion of this review, was living with his maternal grandmother subject to the residence order in favour of his grandmother.

2.4 FAMILY PARTICIPATION.

49. Panel meeting discussions included ongoing consideration of family participation and legal advice was sought in relation to requesting participation by maternal grandmother given her significant role in supporting her daughter and grandchildren and mother's eldest child, Adam. It was agreed the social workers (SW) who had ongoing or most recent involvement with family members, supported by a manager, would ensure each parent, maternal grandmother and Adam received the SSCP SCR leaflet for families along with a letter requesting their participation and would discuss these. These discussions clarified that any family member participation was aimed at securing their views on their experiences of multi-agency service provision, what helped them and any improvements that could better support other families in similar circumstances.
50. Maternal grandmother was willing to participate and arrangements were made for the independent reviewer accompanied by a SW who knew the family well to meet her towards the end of August 2019. Positively, Adam was also present at the meeting and participated in the review. Towards the end of the review process, mother advised a SW she would like to participate. The independent reviewer met with mother towards the end of September 2019. It did not prove possible for a SW to meet with father however this practitioner ensured father was aware the SCR was being undertaken. The family member perspectives are included in Section 3.4 and also referenced as relevant within Section 5.

2.5 PARALLEL PROCEEDINGS.

51. The parallel proceedings in relation to the incident considered within this SCR process have been the SUDC process, the Coronial inquest and the GMP criminal investigation. The outcome of a Home Office forensic post-mortem was that the cause of death was inconclusive pending further investigation. An inquest was initially arranged for January 2019 but vacated. The inquest was held in March 2019 with the Coroner reaching an Open conclusion.
52. The GMP criminal investigation related to the offence '*overlay whilst intoxicated*' under Sec 1(2)b Children & Young Persons Act 1933 whereby Section 1(2)(b)⁷ was inserted by the Serious Crime Act 2015. On conclusion of these investigations, no charges were brought.

2.6 EQUALITY AND DIVERSITY CONSIDERATIONS.

53. There are complex ethical dilemmas when considering interventions in pregnancy with parents who have complex social or health support needs and are engaged in behaviours that have the potential to cause harm to the unborn infant. A significant dilemma is the complexity of the statutory pre-birth assessment in part because the foetus has no legal status. In addition, early intervention in the United Kingdom can be problematic as a pregnant mother can seek a termination of pregnancy up to the 24th week of her pregnancy under the Abortion Act (1967). As a result, in practice there may be conflicts between the pre-

⁷ Sec 1(2)b Children & Young Persons Act 1933 1(2)(b) inserted (3.5.2015) by Serious Crime Act 2015- '*where it is proved that the death of an infant under three years of age was caused by suffocation (not being suffocation caused by disease or the presence of any foreign body in the throat or air passages of the infant) while the infant was in bed with some other person who has attained the age of sixteen years, that other person shall, if he was, when he went to bed [F12or at any later time before the suffocation], under the influence of drink [F13or a prohibited drug], be deemed to have neglected the infant in a manner likely to cause injury to its health. [F14(2A)]The reference in subsection (2)(b) to the infant being "in bed" with another ("the adult") includes a reference to the infant lying next to the adult in or on any kind of furniture or surface being used by the adult for the purpose of sleeping (and the reference to the time when the adult "went to bed" is to be read accordingly*'.

birth procedure for intervention and the instigation of legal proceedings which is not possible prior to birth. There is also limited focus on the pre-birth assessment in research which only forms a small part of the literature assessment base in safeguarding and protection work.^{8 9}

54. There is a growing body of evidence to demonstrate that very young babies are extremely vulnerable to abuse either intentionally or unintentionally.¹⁰ Early work with parents and families to assess the risk, plan intervention and assess parental motivation to manage the risk in the antenatal period can reduce the risk of harm to an infant. This intervention can be offered under the Framework of Early Help or through the statutory social work pre-birth assessment process.
55. The Equality Act (2010) introduced the concept of '*protected characteristics*' with the 9 characteristics being age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, and sexual orientation. Baby MD's family were White British. A person is classed as being disabled under the Equality Act if they have a physical or mental impairment which has a substantial and long-term effect on their ability to do normal daily activities. In this case, mother had a history of mental health difficulties, however there was no evidence of these having a significant impact on her abilities during the review timeline. Both parents had a significant history of alcohol misuse, however the Act does not include such issues as constituting a disability. The pregnancy and maternity characteristic applies to discrimination in respect of breast feeding and employment rights and is not relevant to this review.

SECTION 3: BABY MD: FAMILY TABLE, A PORTRAIT AND THE FAMILY CONTEXT.

3.1 FAMILY TABLE- SUBJECTS OF SCR.

The table below denotes the age, gender, place of residence and known family relationships of the subjects of the SCR at the time of the incident:

	GENDER AND AGE AT TIME OF INCIDENT IN AUGUST 2018	RELATIONSHIP	RESIDENCE
MOTHER	Female aged 32 Years.	Mother to all the children.	Address 1.
FATHER	Male aged 36 Years.	Father to Poppy and Luke. Paternity of Baby MD unclear. Not birth father to Adam	Understood to be living at his own mother's home prior to the incident. Disclosed living at Address 1 after the incident.
BABY MD **	Aged 5 Weeks	Baby of Mother.	Living with mother.

⁸Hodson A., (2012) How Research on Pre-Birth Assessments Should Affect Practice. Community Care 30.8.2012. Available at: <https://www.communitycare.co.uk/2012/08/30/how-research-on-pre-birth-assessments-should-affect-practice/> (Accessed: 21.07.19)

⁹ Calder, M.C. (2003) Unborn Children: A Framework for Assessment and Intervention. In: Calder, M.C. and Hackett, S., eds. Assessment in Child Care — Using and Developing Frameworks for Practice. 2nd Ed, Russell House Publishing.

¹⁰ Ofsted (2011) Ages of concern: learning lessons from serious case reviews. Available at: <https://www.gov.uk/government/publications/learning-lessons-from-serious-case-reviews> (Accessed: 21.07.19)

ADAM *	Male in his mid-teens	Son of mother.	Address 1
POPPY *	Female aged 3 Years.	Daughter of mother and father.	Address 1
LUKE *	Male aged 1 Year.	Son of mother and father.	Address 1

* pseudonyms have been used for Child MD's siblings.

** denotes subject of the SCR- gender not included for anonymity purposes.

3.2 A PORTRAIT OF BABY MD.

56. Baby MD was mother's seventh child. Her pregnancy was complicated requiring careful monitoring and there were known concerns about mother's limited engagement with ante-natal care. However, Baby MD was in a physically good condition when born at 38 weeks gestation. Practitioner feedback was Baby MD's needs were understood by mother, who was attentive towards her baby and that Baby MD was healthy, well cared for, feeding well, thriving and was an alert and responsive baby.

3.3 THE FAMILY CONTEXT.

57. **Mother.** Mother had endured a very difficult childhood with significant adverse childhood experiences (ACE). This resulted in her being subject to CP planning. She had a long history of both mental health difficulties (depression, anxiety and self-harm) and alcohol misuse. She had experienced significant levels of domestic abuse with more than one partner. Practitioner feedback was she exhibited emotional warmth and affection towards her children and provided '*good enough*' practical care. The home conditions were generally '*good enough*' but deteriorated around the time of incidents of concern.
58. Mother faced significant life challenges with assessments having identified the following issues: poor self-esteem, poor education, no employment history, experience of being homeless, being imprisoned and frequent house moves including into temporary accommodation which resulted in her not having a stable home in which to raise her children. Mother did not have a diagnosed learning disability but had disclosed struggling to read and write. Practitioner feedback was they had to take time in explaining concerns and advice simply but she did then understand information provided. Mother would engage with some practitioners more readily than others and expressed frustration at having to continually repeat her history.
59. **Father.** Father's childhood experiences and background were not well understood and the majority of practitioners had little or no contact with him and therefore limited opportunity to observe his interactions with the children. It was known that he had significant alcohol misuse issues, a history of domestic abuse incidents from 2004 onwards perpetrated against a number of partners and that he had an extensive criminal history. It was understood that he lived at times with his mother but also that family support was limited when he was drinking. There was evidence he worked at times during the review timeline and that he was keen to work.
60. **The parental relationship:** This commenced around August 2011 when mother was pregnant with her fourth child. Father as referenced within this review was not the father of mother's unborn baby. He was birth father to Poppy and Luke and the review has clarified he had parental responsibility for these children, attending when their births were registered with his name recorded on their birth certificates.

61. **Baby MD's siblings:** Poppy and Luke were both described as happy, smiling children who were securely attached to their mother. There were no concerns about their health or developmental progress. They interacted positively with mother, each other and with Adam. Age appropriate toys for the children were evident in the home. Whilst their presentation when seen was generally satisfactory, there were times when they and their clothes were 'grubby'. Poppy settled well when she commenced at nursery aged 3 years and was observed to have good language and self-help skills.
62. Adam, mother's eldest child was in his mid-teens at the time of the incident. He was cared for predominantly by his maternal grandmother until May 2015 when he chose to move to live with his mother and half-siblings. He was described as a mature, quietly spoken and polite young man who was protective of and loyal towards his mother and very loving towards his younger siblings. Practitioner feedback was that Adam had a caring role within the family and was observed at times to be making formula feeds or vacuuming during practitioner visits. Adam's school attendance rate whilst residing in GMLA 2 was low and deteriorated after an initial good attendance rate following the move to Salford.

3.4 THE PERSPECTIVES OF FAMILY MEMBERS.

63. These perspectives are provided from the notes of the meetings with maternal grandmother and Adam and subsequently with mother. They are also referenced as relevant within the review.
64. **Adam's perspectives on what helped/could have helped more:** Adam said '*having my own plan helped me and my SW helped including with sorting out practical issues out for me e.g. supporting my school attendance after I moved to Salford. There were times when the Police didn't help when they came to the house e.g. when they just took him out of the house. I don't think practitioners (in Salford) could have supported me more in disclosing what was happening at home*'. Adam said '*I was asked the questions but couldn't say because I thought the children would be taken into care*'.
65. **Maternal grandmother's perspectives on her daughter and the parental relationship:** Maternal grandmother said '*mother loves her children very much and would sign written agreements not to have contact with father because she was worried about losing them. I was very worried for my grandchildren and contacted CSC (in GMLA 1) after the birth of my grandson (mother's fourth child) begging them to help her. I made contact with CSC whenever I had concerns for my grandchildren. While father did drink alcohol, she also had a long-standing alcohol problem and drank regularly. My daughter was always alert to the fact that someone might visit but would relax at the weekends because no-one visited then. They both felt no action would be taken against them because it hadn't been before and the relationship had gone on for a long time.*'
66. Grandmother said '*I tried my hardest to support my daughter in ending the abusive relationship with father and her brothers and sisters tried but it continued. At times, family members stopped having contact with her because she remained in the relationship, but I was always clear with my daughter that I was there for her as long as she wasn't seeing him. I always felt something was going to happen because of his abuse towards my daughter but thought I would be burying her and not a grandchild. I did believe my daughter at first when she said the relationship had ended but then realised, she was just saying this and that it hadn't truly ended. Even when my daughter moved to a new property to help her end the relationship, he would ring her up and then soon have her new address.*'
67. **Maternal grandmother's perspectives on what helped/could have helped more:** Grandmother said '*The Police responded as they should have done to incidents but the Courts then didn't do enough e.g. didn't send father to prison for long enough*'. One social worker (in GMLA 2) was good when she told my

daughter very clearly that she didn't believe her when she said the relationship was over and another social worker (in GMLA 2) found my daughter and him together at a shop'

68. Grandmother said, *'They (practitioners) shouldn't have believed my daughter when she said the relationship was over- it had gone on for a long time. They should have been much more sceptical, they should have challenged my daughter a lot more and been much more forceful e.g. being very direct and very clear about what might happen to her and to her children if she didn't end the relationship. Practitioners should be very clear about the risks of drinking when caring for a baby including the risk of overlay. My daughter's alcohol use should have been tested out as she always drank regularly. They should be more curious about why parents don't attend appointments. I know my daughter missed some of these due to having bruises. Practitioners should always believe and take concerns raised by family members seriously. On one occasion, my grandson told me about the violence in the home and I reported it to CSC (in GMLA 2). A social worker spoke to him alone but felt he was making it up. I know some family members might be being malicious but most are just very worried about the children as I was about my grandchildren.'*
69. Grandmother asked the following questions: *'Why didn't they check for evidence of father being there e.g. why didn't they look round the house when they visited? He was upstairs hiding at times and they would have found him. Why didn't they do more unplanned visits which may have led to him being found at the home? Can't there be random visits at weekends? Didn't they look for evidence of alcohol use e.g. in the bins?'*
70. **Mother's perspectives on what helped/could have helped more:** Mother said, *'I knew everyone was trying to help and support me but I couldn't tell them about my worries and what was happening because they thought the relationship was over. My family support workers (in GMLA 2 and Salford) helped me most. They made me feel comfortable, I could talk to them and looked forward to their visits. They helped me with lots of practical things such as getting clothes and kitchen things after I moved house. I prefer to always be told the truth about things there and then and that didn't always happen. I've been told there were worries about my drinking but no-one told me about that at the time and should have done if they were worried. I do like a drink but don't have a drink problem.'*
71. *At that time, I couldn't end the relationship because I couldn't see how I could do that. I was too scared of what he would do if I did end it. The written agreements I was asked to sign were right and I had to sign them because of my worries about my children being removed if I didn't. I couldn't not sign them.'*
72. *I tried to arrange things before one house move so he wouldn't know where we were but it didn't work and he moved with us. The house moves made things more difficult because it takes me a long time after meeting someone to be able to trust them. The house moves also meant I ended up further away from my own family so it became more difficult to get support from them. I was suffering from anxiety and panic attacks then which have gone now that the relationship has ended. I can see everything clearly now but couldn't while I was with him. It would have helped if the house moves hadn't taken me further away from my family'.*

SECTION 4: THE SIGNIFICANT PRACTICE EVENTS.

4.1 GMLA 1- historic information and a summary of significant practice events up to and including the 20th April 2011.

73. The table below highlights relevant historic information and significant practice events within GMLA 1 up to and including the 20th April 2011:

YEAR/MONTH	GMLA 1- SIGNIFICANT PRACTICE EVENTS
1993	Mother was subject to a CP plan aged 7yrs in GMLA 1 due to safeguarding concerns which included poor home conditions, poor relationship with her mother and missing from home episodes.
2001-2003	Mother gave birth to her first child whilst in her mid-teens- Adam. Referral received by CSC from GMP in 2003- mother had been arrested for being drunk while caring for Adam. Home conditions were poor. Mother and Adam moved to live with maternal grandparents. Initial Assessment (IA) completed. Outcome: Recommendation that mother and Adam continued to live at grandparent's home and for mother to access support from Sure Start.
2004	GMP first aware of domestic abuse in respect of father.
2005- 2006	Mother gave birth to her second and third children. GMP first aware of domestic abuse in respect of mother.
March 2009	CSC informed that maternal grandmother was caring for the children due to mother's poor mental health including depression and self-harm incidents. Solicitor's advice had been sought by mother and grandmother. Outcome: SW visited the home to assist with care arrangements for the children.
May 2009	Cafcass ¹¹ involved and mother's second and third children commenced living with their birth father who had secured a Residence Order ¹² and remained in his care.
August 2009	Entry in GP records noted mother had a history of anxiety, depression and self-harm.
March, May & September 2010	Mother attended Accident and Emergency (A&E) 3 times- 2 self-harm incidents and 1 incident of being found intoxicated in a public place. Mother's daily alcohol intake was noted to be a concern. Outcome: Mother was assessed once by a Mental Health Liaison practitioner in A&E and was followed up by her GP monthly until August 2010 when she was recorded as feeling well on antidepressants.

4.2 GMLA 1- a summary of significant practice events from the 21st April 2011 up to and including the transfer to GMLA 2 in early August 2014.

74. The table below highlights the significant practice events within GMLA 1 from the 21st April 2011 up to and including the transfer to GMLA 2 in early August 2014:

YEAR/MONTH	GMLA 1- SIGNIFICANT PRACTICE EVENTS
April 2011	Referral received by CSC from A&E: mother had attended intoxicated. Outcome: Referred to the Local Authority Early Intervention Team.
Mid September 2011	GMP responded to a domestic abuse incident involving mother (8 months pregnant with her fourth child) and father. Mother stated he was her new boyfriend and their relationship had commenced 5 weeks previously. Father was under the influence of drugs and alcohol and

¹¹Children and Family Court Advisory and Support Service. Available at: <https://www.cafcass.gov.uk/> (Accessed:17.12.19)

¹² Residence Orders which determined where a child would live along with Contact Orders were replaced by Child Arrangement Orders by the Children Act, 2004. Available at: <https://www.gov.uk/looking-after-children-divorce/types-of-court-order> (Accessed: 17.12.19).

	made threats towards mother. GMP notified CSC of the incident- no further action was taken by CSC. First reference to a relationship between mother and the partner (not birth father to mother's unborn child) referenced as father in this review.
Mid October 2011	GMP responded to a reported domestic abuse incident. Father had punched mother in the face six times causing swelling and a small cut. She had moved out of his property and contacted GMP. Outcome: Father charged with S47 assault. ¹³
Mid October 2011	GMP notification of domestic abuse incident received and actioned by CSC 4 days after the incident. Adam known to be in maternal grandmother's care. Outcome: CSC assessment commenced due to mother's pregnancy and to review plans for the children.
Late October 2011	Referral received by CSC from Maternity Services notifying of the birth of mother's fourth child. Mother agreed to live at maternal grandmother's home after discharge from hospital.
Late December 2011	Strategy Meeting held. Mother had previously signed a CSC working agreement which included she would not allow father to have contact with her baby. Contact had occurred resulting in the children having witnessed a domestic abuse incident over Christmas and there had been a subsequent self-harm incident by mother. Outcome: A Section 47 Enquiry ¹⁴ was completed and legal advice sought. Private law application instigated by grandmother who wanted the children to remain in her care due to concerns about mother's alcohol use and domestic abuse. Initial Child Protection Conference (ICPC) to be convened if required dependent on the outcome of grandmother's application.
Early January 2012	Prohibited Steps Order ¹⁵ (not time limited) granted to grandmother who had acquired parental responsibility through a Residence Order. The Prohibited Steps Order prevented mother from removing her children from grandmother's care without the agreement of the Court. Cafcass was involved in this private law application process. Outcome: Cafcass recommended the Local Authority complete a s.37 Children Act assessment and then closed the case. ICPC not progressed by CSC due to the Prohibited Steps Order providing an appropriate level of safety. CSC completed the s37 Children Act assessment, after which a Family Assistance Order was granted in May with the main issue relating to mother's contact. CSC provided support to grandmother in her care of Adam and mother's fourth child up to around October 2013.
Mid January 2012	Mother convicted of theft and sentenced to a 12-month Community Order ¹⁶ with involvement of Probation Services.

¹³ Section 47 of the Offences against the Person Act 1861 relates to Assault occasioning Actual Bodily Harm (ABH). This offence carries a maximum penalty on indictment of 5 years imprisonment and/or a fine.

¹⁴ Section 47 enquiry: Where a Local Authority have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm, the authority shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare.

¹⁵ Prohibited Steps Order- An injunctive order prohibiting a person from exercising an aspect of their parental responsibility for a child.

¹⁶ A Community Order is a non-custodial sentence which requires an offender to perform community service, observe a curfew, undergo treatment for drug or alcohol addiction, etc., instead of going to prison.

	Outcome: The Order was breached twice resulting in mother being imprisoned for 3 months.
Late January 2012	Referral received by CSC from Probation. Mother had resumed a relationship with father resulting in grandmother no longer allowing her to live at the home- mother became homeless. Outcome: Information logged due to children not being in mother's care.
Early February 2012	GMP notification of a domestic abuse incident involving mother and father received by CSC. Mother had been staying at a friend's home at the time of the incident. Outcomes: Domestic abuse incident discussed at a Multi-agency Risk Assessment Conference (MARAC). Father convicted of S47 Assault and sentenced to 16 months in prison.
June 2012	Indefinite Restraining Order ¹⁷ issued in respect of father.
June 2013	Father released from prison.
End February 2014	Referral received by CSC: mother reported to be in a relationship with father and was pregnant. There were concerns about ongoing domestic abuse. Outcome: CSC intervention including a pre-birth assessment commenced.
March 2014	Maternity Services Special Circumstances form received by GMLA 2 health visitor (HV) Service: This indicated mother had moved to GMLA 2, parents were living together and that GMLA 1 CSC was involved.
May 2014	Father convicted of Shop Theft and Common Assault (against a third party) and sentenced to a 9-month Community Order. First CGM CRC Case Manager became involved. Father assessed using the agency OASys risk assessment tool as posing a medium risk of serious harm. CRC Case Manager notified GMP of father residing with mother in GMLA 1 despite the indefinite Restraining Order. GMP Officers attended the home and mother returned to live at grandmother's home. CRC Case Manager refused a request from father for support in applying for the Restraining Order to be lifted.
Early August 2014	GMLA 1 CSC transferred the case to GMLA 2 due to mother's move to that Local Authority area. Outcome: Referral and pre-birth assessment forwarded to GMLA 2 CSC and accepted. GMLA 1 CSC closed the case.

4.3 GMLA 2- a summary of significant practice events from early August 2014 up to and including the end of July 2017.

75. The table below highlights the significant practice events from early August 2014 following the move to GMLA 2 up to and including the end of July 2017:

YEAR/MONTH	GMLA 2- SIGNIFICANT PRACTICE EVENTS
Mid August 2014	Father informed CRC Case Manager he thought CSC and other agencies would support him in applying to have the Restraining Order

¹⁷ Restraining Order- these orders are intended to be preventative and protective. When sentencing for any offence the court can now, under S12 of the Domestic Violence, Crime and Victims Act, 2004 which amended Section 5 of the Protection from Harassment Act, 1997 make a restraining order for the purpose of protecting a person (the victim or victims of the offence or any other person mentioned in the order) from conduct which amounts to harassment or which will cause a fear of violence.

	lifted. CRC Case Manager sceptical about father saying he was not having any contact with mother at this time.
Late August 2014	GMP contacted by the CPS: Mother and father had made a written application to Court for the Restraining Order to be lifted and the CPS was aware a Strategy Meeting was to be held. Outcome: Court Hearing adjourned to allow for Court consideration of the Strategy Meeting outcome.
Early September 2014	Strategy Meeting held. Information understood by CSC at that point: <ul style="list-style-type: none"> • Mother pregnant for the fifth time. All 4 older children not in her care - oldest two with their grandmother who had secured a residence order and the younger two with their birth father • Mother's chaotic lifestyle including alcohol abuse • Mother's relationship with the unborn baby's father who had an extensive history of domestic abuse towards mother and in previous relationships • Indefinite Restraining Order which both parents had ignored by living together since June 2013 and had stated they intended to live together. Mother advised a SW father had changed since being released from prison • Extensive criminal history in respect of both parents. The rationale for mother's move to GMLA 2 was not fully understood. GMLA 2 was noted to be the first Local Authority to have offered mother accommodation, indicating she may have applied to a number of authorities. Outcome: Second pre-birth assessment completed and an ICPC to be convened.
Early September 2014	Court Hearing to consider application to discharge the Restraining Order. The understanding at Court was that parents were living separately and an ICPC was being considered. Outcome: The Restraining Order was discharged. The SW informed the CRC Case Manager of this decision.
Late September 2014	ICPC held and Poppy was born 5 days later. Outcome: Unborn Poppy made subject to a pre-birth CP Plan under the category of neglect. The CP Plan included a written agreement signed by both parents stating father was not allowed to stay at the house overnight until assessments had been completed, he was required to comply with his Community Order and both parents were required to complete domestic abuse programmes. Core Group meetings held in September, October and November. Risk assessment completed in November.
Mid December 2014	First Review Case Conference held. Both parents attended and were reported to have fully complied with the CP Plan including a requirement to remain ' <i>semi-separated</i> ' with father understood to be staying at the home 2 nights weekly. Father had completed the Freedom ¹⁸ domestic abuse programme and parents were deemed to have addressed the issues of concern.

¹⁸ The Freedom Programme was primarily designed for women as victims of domestic violence, since research shows that in the vast majority of cases of serious abuse are male on female. However, the programme, when provided as an intensive two-day course, is also suitable for men, whether abusive and wishing to change their attitudes and behaviour or whether victims of same sex domestic abuse themselves. Available at: <https://freedomprogramme.co.uk/> (Accessed: 03.11.19)

	Outcome: The CP Plan ceased, and the case was stepped down to Child In Need (CIN).
Mid May 2015	Final CIN meeting held. Poppy's parents judged to have engaged, worked hard and met all the requirements in relation to alcohol misuse and domestic abuse resulting in a significant reduction in the level of risk. Poppy was thriving in her parent's care. Outcome: CIN Plan ceased and case closed to GMLA 2 CSC. HV was to remain involved and would re-refer to CSC if necessary.
Late May 2015	Contact with GMLA 1 CSC by a Children's Centre practitioner raising concerns about Adam and mother's fourth child having moved from grandmother's to mother's care. Outcome: this information was considered by a Multi-agency Screening Service (MASS) manager. A decision was made that CSC intervention was not warranted given the closure of Poppy's case 2 weeks previously.
June 2015	Concerns raised with GMLA 2 CSC about Adam caring for Poppy and mother's fourth child whilst mother and father went out. Outcome: A further period of CIN intervention commenced. Family had been assessed by HV Service at Universal Plus level prior to this incident. The case was re-allocated to a second named HV (previous HV had left the service) due to this concern and re-assessed at CIN.
August 2015	GMLA 2 CSC closed the case after second period of CIN intervention during which there had been no evidence of recent domestic abuse incidents and no concerns about home conditions.
October 2015	HV Service assessment of the family was at Universal level due to there being no identified concerns or unmet health needs.
December 2015	CSC received a GMP notification of a verbal domestic abuse incident. Outcome: Father removed from the property by GMP. Early Help (EH) Plan put in place with a Common Assessment Framework (CAF) completed with mother in February 2016. The EH Plan lead was an education practitioner who had raised concerns about mother's fourth child disclosing fighting between mother and father at home with CSC and had been advised to offer EH support. The EH Plan related to Adam, mother's fourth child and to Poppy.
January 2016	HV home visit by third named HV following notification of incident to discuss the impacts of domestic abuse. Mother stated it was only an argument.
Early March 2016	First CAF meeting- neither parent attended.
Mid March 2016	GMP attended a domestic abuse incident which occurred at the home of mother's friend who reported the incident. Mother didn't want to press charges. Both parents were intoxicated and father punched mother in the face numerous times. A Domestic Abuse, Stalking and Harassment (DASH) ¹⁹ risk assessment was completed, the outcome of which was medium.

¹⁹ Amanda L. Robinson, Andy Myhill, Julia Wire, Jo Roberts and Nick Tilley (Sept 2016) Risk-led policing of domestic abuse and the DASH risk model, College of Policing In the UK. In the UK, the most widely used model in risk-led policing of domestic abuse is the DASH. A series of questions are asked of victims usually by first responding officers at the scene of a domestic abuse incident. As well as recording whether a specific risk factor is present or absent, officers are able to provide contextual data. Scores from the DASH inform the grading of risk as 'standard', 'medium' or 'high'. Assessors can use judgement to alter the risk level of a case if they feel it presents a higher risk than the numerical score suggests. In most police forces, the risk level dictates the type and degree of intervention and safety planning with victims.

	Outcome: Father arrested and subsequently convicted of Common Assault and Criminal Damage and received a 12 months Suspended Sentence Order ²⁰ .
Mid March 2016	Incident discussed by the MASS on the same day. Outcome: Action agreed for CSC to review previous assessments and determine if further assessment was required. If not, the existing EH Plan was to be reviewed and made more stringent, the Victim Care Unit was to offer support to mother and would make GMP aware of any further actions required to safeguard her and the children.
Late March 2016	HV home visit following notification of domestic abuse incident. Mother reported father was staying at his mother's home.
Late April 2016	Second CGM CRC Case Manager became involved. Father assessed using the agency OASys risk assessment tool as posing a medium risk of serious harm. His initial compliance with his Suspended Sentence Order was poor.
Late April 2016	Second CAF meeting- mother attended.
Mid May 2016	Referral received by CSC from CRC Case Manager. The referral was made due to the recent conviction of father of Common Assault against mother and the domestic abuse history between 2011-2016 provided by the GMP Public Protection Investigation Unit (PPIU).
Mid June 2016	Third and final CAF meeting. The EH Plan outcomes had been largely achieved. Outcome: EH Plan ceased.
Late June 2016	CRC Case Manager discussed the referral with a SW and was advised that a Child and Family Assessment had been completed and no concerns had been raised by professionals. Outcome: Case closed to CSC and CRC Case Manager to make a further referral if new concerns were identified.
Late July 2016	HV home visit: Mother advised she was living with father again and that she was pregnant.
Early August 2016	Enforcement action taken by CRC Case Manager due to father's poor initial compliance with the Suspended Sentence Order. He appeared in breach Court and received a further 20 hours Unpaid Work after which there was a slight improvement in father's compliance until October 2016.
Late September 2016	HV home visit. Developmental assessment completed for Poppy who was recorded as being well dressed and age appropriate toys were available.
Late February 2017	Home visit by CRC Case Manager: Mother seen with the children including newly born Luke. Mother stated father was no longer living at the home. Outcome: CRC Case Manager contacted CSC to discuss making a second referral due to mother having recently had a baby. Advice was given not to refer as father was not living at the family home and there had been no incidents since the last CSC assessment in June 2016.

²⁰ A Suspended Sentence Order (SSO) is a custodial sentence and should only be used where the court is minded to pass a custodial sentence of less than 12 months. However, it is made up of the same requirements as the Community Order, so in the absence of breach is served wholly in the community.

	CRC Case Manager initiated breach proceedings due to father having failed to make contact and his whereabouts being unknown. A warrant for his arrest was issued by the Court.
Late February 2017	HV home visit- father reported to be asleep upstairs. Home recorded as tidy and ' <i>lovely interactions</i> ' between mother and Luke observed.
Late February and early March 2017	Two telephone contacts between the CRC Case Manager and the HV Service to discuss the case.
March 2017	Previous education EH Plan lead contacted a CSC MASS practitioner raising further concerns about mother's fourth child including poor school attendance. Outcome: Education practitioner advised to offer further EH support as there had been no recent evidence of domestic abuse and mother had advised the MASS practitioner she was not in a relationship with father although he continued to play an active part in the children's lives. Second EH Plan commenced led by the same education practitioner as previously.
March 2017	CSC received a referral from the CRC Case Manager. Outcome: CRC Case Manager advised by an EH MASS Support Worker at the beginning of April that an EH Plan was in place and that involved practitioners had been requested to monitor any concerns. Mother had been seen- she reported father was living at his mother's but visiting regularly and staying over at times. She admitted father had been in bed when the CRC Case Manager had visited.
April 2017	Termination of father's 12 month Suspended Sentence Order. Outcome: The warrant for father's arrest due to him breaching the Suspended Sentence Order was in force. Due to his poor compliance, he had not addressed his risk factors or achieved the objectives of his sentence plan which included domestic abuse and alcohol misuse interventions.
Late June 2017	After undertaking 2 home visits to try to engage mother in the offered EH intervention, the education EH Plan lead escalated the case to CSC. The EH Plan had made limited impact and a significant history of concerns was not being recognised by mother and father who had declined offers of support. They wanted to move back to GMLA 1 for a ' <i>fresh start</i> ' raising concerns this was possibly to avoid the concerns being escalated. Outcome: Strategy Meeting to be convened.
July 2017	Mother attended A&E due to a self-harm incident.
Late July 2017	Strategy Meeting held. Outcome: ICPC to be convened.

4.4 GMLA 2 and Salford- a narrative of significant practice events during the 12 months prior to the date of the incident.

76. Early in August 2017, the case was allocated to a new GMLA 2 CSC SW who decided a further period of CIN intervention would be offered. Three CIN visits were completed in August by the SW and a CIN meeting was held. Mother initially appeared to engage with this further period of CIN intervention. The SW made contact with the GP Practice and the HV to ensure support was in place for mother following the self-harm incident in July.

77. Towards the end of August, GMP received a call from a third-party reporting that mother had been assaulted by father who was arrested when Officers attended. A DASH risk assessment was completed, the outcome of which was medium. The incident was discussed at the Daily Risk Management meeting and referrals were made to CSC, Adult Social Care, Mental Health and Renascence²¹.
78. Early in September, GMP again received a call from a third-party reporting an ongoing domestic abuse incident. Father was arrested by attending Officers for being in breach of Court bail. A DASH risk assessment was completed, the outcome of which was medium. The incident was discussed at the Daily Risk Management meeting and referrals were made to CSC, Health Services, Voluntary Services and Probation. Three days later an arrest warrant relating to father was issued by the local Magistrates Court for breach of the March 2016 Suspended Sentence Order.
79. Concerns about the family escalated during September with the 2 recent domestic abuse incidents, a deterioration in mother's engagement with the CIN Plan and also concerns being raised by a parent with school which included substance misuse, adults visiting the home, Luke being left crying for hours and the impacts on the children. These concerns were shared with CSC in writing by the education EH Plan lead who had also advised the reporting parent to contact CSC. The SW visited mother on the same day as the concerns were shared with school to discuss these with her. On the day of the visit mother and the children had moved to live temporarily with maternal grandmother where they were seen by the SW. Mother denied the concerns, saying they were malicious.
80. Early in October, a Strategy Meeting was held at which concerns were also shared about Adam's school attendance having further deteriorated to 36%, mother had not taken Luke to health clinics and she had not engaged with the Family Support Worker (FSW). The outcome of this meeting was for a Section 47 Enquiry to be completed and an ICPC to be convened.
81. Towards the end of October, GMP received a call from the SW who had not been able to gain access to mother's home and was concerned a child was '*home alone*'. A neighbour advised the SW of mother and father having left via the rear of the home as the SW arrived. When GMP Officers attended, mother stated she had been shopping. Father was found nearby and assaulted the Officer who arrested him for breach of the Suspended Sentence Order. After the incident mother and the children were taken to grandmother's home by the SW. Following a review of the incident by the GMP PPIU, a referral was made to CSC.
82. At the end of October, the ICPC was held which was attended by mother and grandmother. Mother and the children were living at grandmother's address at this point and Adam, Poppy and Luke were the subjects of the Conference. Feedback from maternal grandmother to the independent reviewer was that she was very concerned about the children and had demanded mother's fourth child was returned to her care which mother agreed to. Feedback from the EH Plan lead indicated this move occurred in July 2017. Adam's feedback was that he chose to remain with his mother because he wanted to try to keep Poppy and Luke safe and he had friends in that area.
83. The concerns leading to the Conference were recorded as mother's lack of engagement with the CIN intervention with the CIN Plan not having reduced the risks, long standing concerns for mother's mental health, alcohol misuse, changes of address, a long history of domestic abuse between mother and father and concerns about possible ongoing domestic abuse. Adam, Poppy and Luke were made subject to CP Plans under the category of neglect (failure to protect from domestic abuse). The Conference summary notes stated, '*the Conference has reached a unanimous decision that all three children should be made*

²¹ The Renascence Complex Needs Service provides support individuals coping with complex issues including domestic abuse which may prevent them from accessing mainstream services initially.

the subject of a CP Plan and whilst neglect (failure to protect from domestic abuse) will be the primary risk category covering the CP Plan, professionals will need to be very clear that these children are at risk on both a physical and emotional level'.

84. The first Core Group meeting was held 10 days later and was attended by mother who had by then been provided with temporary accommodation in Salford for a period of up to 12 months to assist her in ending her relationship with father. Mother disclosed being pregnant at this meeting. The SW made a referral to the Salford Safeguarding Unit due to mother's change of address.
85. Practitioner feedback was that mother became very upset during an HV home visit prior to the move to Salford, disclosing she had received poor parenting herself and her self-harm issues. The HV's perception was that mother wanted a different life for her own children. The HV referred mother for counselling but she was reluctant to engage with this.
86. In the middle of November, father was seen by a Mental Health Liaison Service practitioner in the SRFT A&E department- he was intoxicated, reported having suicidal thoughts and stated he had absconded from another hospital earlier that day and had been riding round on buses. He said he was homeless when asked for his address and was recorded as having '*no fixed abode*'. He was too intoxicated to be assessed and left the department after being asked to wait until an assessment could be completed. Father's GP Practice was notified of the attendance.
87. Early in December, the second Core Group meeting was held which was attended by mother. During this month, mother attended for a new patient medical appointment after registering with a Salford GP Practice. At this appointment, she disclosed being an ex-drinker. It was recorded mother had learning difficulties as she disclosed struggling to read and write. She did complete a referral form at the Practice as required to notify Community Midwives of her pregnancy.
88. At the beginning of January 2018, the Transfer-in Child Protection Conference was held in Salford. Mother was understood to be 14 weeks pregnant with Baby MD at this point. The safeguarding concerns shared by GMLA 2 CSC were in relation to domestic abuse, parental substance misuse, maternal mental health, Adam's very poor school attendance in GMLA 2, a chaotic home environment and Poppy not having accessed nursery or community activities. It was understood by Salford CSC at the point of the case transfer that mother had 3 other children who had ceased living in her care in approximately 2014, that Adam and mother's fourth child had been living with grandmother subject to a Residence Order with Adam returning to his mother's care in 2015 and that mother's second and third children lived with their birth father subject to a Residence Order.
89. The Salford CSC SW allocated to the case attended the Transfer-in Conference and remained the allocated SW up to the date of the incident. In addition to attending Salford practitioners, the Conference was well attended by a number of GMLA 2 practitioners including the SW, FSW, HV, School Nurse and the Safeguarding Lead for Adam's school who all knew the family and case well. GMP was not represented having no new information to provide since the October ICPC and provided a report which included a full Police history. At the Conference, mother stated father had had no contact with herself or the children. The outcome of the Conference was that Poppy and Luke remained subject to CP Plans under the category of neglect and Adam became subject to a Vulnerable Young Person's Plan (VYPP). The CP Plan included a written agreement put in place by Salford CSC stating father was not allowed any contact with the children prior to completion of a risk assessment in light of his criminal violent history. A Children & Families Assessment was also to be undertaken by Salford CSC. The case was closed to GMLA 2 CSC following this Conference.

90. The first Core Group meeting convened by Salford CSC was held 8 days later. Towards the end of January, mother informed the recently allocated HV during a home visit that she had suffered from depression as a teenager but not since and that she suffered from anxiety but managed this. Poppy commenced at a Local Authority day nursery at the end of January.
91. At the beginning of February 2018, mother attended MFT A&E with abdominal pain. Prior to this date, mother had been offered 2 appointments by the Community Midwives but had not attended these. In A&E, she disclosed being 22 weeks pregnant and said she had not sought antenatal care as she *'didn't want anyone to know about this unplanned pregnancy'*. An ultrasound scan identified she was 17 weeks pregnant. Mother was admitted and steps were taken to ensure antenatal care would be offered by St. Mary's Maternity Hospital (St. Mary's). A Maternity Information Referral Form was also completed which ensured the concerns identified were *'flagged'* on the electronic recording systems. This form is also commonly known as a Special Circumstances form and it is used to share relevant information with other health practitioners, namely the HV Service via Child Health.
92. Mother was offered a pregnancy booking appointment in the middle of February which she cancelled. The second Core Group meeting was held on the same day. Mother was given another appointment for 4 days later which she failed to attend. A further appointment was offered for the end of February which mother cancelled.
93. Towards the end of February, the Salford Humankind Family Support Service received a referral from the SW. This outlined support was required in the following areas: impact of previous domestic abuse, support for both the children and mother, B.E.A.C.H²² self-esteem groupwork for mother, encouragement in accessing and engaging in activities in the community and assisting the family in finding and maintaining a permanent home in Salford.
94. Early in March 2018, mother (22 weeks pregnant) attended a booking appointment at St. Mary's. Mother informed the Midwife this was her 7th pregnancy and that 3 children did not live with her. She disclosed that her children had a SW, she was separated from father due to domestic abuse and she was living at a safe address. She named her mother as her next of kin. Mother was routinely asked about her alcohol consumption and reported not drinking any alcohol or any drug use. In relation to her mental health, she disclosed she had been depressed in the past but had stopped medication 8 months previously. In relation to smoking, she disclosed smoking 5 cigarettes daily- the risks of smoking in pregnancy were explained and discussed. Mother was identified as having a raised body mass index which increased her risk of pregnancy complications including gestational diabetes²³. She had also previously given birth pre-term at 34 weeks gestation. Due to these added risks, mother was informed her pregnancy would require increased monitoring including by Obstetricians alongside Midwives. Maternity Services made a referral to Salford CSC following this attendance in line with expected practice.
95. Early in March, Adam commenced at a Secondary School in Salford where he settled well with his attendance being initially good and he made some friends. The first VYPP meeting for Adam was held later that month.

²² B.E.A.C.H sessions are provided by the Humankind Family Support service. The 5 sessions are designed for people experiencing low confidence and/or low self-esteem. They aim to support participants in developing their self confidence and self-esteem with key materials provided at the final session to support participants in continuing to practice the skills learnt.

²³ Gestational diabetes is high blood sugar (glucose) that develops during pregnancy and usually disappears after giving birth. It can happen at any stage of pregnancy, but is more common in the second or third trimester. Gestational diabetes can cause problems for you and your baby during pregnancy and after birth. But the risks can be reduced if the condition is detected early and well managed. Available at: <https://www.nhs.uk/conditions/gestational-diabetes/> (Accessed: 03.11.19)

96. Towards the end of March, the first Review Case Conference was held and positive information was shared: there had been no known contact between mother and father, home conditions had improved, Adam was attending school and Poppy was attending nursery. Outstanding work was noted to be the risk assessment of father which he had not engaged with and safe & healthy relationship work with mother after a Humankind Family Worker (FW) had been allocated. A recommendation from this Conference was for a pre-birth assessment to be completed.
97. At the beginning of April 2018, the case was allocated to a Humankind FW. During April, Adam's punctuality at school became a problem and school staff worked with Adam and the SW regarding this. In the middle of April, mother failed to attend 2 appointments at St. Mary's, the first of these was at antenatal clinic and the second was with the Specialist Obstetric Diabetic team. On the day after the second missed appointment, and on a Saturday morning, Community Midwives attempted to see mother at home but were unsuccessful and arranged for a further appointment to be sent. As part of the plan to monitor mother's complex pregnancy, she had been asked to test her blood glucose levels and to record these. The Diabetic Specialist Midwives were attempting to contact mother each week to obtain the results from her and to discuss them. More than 75% of attempted calls were unanswered. When mother did answer, she was often unable to provide any results, stating she was out of the house or the results provided were assessed to be vague and inaccurate.
98. Towards the end of April, mother (29 weeks pregnant) was contacted by telephone and advised to attend the St. Mary's Antenatal Assessment Unit for an urgent review. She did attend and a first ultrasound growth scan was undertaken which identified unborn Baby MD's growth was at the highest end of normal limits. Mother's blood sugar levels were also raised and she was commenced on insulin. She was then requested to attend at the beginning of May to be reviewed by the Diabetic Consultant, however she didn't attend after which the Consultant sent a letter to mother informing her of the risks and advising her to attend a subsequent appointment 2 weeks later.
99. Early in May 2018, a domestic abuse incident was reported to GMP by a neighbour. Attending Officers arrested father at the home and mother initially said he had just turned up at the house. The Officers observed evidence of a man living at the home. A DASH risk assessment was undertaken, the outcome of which was standard. Father was subsequently charged with S39 assault²⁴. The SW visited the home 5 days later after being notified of this incident and then requested a Strategy Meeting be convened.
100. In the middle of May, mother attended her appointment with the Diabetic Consultant and a second ultrasound growth scan was undertaken. Concerns noted at that appointment were that mother was unable to provide any blood glucose results, she had failed to attend her GP Practice to obtain a repeat prescription of her insulin medication and she ended the consultation early stating she didn't want to stay. The fourth Core Group meeting was held 3 days and mother cancelled a first arranged appointment for the Humankind FW assessment 6 days after this appointment.
101. Towards the end of May, the Strategy Meeting was held to discuss the recent concerns. This was attended by the SW, a SW manager, the HV, GMP and the Humankind FW. An action from this meeting was for the SW to refer mother to the Salford Independent Domestic Abuse Support Service (SIDASS), as mother had not referred herself to this service as required by the CP Plan. On the next day, mother cancelled a second assessment appointment arranged for the Humankind FW assessment. On the day

²⁴ Common assault (section 39, Criminal Justice Act 1988)- A person is guilty of common assault if they either inflict violence on another person – however slight this might be – or make that person think they are about to be attacked.

after that, mother cancelled an antenatal visit arranged by the HV. The HV had made a referral in January to the Helping Hands Service for safety equipment to be fitted in the home and was informed on this date that the service had attempted unsuccessfully to complete the work on 3 occasions and was therefore closing the case.

- 102.** At the end of May, the SW visited paternal grandmother's home within GMLA 1 in an attempt to engage father who had advised GMP this was his address on his release from custody after the most recent domestic abuse incident. The SW did not gain access however a neighbour was proactive in asking who the SW was looking for and confirmed father was living there. The SW left a note asking father to make contact but did not receive a response. Prior to GMP providing CSC with this address, it had been understood father had '*no fixed abode*'.
- 103.** At the beginning of June 2018, mother contacted GMP reporting Adam as having been missing for 5 days. Attending Officers identified that children in the home were subject to CP Plans on the GMP systems and noted both the home conditions and the fact that an intoxicated man was in the home. The Officers took further action after the incident and identified the man was father who had provided false details at the time. A referral was made to CSC by the GMP PPIU in light of this incident. Adam advised GMP Officers when located that his mother had known where he had been staying- he returned home the next day.
- 104.** The SW visited the home 3 days after the most recent GMP visit having now received GMP notifications in relation to the incidents attended both in May and June and then took prompt action to escalate the case. At this point, a decision was made by Salford CSC to present the case to a Legal Planning meeting to determine if the legal threshold for taking Care Proceedings²⁵ process had been met. On the same day as the SW visited, mother contacted the Specialist Midwives stating she could not attend her appointment as '*something had come up*' and would not disclose any further details.
- 105.** Mother (36 weeks pregnant) attended an appointment with the Specialist Midwives one week later. A third ultrasound growth scan was undertaken which identified that unborn Baby MD's growth remained at the highest end of normal boundaries. A Legal Planning meeting was held 8 days after the last SW visit at which it was determined the legal threshold for taking Care Proceedings had been met.
- 106.** In the middle of June, a joint visit was undertaken by the HV and Humankind FW after mother had cancelled several previous home visit appointments offered by both practitioners. Mother denied having any contact with father. The HV completed an antenatal visit including the provision of safe sleep advice. The SW visited the home 5 days later but could not gain access. The SW checked the rubbish bins finding 10-15 beer cans and raised this concern with the Midwife. When mother was subsequently questioned about the beer cans by the SW, she stated they had been there since father had last been found at the home. The SW was sceptical about the information provided by mother.
- 107.** The Initial Pre-Proceedings meeting was held 9 days after the Legal Planning meeting and a working agreement was developed but not signed by mother on this date. Also, on this date, the Humankind FW completed the Family Assessment and determined a plan of work. The fifth Core Group meeting was

²⁵ Care Proceedings- When parenting is not improving enough to protect the child from significant harm, the local authority will convene a legal planning meeting to obtain legal advice. At the meeting, a decision should be made in principle about whether the s31 legal test has been met. The local authority should then decide, based on a robust analysis of the level of assessed risk, whether it is in the best interests of the child to begin pre-proceedings (in accordance with the relevant statutory guidance available at <https://www.gov.uk/government/publications/children-act-1989-court-orders--2>) and the Local Authority will provide a further period of support for the family with the aim of avoiding proceedings or whether proceedings should be initiated immediately

held the next day at which it was reported Poppy had not been taken to 24 out of 37 possible nursery sessions.

- 108.** Towards the end of June, mother was admitted to St. Mary's for induction of labour with Baby MD being born on 3 days later in a good physical condition at 38 weeks gestation. Whilst mother's late booking and poor compliance with antenatal care may have indicated she was ambivalent about the pregnancy; she was noted to be receptive to Midwifery advice and attentive to her baby. Safe sleeping was discussed on admission to the postnatal ward and during Baby MD's neonatal examination in accordance with expected practice.
- 109.** The ICPC (pre-birth) for Baby MD was held the day after the birth at which the pre-birth assessment completed in June was presented. Baby MD was made subject to a CP Plan under the category of neglect and a detailed CP Plan was established. This included the provision of safe sleep advice due to mother smoking and being known to have a history of alcohol misuse. A Pre-discharge Planning meeting was held at St. Mary's on the same day at which mother signed the working agreement provisionally developed at the first Pre-Proceedings meeting which stated she would not allow father in the home or have any contact with Baby MD prior to a risk assessment of him being completed. Legal advice was to be sought should any contact occur to clarify whether the legal threshold for an Emergency Protection Order²⁶ application had been met.
- 110.** After discharge from hospital, mother and Baby MD were seen twice at home by St. Mary's Community Midwives. At the first post-discharge home visit by a St. Mary's Community Midwife on the day after discharge, a safe sleep assessment was completed which included discussion about the risks posed by smoking in the home and advice was given. No concerns were noted at the second visit 3 days later at the beginning of July. A detailed discharge summary was forwarded to the GP Practice from St. Mary's. This included the name of the allocated SW and that CSC should be contacted if agencies became aware of father having any contact with the family. Practitioner feedback was that this information would initially be saved within the mother's GP record due to records only being generated for the baby once registered with the Practice and that it is important to ensure such information is then also saved onto the baby's record.
- 111.** During the first week of July, the Humankind FW supported mother and the children in moving to emergency accommodation within Salford. This move followed discussions by the Humankind FW with GMLA 1 Council officials about father having become aware of mother's first address in Salford. The HV completed a primary visit the following week when Baby MD was 15 days old after mother had cancelled 2 previously arranged primary visits. Safe sleep advice was reinforced at this visit. Following the move to emergency accommodation, responsibility for Community Midwifery care was transferred from MFT to the NHSFT in a fourth GMLA area which provided maternity care within the area of mother's new home address.
- 112.** Three home visits were undertaken by Community Midwives from this NHSFT during July prior to their discharge after the third visit towards the end of July when Baby MD was 28 days old. Safe sleep advice was reinforced at the first visit. No concerns about Baby MD's well-being, care or growth were noted. The sixth Core Group meeting was held in the middle of July.
- 113.** At the beginning of August 2018, a Pre- Proceedings meeting was held which mother attended with Baby MD. The incident leading to initiation of the SCR occurred on the day after this meeting.

²⁶ An Emergency Protection Order (EPO) – a court may make an EPO only if it is satisfied that there is reasonable cause to believe that the child is likely to suffer significant harm if the child is not removed to accommodation provided by the Local Authority or remain in that accommodation.

SECTION 5: ANALYSIS INCLUDING GOOD PRACTICE, LEARNING POINTS AND RECOMMENDATIONS.

114. This section analyses the significant practice events in relation to the KLOE. Learning points, good practice and recommendations have been identified throughout the text.

5.1 KLOE 1: Evidence base of decision making throughout multi-agency involvement, including the way in which historical information was understood to inform capacity to change or ability to meet the children's needs in the long term.

115. *GMLA 1- evidence base of decision making from the 21st April 2011 up to early August 2014:* Prior to the start of the review timeline, GMLA 1 CSC had been involved during mother's childhood, briefly in 2003 following an incident of her being intoxicated whilst caring for Adam and again briefly in March 2009 when mother was experiencing mental health difficulties and grandmother was caring for her 3 children. Following this intervention, CSC had no contact with the family until the 21st April 2011. In May 2009, mother's second and third children moved from grandmother's home to their birth father's care following private law proceedings and Adam remained in grandmother's care. During 2009 and 2010, there were ongoing concerns about mother's mental health and alcohol abuse. In August 2009, the GP recorded mother (aged 23 years) had a history of anxiety, depression and self-harm. During 2010, mother attended A&E on 3 occasions due to 2 incidents of self-harm and 1 incident of being intoxicated.

116. In April 2011, GMLA 1 CSC received a referral from A&E providing limited information about mother's attendance whilst intoxicated. There was no evidence CSC practitioners were made aware of the 3 A&E attendances during 2010 and mother was not caring for any of her children at that time or when the referral was received. A referral was made to the Early Intervention Team however it is not known whether mother accepted this support.

117. Information reviewed indicates the parental relationship commenced around August 2011 with the first 2 reported incidents of domestic abuse occurring in September and October towards the end of mother's pregnancy with her fourth child. Father as referenced in this review was not the birth father of her unborn baby. GMP notified CSC of both incidents. The first incident was notified as father making verbal threats towards mother and no further action was taken by CSC. The second involved father assaulting mother and resulted in CSC intervention including assessments given mother's advanced pregnancy and a review of the care arrangements in place for her previous children. Mother had been living with father when the second incident occurred. Following the birth of her fourth child at the end of October, she agreed to live with her baby at grandmother's home. A working agreement was put in place by CSC and signed by mother which included the expectation she would not allow father to have any contact with her baby.

118. At the end of December 2011, a Strategy Meeting was promptly convened after a domestic abuse incident had occurred over Christmas between mother and father. This had been witnessed by the children and there had then been a self-harm incident in respect of mother. Expected practice was followed with a Section 47 Enquiry undertaken, legal advice sought and a plan agreed for an ICPC to be convened should grandmother's private law application for a Prohibited Steps Order not be successful. This Order, which prevented mother from removing Adam and her fourth child from grandmother's care was granted at the beginning of January 2012. This was deemed by CSC to provide sufficient security and safety for the children and the ICPC was not convened.

119. Whilst mother initially continued to live at grandmother's house with Adam and her fourth child on conclusion of the private law proceedings, CSC received a referral from Probation at the end of January 2012 indicating she was homeless. The referral stated mother had resumed a relationship with father and grandmother had therefore told her to leave the home. Probation was involved due to mother having

been convicted earlier in January of theft, receiving a 12-month Community Order. This information was logged by CSC and further action wasn't taken due to the children not being in her care. A Family Assistance Order was subsequently granted in May due to concerns about mother's contact with Adam and her fourth child and CSC continued to support grandmother in her care of these 2 children up to around October 2013.

- 120.** In February 2012, there was a significant domestic abuse incident resulting in father being convicted 1 week later of S47 assault for which he was imprisoned until June 2013 and an indefinite Restraining Order was issued in June 2012. CSC was notified by GMP of this incident and was aware that mother's children were not in her care. The incident was discussed at a MARAC²⁷ which would have determined actions aimed at supporting mother. After this incident, no information of concern relating to mother was shared with CSC by other agencies prior to February 2014.
- 121.** In February 2014, CSC received a referral in relation to mother having resumed her relationship with father and she was pregnant. Expected practice was followed with CSC intervention including a pre-birth assessment commencing. In May 2014, father was sentenced to a 9-month Community Order for Shop Theft and Common Assault against a third-party. There was evidence of information sharing between the CRC Case Manager and GMP about mother and father living together within GMLA 1 and action was taken with GMP visiting the home after which mother moved back to live at grandmother's home. Information reviewed does not evidence GMLA 1 CSC being informed of father's conviction or breach of the Restraining Order prior to this CSC transferring the case at the beginning of August 2014 to GMLA 2 CSC due to mother's move to a property in that area. A referral and the pre-birth assessment were forwarded to GMLA 2 and the case was closed to GMLA 1 CSC following the transfer.
- 122.** Practice within GMLA 1 has changed significantly since August 2014 including in relation to pre-birth assessments and case transfers. The perspective of GMLA 2 was that the transferred pre-birth assessment was brief given the historic involvement and did not come to a clear conclusion other than recommending an ICPC. The current GMLA 1 CSC processes ensure that cases are not transferred prior to a robust plan being in place and the transfer point would be at a Case Conference with both the GMLA 1 and receiving CSC SWs present.
- 123. In conclusion,** the GMLA 1 CSC responses to referrals considered whether or not mother was caring for any children or was pregnant at that time. There was no further action taken by CSC following notification of the first domestic abuse incident (mother was 8 months pregnant) in September 2011, however information shared was this was a verbal domestic incident. The totality of mother's mental health difficulties was not likely to have been fully understood by either GMP or CSC at that time as there was no evidence of mother's 3 A&E attendances in 2010 being shared. There was a proactive CSC response to the GMP notification of the second incident in which father assaulted mother.
- 124.** During the time period from April 2011 to August 2014, there was evidence of the toxic trio²⁸ being present with 4 incidents of domestic abuse, evidence of father being under the influence of drugs/alcohol during

²⁷ A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken to increase public safety. In a single meeting, MARAC combines up to date risk information with a timely assessment of a victim's needs and links those directly to the provision of appropriate services for all those involved in a domestic abuse case: victim, children and perpetrator. Available at: <https://www.reducingtherisk.org.uk/cms/content/marac> (Accessed: 03.11.19)

²⁸ The 'toxic trio' is a combination of domestic abuse, mental ill health and substance misuse within a family. Each of these problems on their own is difficult and can have a severe impact on family life, particularly for children growing up and for other adults around them. The combination of domestic abuse, mental ill health and substance misuse makes the situation even harder and hence the term 'toxic trio'. Available at: <https://thesafeguardingacademy.com/the-toxic-trio/> (Accessed: 28.07.19)

1 incident and some evidence of mother's alcohol misuse and mental health challenges with the most recent recorded self-harm incident occurring in December 2011. Alongside these risk factors, further key risk factors were mother not having been able to provide consistently good enough care for her 4 children and father having multiple risk factors including a history of violence. The totality of this historic information was not shared with GMLA 2 CSC as required to support the receiving CSC in effective further case management. Practice has since changed within GMLA 1 CSC to ensure cases are transferred effectively with a robust plan in place.

- 125. GMLA 2- evidence base of decision making from early August 2014 up to and including the first Review Conference in December 2014:** Towards the end of August GMP was contacted by the CPS as mother and father had submitted written applications requesting discharge of the indefinite Restraining Order by Court. CPS enquiries had identified a Strategy Meeting was being arranged and the date to hear the application was deferred so the outcome of this meeting could inform the Court considerations.
- 126.** GMLA 2 had accepted the case transfer including the GMLA 1 recommendation for an ICPC and convened a Strategy Meeting. The information understood by GMLA 2 CSC at this meeting held early in September 2014 referenced domestic abuse as the key risk issue. It was also understood mother had a history of alcohol abuse and had a chaotic lifestyle. The issues of father's alcohol misuse, mother's mental health challenges including self-harm and mother's own history of being subject to CP planning did not appear to have been understood. The fact that parents had been living together since June 2013 after father's release from prison thereby breaching the indefinite Restraining Order was understood. Father's CRC Case Manager attended the Strategy Meeting enabling information held by that agency to inform decision making. The understanding of the care arrangements of mother's previous 4 children were incorrect, with attendees understanding her 2 elder children were in the care of grandmother and her younger 2 with their birth-father. The outcome of the meeting was for a second pre-birth assessment to be completed and a Pre-birth Conference to be convened.
- 127.** The Court hearing took place the day after the Strategy Meeting and was informed by the understanding that a Case Conference was being considered and that parents were living separately. The outcome of the hearing was that the Restraining Order was discharged. The SW informed the CRC Case Manager of this decision on the day of the hearing.
- 128.** The second pre-birth assessment was completed by GMLA 2 CSC prior to the Pre-birth Conference. The outcome was positive with the summary including: *'parents were working with CSC and were being open and honest. There were still clear risks present in relation to the history of domestic abuse and the vulnerability of mother due to her isolation and her emotional vulnerability which resulted in her being reliant on her relationship with father. The risk of domestic abuse remained high as no specific work had been undertaken around the issue. There was currently no evidence to suggest alcohol was an issue for either parent. They were initially saying they would maintain their own tenancies however their plan had recently changed with them now saying they wanted to live together'*. Given the indefinite Restraining Order had been discharged, agencies therefore now had no legal means of challenging their plans.
- 129.** Expected practice changed in 2015 and current processes to manage an application to vary or discharge a Restraining Order are now more stringent. The revised GMP Domestic Abuse policy includes guidance on managing such applications. A Specialist Domestic Abuse Officer would now visit the victim of the abuse to obtain a further statement. The CPS would also request GMP to undertake a joint risk assessment with CSC prior to the application being considered.
- 130.** Unborn Poppy became subject to a CP Plan under the category of neglect at the Pre-birth Conference towards the end of September 2014. The CRC Case Manager and a GMP practitioner attended this Conference - both these agencies held significant information about parents and the risk factors in the

case, supporting effective multi-agency decision making. The rationale for use of the neglect category in a case where domestic abuse was the key issue was unclear. The SW's report had recommended a CP Plan under the category of neglect. The Conference minutes stated: *'It is a unanimous decision of the Conference that the unborn baby should be made subject to a CP Plan under the category of neglect. There is a clear history of domestic abuse in the parental relationship with father having received a custodial sentence for domestic abuse fuelled by alcohol abuse. Parents are self-reporting that alcohol is no longer a factor and there is no evidence to indicate alcohol misuse in the family home, there has also been a period without incidents of domestic abuse being reported. However, there has been no formal work undertaken with either parent in respect of domestic abuse or alcohol abuse'*.

131. By the time of the first Review Conference in December 2014, father's case was about to be closed to the CRC Service and this agency along with GMP weren't represented. A process was in place to risk assess GMP attendance at Review Conferences considering the agency information obtained since the ICPC and workload priorities. In this instance, GMP had no new information to share and sent apologies along with a report which included the recommendation: *'We are in the early stages of this plan in which there is significant history. We would wish to see a sustained period of stability and would recommend the plan continue'*.
132. A revised system was put in place by GMP in April 2019 with the Central Case Conference unit being replaced by district units. It was anticipated this change would support greater understanding of local cases by district units and increased attendance at relevant Review Conferences as well as all ICPCs.
133. Attendees at the first Review Conference were the SW and the HV. Whilst the Conference wasn't quorate, the Chair decided to proceed. Both parents attended the Conference and there had been no concerns about their parenting of Poppy or their compliance with the CP Plan. They were understood to have complied with a written agreement signed by them both to remain *'semi-separated'* with an understanding father was living at his own mother's home and only staying at mother's home 2 nights weekly. There were differing opinions with an HV perspective that the CP Plan should cease and a SW perspective it should continue. A decision to step the case down to CIN was made partly influenced by there not having been any reported domestic abuse incidents in 3 years. However, father had been convicted of Common Assault against a third party in May 2014, he had been imprisoned for 16 months in the previous 3 years and there was a GMP recommendation for the CP Plan to continue. There was evidence that his propensity to violence remained a risk factor.
134. The CP Plan had included requirements for both parents to complete domestic abuse programmes and for father to comply with his Community Order. Father had completed the Freedom domestic abuse programme by the time of the Review Conference. It is not clear whether mother had also completed this, however father's CRC Case Manager had been advised of mother being able to commence this by the SW towards the end of October. Father's compliance with his Community Order was sporadic and inconsistent. There was evidence this was understood across agencies with the CRC Case Manager present at meetings including the Strategy Meeting, Pre-birth Conference and first Core Group meeting along with telephone communication with the SW towards the end of October.
135. GMLA 2 practice has changed since the review timeline following a significant amount of work in respect of rescinding CP Plans after 3 months- such recommendations are no longer allowed without Head of Service oversight. Quality assurance processes in relation to CP planning have been enhanced in Salford through implementation of a review of cases by an Advanced SW when children have been subject to CP Plans for a period of 6 months and consideration given to the need for Legal Planning discussion when CP Plans have been in place for almost 12 months.

136. Practitioner feedback was that achieving quoracy at Review Conferences for babies/toddlers with no siblings is challenging as the number of practitioners involved is often limited. Whilst GMP might be unable to attend, a report including their recommendation and telephone contact details for further discussion are provided. Salford CSC addresses this issue by contacting GMP for an opinion as standard practice when necessary.

Learning Point 1: Achieving quoracy at Review Case Conferences is required for effective multi-agency decision making but can be challenging if a limited number of agencies are actively involved. A decision can be made to proceed with the Conference provided all relevant reports and information are available. GMP may not be represented at Review Case Conferences, however the report and recommendation provided should always inform decision making.

Seeking a further GMP perspective when there are conflicting opinions as to whether or not a CP Plan should cease supports effective multi-agency decision making with GMP, as a key safeguarding agency, having attended the ICPC and able to provide an informed further perspective.

137. **In conclusion**, GMLA 2 did not receive all available historic information when accepting the case transfer. Whilst the outcome of the second pre-birth assessment was positive, the summary related primarily to the risks posed by domestic abuse with more limited reference to alcohol misuse of which there had been no evidence since the case had been transferred. It was positive father engaged with this assessment and that mother was identified as being reliant on her relationship with him due to her vulnerabilities. However, the summary didn't reference the long-term history and potential impacts of mother's inability to consistently provide good enough care for her previous children or father's criminal history. Whilst unborn Poppy's parents said initially, they would live separately as recommended, within a short space of time they were clear in their intent to live together. It was known at the September 2014 Strategy Meeting that they had been living together since father's release from prison in June 2013 despite the indefinite Restraining Order, therefore a likely hypothesis would be they would continue to live together. Once the Restraining Order had been discharged after the Strategy Meeting, there was no legal means to challenge parents about their intentions.
138. The decision to use the category of neglect as opposed to emotional abuse at the Pre-birth Conference in September 2014 meant it didn't reflect domestic abuse as the key risk issue and the parental relationship and potential impacts of domestic abuse on Poppy were included at the bottom of the agreed outline CP plan. GMLA 2 CSC has taken action to ensure that key risk issues are consistently at the top of CP Plans. In this case, the history of domestic abuse over a 3-year period had commenced shortly after the relationship began in 2011 with a significant third incident having occurred in February 2012 resulting in father being imprisoned for 16 months for S 47 assault. Both parents also had a history of domestic abuse with previous partners.
139. The Review Case Conference was held in line with expected practice 3 months later. The information reviewed indicates the decision making at this Conference was influenced by over-optimism in light of a limited period of positive changes by both parents, no reported domestic abuse incidents since father's release from prison in June 2013 and no observed evidence of parental alcohol misuse. It does not appear that the clear GMP recommendation for continuation of the CP Plan informed decision making. The challenges faced by the attending SW and HV were that they had known parents for only 4 months, the Restraining Order had been lifted at Court, the issues leading to mother's other children not being in her care weren't well understood and practitioners had not identified any evidence of concern.
140. Overall, the move across Local Authority boundaries without an effective case transfer and all available historic information resulted in '*start again syndrome*' with parents afforded an opportunity to parent Poppy. Challenging the ineffective case transfer and/or seeking legal advice after the transfer in light of mother's previous 4 children not being in her care would have supported decision making at that point.

- 141. GMLA 2- evidence base of decision making from the CIN planning in December 2014 up to and including the end of July 2017:** The period of subsequent CIN planning from December 2014 up to May 2015 was also positive with no reported domestic abuse incidents or concerns noted about parental compliance with the plan or their care of Poppy. Information shared at the last CIN meeting in the middle of May was that both parents had completed all necessary work in relation to domestic abuse and alcohol abuse. It was understood that neither was reliant on alcohol with this risk factor being understood to have significantly reduced. It was also understood parents were living together at this point with reference made to father staying at his own mother's house if he occasionally went out. The CIN planning ceased after this meeting and the case was closed to GMLA 2 CSC. Poppy was 8 months old and the HV Service involvement continued.
- 142.** Later that month, GMLA 2 CSC was notified of concerns raised by a GMLA 1 Children's Centre practitioner about Adam and mother's fourth child having returned to mother's care. The information shared was considered by a MASS manager and a decision made that CSC intervention was not required given the closure of Poppy's case to CSC 2 weeks previously. Practitioner feedback was it is not uncommon for children to return to parental care from relatives caring for them following private proceedings and that CSC may not be made aware. Where they are, each situation is considered on a case by case basis.
- 143.** Whilst GMLA 2 CSC understood grandmother had a Residence Order, she had also secured a Prohibited Steps Order which prevented mother from removing her children from grandmother's care. A Prohibited Steps Order may be granted for a specific time period or it may remain in force up to a child's 16th and, occasionally, up to their 18th birthday. In this instance, a specific time period was not determined at Court. The rationale for the children returning to mother's care was not fully understood by practitioners, however there was some understanding that Adam chose to live with his mother. Maternal grandmother advised the independent reviewer she was unwell herself at that time, she understood the parental relationship had ended and mother seemed to be doing well. The Prohibited Steps Order hadn't been rescinded, it was just agreed between mother and grandmother the children would return to mother's care. Adam had also wanted to return to mother's care.
- 144.** At this time, parents were living together, and father was not birth father to either of the returning children. He had been convicted of Common Assault in May 2014 and sentenced to a 9-month Community Order with CRC involvement. This information was known to CSC through the CRC Case Manager being actively involved during the CP planning. The CRC Case Manager's risk assessment had identified he posed a medium risk of serious harm. There was no evidence mother had provided care to either child since she had ceased living at grandmother's home in January 2012. However, positive factors were that mother and father had been judged to have engaged well with agencies over a 9-month period and had met the expectations of plans put in place to safeguard Poppy. They were understood to be coping well with her care and meeting her needs, however the addition of 2 further children to a vulnerable family required further assessment in relation to risk and parenting capacity.

Learning Point 2: It is not uncommon for children who have lived with relatives under private law arrangements to return to their parent/s' care. If concerns about such a move are raised with CSC by an agency or the involved relatives, careful consideration on a case by case basis is required particularly when there are current or have been recent safeguarding concerns relating to the parent/s. Considerations as to the action required by CSC should be informed by a good understanding of Orders previously issued and their current legal status. In cases where CSC was involved with the family when Orders were issued, and particularly when an Order informed CSC decision making as in this case, relevant information should be obtained. Access to the private law papers at an early stage would support

a good understanding of the concerns about parental difficulties and assessment of a parent's capacity to change.

This additional information would support a robust CSC response and decision making including about the assessments required. It is important the risk and protective factors for the returning children and any children already in parents' care are identified including whether vulnerable parents are likely to be able to effectively meet the needs of all the children.

All agencies should have systems and processes in place to ensure the circumstances of such children returning to parental care are understood and correctly recorded to inform effective care planning.

145. In June 2015, a further concern was raised about Adam having been left caring for Poppy and mother's fourth child until 3am one morning whilst parents went out. A second HV was allocated to the case on the service being notified of this as the previously involved HV was no longer in post. A further brief period of multi-agency intervention was implemented through CIN planning. Mother denied leaving Adam caring for the children for a prolonged period, saying they had only been out for 2-3 hours for a meal, that the younger children had been left asleep and that Adam was a '*sensible boy*'. Parents were felt to have made a mistake and the CIN plan ended early in August 2015 with CSC closing the case. In October 2015, after discussing the case within safeguarding supervision, ongoing involvement by the HV Service ceased due to no further concerns being raised and the children having no unmet health needs.

146. In December 2015, a verbal domestic incident occurred and a period of EH intervention was put in place. A third HV had been allocated to the case following notification of the incident and visited in January 2016 to discuss it with mother who reported it was just an argument. During this period of EH intervention, a significant domestic abuse incident occurred in March 2016 resulting in father being convicted of Common Assault against mother, receiving a 12 months Suspended Sentence Order with a second CRC Case Manager becoming involved towards the end of April. Both parents were intoxicated at the time of the incident which occurred at the home of mother's friend who reported the incident. Mother had not wanted to press charges.

147. The outcome of the GMP DASH risk assessment was medium. The incident was discussed at the MASS on the same day and a multi-agency plan was agreed. CSC was to review previous assessments and determine if further assessment was required. If not, the existing EH Plan was to be reviewed and made more stringent, the Victim Care Unit was to offer support to mother and make GMP aware of any further actions required to safeguard her and the children. The HV visited mother to discuss the incident who reported father to be living at his own mother's home.

Good Practice 1: The newly allocated HV was proactive in visiting the home to discuss the 2 new domestic abuse incidents with mother.

148. The CRC Case Manager made a referral to CSC in the middle of May 2016 due to the recent domestic abuse incident and the previous history of domestic abuse. Towards the end of June, this practitioner was advised by a SW that a further Children and Families Assessment had been completed with no concerns raised by practitioners and that a further referral should be made if new concerns arose. The first EH Plan had ended in the middle of June only 3 months after the significant domestic abuse incident. Within GMLA 2, EH was not a CSC provision but a multi-agency responsibility with an education practitioner leading the plan. Therefore, the advising SW may not have been aware the EH Plan had ended.

149. Mother informed the HV at the end of July 2016 she was pregnant and was living with father again. There is no evidence a referral to GMLA 2 CSC was considered by any agencies during mother's pregnancy with Luke. Whilst the case met the criteria for a referral to CSC for a formal pre-birth assessment given

the history of previous concerns, by that point mother had been caring for Poppy for almost 2 years with her care deemed to be '*good enough*'.

- 150.** During this pregnancy and up to the point of Luke's birth in February 2017, there were no identified issues of concern other than enforcement action taken by the CRC Case Manager in August 2016 due to father's limited compliance with his Suspended Sentence Order. The CRC Case Manager undertook a visit to mother's home shortly after Luke's birth in an attempt to locate father's whereabouts. Mother stated father wasn't living there. The CRC Case Manager instigated breach proceedings after this visit. After liaising with the HV Service, the CRC Case Manager was aware father was living at mother's home and made a second referral to CSC at the beginning of March. The HV had no concerns on visiting noting the home was tidy and observing '*lovely interactions*' between mother and Luke.
- 151.** The CRC Case Manager received feedback on the referral made from an EH MASS Support Worker at the beginning of April advising that an EH Plan was in place with involved practitioners requested to monitor any concerns. Mother had informed this Support Worker father was living at his mother's but visiting regularly and staying over at times. Mother had also disclosed father had been asleep in bed when the CRC Case Manager had visited in February.
- 152.** Father's Suspended Sentence Order was terminated at the end of April 2017 and the second CRC Case Manager involvement ended. Father's compliance and engagement with his CRC Case Manager had been poor and he had not addressed the identified risk factors or achieved the objectives of his sentence plan which included domestic abuse interventions and work to address his alcohol misuse. On termination of his Order, father was wanted under the arrest warrant issued following the breach proceedings in February.
- 153.** At the end of June 2017, concerns were escalated by the education EH Plan lead due to this intervention having had limited impact and the significant history of concerns which was not recognised by parents who had declined offers of support. They were also indicating they wanted to move back to GMLA 1 raising concerns they were trying to avoid the case being escalated. The concerns were:
- Adam and mother's fourth child had returned to mother's care having moved from their grandmother's despite the understood Residence Order. School representatives and the EH Plan lead felt the case needed to be managed via a CIN Plan.
 - Domestic abuse being minimised and unreported and that it was taking place in front of children
 - Parental substance misuse – particularly alcohol
 - Limited engagement with Probation
 - Lack of honesty about parental relationship intentions
 - Mother's mental health
 - Poor school attendance which had resulted in Education Welfare Officer involvement leading to Court action
 - The impact upon the children was evidenced as: emotional impact having witnessed or been aware of domestic abuse in the family home, poor presentation of children - grubby and unkempt, educational achievement being limited due to poor school attendance, health needs not being met due to a failure to engage with routine health appointments.

Good Practice 2: The education EH Plan lead was proactive in collating the safeguarding concerns including the impacts on the children to effectively escalate the case to CSC and in ensuring their concerns about the case were raised including verbal challenge of the SW decision not to convene an ICPC after the July 2017 Strategy Meeting.

- 154.** In July, mother attended A&E following a self-harm incident. A Strategy Meeting was held at the end of July at which a decision was made to convene an ICPC. Around this time, the case was allocated to a new SW who determined a further period of CIN intervention was appropriate. This decision was verbally challenged by the education EH Plan lead at a subsequent CIN meeting. The CSC perspective on this meeting was that, whilst this view was expressed by the EH Plan lead, the agreed outcome was for the case to continue at CIN and be reviewed. Where a practitioner cannot resolve such concerns through discussion, the Local Safeguarding Children Board (LSCB) escalation processes should be used. GMLA 2 CSC was taking improvement action to ensure partner agencies are appropriately engaged in decision making processes.
- 155. In conclusion,** no concerns were identified about parental care of Poppy or parental engagement with the CIN plan up to it ceasing in the middle of May 2015. Concerns were then raised about the return of Adam and mother's fourth child to her care. Whilst this was considered by a CSC MASS manager, a decision was made not to reopen the case given its closure 2 weeks previously. The evidence base for this decision was not robust with the background to mother not caring for her first 4 children being poorly understood by GMLA 2 CSC. Also, whilst parents had engaged well with agencies between August 2014 and May 2015, there was a significant history of concerns from the start of their relationship in August 2011 whilst they had been living in GMLA 1. The next concern raised about Adam caring for his siblings led to a further brief period of CIN intervention after which CSC closed the case in August 2015.
- 156.** In December 2015, the reported verbal domestic abuse incident was the first such incident reported since February 2012 and an EH Plan was commenced. The next domestic abuse incident in March 2016 was significant and its management is discussed in Section 5.3. CSC undertook a Children and Families Assessment which did not result in the case being escalated to CIN or CP Planning. A hypothesis for this might be that the extent of the domestic abuse history was 'lost' due to the move from GMLA 1 to GMLA 2 and that multi-agency practitioners were reassured by mother saying the relationship had ended.
- 157.** In June 2017, the education EH Plan lead effectively escalated the case. The information collated at this point included both the concerns raised and their negative impacts on the children. This was the first point at which significant concern about the children's well-being was identified in the case after the family moved to GMLA 2. In relation to the toxic trio, there were 2 domestic abuse incidents one of which involved both parents being intoxicated and 1 self-harm incident by mother between December 2014 and the end of July 2017.
- 158. *GMLA 2 and Salford- evidence base of decision making during the 12 months prior to the date of the incident:***
- 159.** Whilst mother initially complied with the further period of CIN intervention instigated by the recently allocated GMLA 2 SW, new concerns quickly arose with the 2 further domestic abuse incidents and previous concerns escalated resulting in a further Strategy Meeting being held at the beginning of October 2017 at which a decision was made to complete a Section 47 Enquiry and convene an ICPC. By this point, mother had been subject to 4 reported domestic abuse incidents since December 2015.
- 160.** The week prior to the ICPC, father had been found at mother's home and had assaulted the GMP Officer who arrested him for breach of his Suspended Sentence Order. The ICPC was held at the end of October. Adam, Poppy and Luke were made subject to CP Plans with the category of neglect (failure to protect from domestic abuse)²⁹ being recorded as the primary risk category with the Chair recording that

²⁹ Community Care (2018) Why social workers should question the use and origins of 'failure to protect' in domestic violence cases. Available at: <https://www.communitycare.co.uk/2018/10/23/social-workers-question-use-origins-failure-protect-domestic-violence-cases/> (Accessed: 25.07.19)

professionals needed to be very clear the children were also at risk on both a physical and emotional level. Concern has been raised about use of the term of failure to protect in domestic abuse cases as it puts the onus on a mother who is herself a victim of abuse to protect her children.

- 161.** Mother and the children were living at grandmother's home at this point, grandmother attended the ICPC to support mother and it was understood mother wanted to permanently end her relationship with father. Core Group meetings were held in November and December prior to the case being transferred to Salford due to mother being offered temporary accommodation there. The concerns for the children's welfare and the level of risk in the case were fully understood by involved GMLA 2 practitioners who hoped mother could succeed in ending her relationship with father by moving to Salford.

Good Practice 3: After the Strategy Meeting held in October 2017, involved GMLA 2 practitioners were clear about the level of risk in the case and proactive in supporting mother up to the point of the case being transferred to Salford. Positive practice was also seen with these practitioners taking action to ensure there was a very robust and effective case transfer. These actions included prioritising attendance at the Transfer-in Conference and the continued involvement of the GMLA 2 FSW until a Salford Humankind FW was allocated, enabling continuity of family support for mother and the children at a difficult time.

- 162.** The outcome of the Transfer-in Conference at the beginning of January 2018, was that Poppy and Luke were made subject to CP Plans under the category of neglect and Adam, as a young person aged 15 or over meeting the threshold for a CP Plan, became subject to a VYPP. The robust transfer from GMLA 2 to Salford provided Salford practitioners with a clear understanding of the case and level of risk. Practitioner feedback was that information about mother's capacity to change would have further supported case management, however this had not been assessed so was not provided by GMLA 2.
- 163.** The negative impacts of the difficulties in Adam's family life had included the fact he had adopted a caring role, that he was aware of the domestic abuse and was worried about and protective of his mother and siblings and that his school attainment was hampered partly due to his poor attendance both in GMLA 2 and Salford. The feedback received from Adam was that he valued having his own plan with separate meetings which enabled his voice to be heard. He didn't want his mother to attend these meetings. Since the timeline of this review VYPP planning has been embedded into practice within Salford as The Young Person's Plan (YPP) following a positive evaluation and feedback from young people that they preferred the word vulnerable not to be included.
- 164.** At the beginning of March, mother had attended her pregnancy booking appointment at St. Mary's having previously cancelled two and failed to attend one previous appointment. Due to the concerns noted at this appointment, a referral was made to Salford CSC in line with expected practice. Practitioner feedback was there was good communication between Maternity Services and the SW following this referral with the concerns about her complicated pregnancy and poor engagement with antenatal care informing multi-agency safeguarding practice.
- 165.** At the first Review Conference towards the end of March, it was agreed the plans would continue, positive information was shared and no concerns had been identified. There was evidence mother was meeting her children's needs more effectively and she was understood to have had no contact with father.
- 166.** At the beginning of May, domestic abuse concerns recurred with an incident being reported to GMP by a neighbour. Whilst mother informed attending Officers father had just turned up at the house, they observed evidence of a man living there. A DASH risk assessment was undertaken, the outcome of which was standard. The SW visited the home after being notified of this incident, and then requested a Strategy Meeting was convened to discuss the new concerns.

167. In April, there had been early evidence of concern relating to Adam's punctuality at school which was shared with the SW. During May, there was further evidence the family situation was deteriorating with mother cancelling several visits arranged by the HV and Humankind FW and the Helping Hands Service not having been able to access the home on 3 occasions- this information was shared promptly with the SW. In June, information was shared about Poppy's nursery attendance having deteriorated.

168. At the beginning of June, father was found at the home by GMP Officers who attended due to mother reporting Adam as missing for 5 days. The Officers identified children in the home were subject to CP Plans and noted the home conditions and the presence of an intoxicated man. Positive practice was seen with these Officers taking further action after the incident to clarify who the man was and, identifying it was father. A referral was made to CSC by the GMP PPIU thereby ensuring CSC was fully informed of this incident.

Good Practice 4: The GMP Officers who attended this incident identified there were vulnerable children in the home and were then proactive in ensuring the identity of the intoxicated man was clarified. On reviewing the incident, the PPIU took further action to ensure this significant information was shared effectively with CSC by making a referral. The PPIU had taken the same action following GMP attendance at the home in October 2017.

169. The SW visited the home 3 days after this GMP attendance and then took prompt action to escalate the case resulting in it being presented to a Legal Planning meeting 8 days later at which it was determined the legal threshold for escalation into Care Proceedings had been met. At the next home visit the SW identified evidence of alcohol use and shared this with the Midwife.

Good Practice 5: The review has identified a number of instances of good practice in relation to professional curiosity and healthy scepticism during the review timeline. These included the CRC Case Manager being sceptical about father's assertions he was not in contact with mother, GMP Officers observing evidence of father living at the home, research by GMP Officers attending a further incident to identify the intoxicated man found at the home and the SW identifying beer cans in the rubbish bin.

170. The Pre-birth Conference for Baby MD was held at the end of June, the day after birth, mother was in hospital and couldn't attend. Baby MD also became subject to a CP Plan under the category of neglect. Throughout the review timeline, whilst the key risk issue continued to be domestic abuse, the CP Plans were made under the category of neglect at each of the 5 Conferences held. Mother and father had been known to be in a relationship at the Pre-birth Conference for unborn Poppy with both parents engaging with agencies at that time. The review has not been able to clarify why the neglect category was chosen at that Conference.

171. At each of the subsequent conferences, mother was saying she had ended her relationship with father and there was also evidence of neglect. However, there was evidence of father being at the home shortly prior to the ICPC in October 2017 which could have prompted a change in the category used from neglect to emotional abuse. There was no evidence of any further contact prior to the Transfer-in Conference in January and the first Review Conference in Salford in March 2018. However, there had then been evidence of further contact prior to the Pre-birth Conference for Baby MD in June which could also have prompted a change of category. It is important that the most appropriate category of abuse is determined at the ICPC and then reviewed at each subsequent Conference to ensure it reflects the primary area of

concern at the time the decision is made as indicated within the GM Safeguarding Partnership procedures.³⁰ .

Learning Point 3: When a child becomes subject to a CP Plan, the category of abuse should be determined by the evidence presented to the ICPC and the views of practitioners in attendance. The category should reflect the primary area of concern identified at the Conference.

For the duration of the CP Plan, the category of abuse should be formally reviewed within each Review Conference.

172. The pre-birth assessment had been concluded in June and was presented at the Pre-birth Conference. There was evidence that case discussions during the SW's supervision had included discussion of this assessment on 2 occasions, however these did not support the assessment commencing at 20 weeks gestation in accordance with expected practice. The GM Pre-Birth Assessment guidance indicates this Conference should ideally be held before 32 weeks gestation or earlier when there is a history of pre-term births.

173. Practitioner feedback was it was understood that Baby MD would become subject to a CP Plan along with siblings which may have reduced the sense of urgency for completion of the assessment. However, mother had a history of pre-term birth at 34 weeks gestation and, had Baby MD also been born at around 34 weeks, the CP Plan would not have been in place sufficiently early. An earlier initiation of a CP Plan would have supported the involvement of Maternity Services at the Pre-birth Conference and any Core Group meetings held prior to the birth. Whilst the concerns about mother's poor compliance with antenatal care and her complicated pregnancy had been shared, Maternity Service involvement in the Pre-birth Conference would have enabled detailed multi-agency discussions about the risks these posed and the CP Plan for unborn Baby MD could have included actions to support her attendance.

Learning Point 4: It is important that the GM Pre-Birth Assessment guidance including the recommended timescales are followed to facilitate effective and timely care planning.

174. Overall, mother booked late in her pregnancy, attended only 4 antenatal appointments and a further 5 were either cancelled or not attended. Her complicated pregnancy required management by a Specialist Obstetric Diabetic team in addition to hospital and Community Midwives. Evidence of her poor compliance was responded to through home visits, telephone calls and by letter. Following her discharge, a detailed discharge summary was forwarded to the GP Practice.

Good Practice 6: There was a prompt response and good communication between hospital and community Maternity Services after mother missed 2 hospital appointments in April with Community Midwives attending the home on the day after the second missed appointment.

The discharge summary from St. Mary's Maternity Hospital to the GP Practice was detailed and provided key required safeguarding information including the main risk issue and the name of the allocated SW.

Learning Point 5: Significant information provided prior to a baby being registered at a GP Practice will be held on mother's records initially. Expected practice is for this information to then be saved onto the baby's own record which is generated once the baby is registered with the Practice. It is important that all Practices have the required systems and processes in place to meet this expectation.

³⁰ GM Safeguarding Partnership procedures. 4.9 Child Protection Review Conferences. Available at: https://greatermanchesterscb.proceduresonline.com/chapters/p_cp_review.html (Accessed: 02.11.19)

- 175.** The review has clarified an inconsistency in the sharing of Special Circumstances forms by GM Maternity Services with GP Practices. These forms are used to share safeguarding concerns and risks identified by Maternity Services and are completed as soon as concerns are raised, generally following attendance at a pregnancy booking appointment. There is a consistent approach in these being shared through Child Health systems with the HV Service. The St. Mary's communication processes did not include sharing them with GP Practices during mother's pregnancy with Baby MD. However, the Maternity Service provider within the fourth GMLA has processes in place to also share them with local GP Practices. The GM Designated Nurses intend to review these Maternity Service processes across the GM footprint.
- 176.** The delivery of community antenatal care is no longer largely provided within GP Practices through which there were opportunities for direct communication between Community Midwives and a GP. GPs and their staff, along with other providers of universal services, are recognised as having a unique role in safeguarding and child protection. GP Practices provide primary medical care services to families and have systems in place to link family members living at the same address. The records held by Practices provide an important 'hub' for clinical and social information³¹. The information collated within Special Circumstance forms should contribute to this 'hub' which provides the GP Practice evidence base for decision making.

Learning Point 6: The individual patient records held by GP Practices contain both information generated by the Practice and information shared by other health services and partner agencies. Family members living at the same address are linked on Practice systems supporting an understanding of information held about a family unit including key safeguarding information.

The GP records provide the evidence base for GP decision making in relation to meeting statutory safeguarding responsibilities. The formal sharing of Maternity Service Special Circumstances forms with GP Practices ensures Maternity Service concerns inform this evidence base. This process would also support a shared understanding of the concerns across the Maternity Service, GP Practice and HV Service and facilitate effective information sharing between these key health services.

- 177. *Safe Sleep advice and assessment.*** This SCR was not commissioned to review the incident or the multi-agency safeguarding practice in response to it. However, the review of agency information up to the date of the incident identified that the provision of safe sleep advice and completion of a safe sleep assessment was in line with expected practice. Overall, this advice was provided on 6 occasions by health staff. Understanding of the risks associated with safe sleeping by partner agencies was also evidenced with the SW making the Midwife aware of finding beer cans and the Chair of the Pre-birth Conference including the provision of safe sleep advice in the CP Plan due to the fact that mother smoked and was known to have a history of alcohol misuse.
- 178.** The Triennial Review of Serious Case Reviews (2011-2014)³² included the review of 31 Sudden Unexpected Deaths in Infancy. The majority of these babies (81%) were known to CSC with 27% being subject to a CP Plan at the time of their death. This research identified most of these children had died while co-sleeping with a parent or in other dangerous sleeping environments such as on a sofa, on soft bedding, or in makeshift bedding. Many of the families appeared to have led chaotic lives with frequent house moves, periods of homelessness, or inappropriate housing. Parental mental health concerns along

³¹ Royal College of General Practitioners. Child Safeguarding Toolkit. Available at: <https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/child-safeguarding-toolkit/introduction.aspx> (Accessed: 21.09.19)

³² DfE (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/533826/Triennial_Analysis_of_SCRs_2011-2014_-_Pathways_to_harm_and_protection.pdf (Accessed: 28.07.19)

with substance/alcohol misuse were common. Further research³³ into these deaths undertaken in 2018 stated that they now occur largely in association with social deprivation and modifiable risk factors. It concluded that more consideration was needed on how best to support such vulnerable families.

- 179.** In December 2015, multi-agency safe sleep guidance developed jointly by Salford, Bolton and Wigan Safeguarding Children Boards was published³⁴. This guidance includes the use of pictorial aids to support parents with literacy difficulties and has continued to evolve in light of recent research findings. The provision of safe sleep advice to parents where their baby is known to be at increased risk of sudden infant death due to modifiable risk factors including smoking during and after pregnancy and substance/alcohol misuse is acknowledged to be an extremely challenging area of practice. It is important that a strategic focus on this issue is maintained and that options for the most effective safe sleep interventions with such vulnerable families continue to be explored.

Learning Point 7: Recent research findings have clarified that SUDIs now occur largely in association with social deprivation and modifiable risk factors and that more consideration is needed on how best to support such vulnerable families. It is important that CDOPs and Public Health maintain a strategic focus on this issue which includes the exploration of more effective interventions to support this challenging area of practice.

- 180. In conclusion**, whilst there was some delay in convening the ICPC after the GMLA 2 Strategy Meeting in July, there was then an effective multi-agency response following the reconvened meeting at the beginning of October 2017. This was the point in the review timeline at which the level of risk posed by the parental relationship and its impacts on the children became clear. The transfer of the case from GMLA 2 to Salford was very robust. The effective information sharing and communication between GMLA 2 and Salford practitioners including the positive practice seen at the Transfer-in Conference supported ongoing effective case management by involved Salford multi-agency practitioners. However, a gap in the evidence base was an understanding of mother's capacity to change.
- 181.** The review has evidenced good multi-agency communication and sharing of evidence of concern from October 2017 up to the date of the incident. Prompt action was taken to safeguard the children as soon as there was evidence of father being found in the home and a further domestic abuse incident after mother moved to Salford. Learning Point 7 highlights the importance of exploring more effective safe sleep interventions for vulnerable families where modifiable SUDI risk factors are evident.
- 182. Assessment and management of mother's Adverse Childhood Experiences (ACEs):** mother experienced a very difficult childhood within GMLA 1 and had been subject to CP planning. Mother had her first child in her mid-teens and there was evidence of her misusing alcohol at the age of 17 years. She had her second and third children when aged 19 and 20 years and GMP were aware domestic abuse was a feature in her life around this time.
- 183.** The GP Practice records noted mother having a history of anxiety, depression and self-harm when she was aged 23 years in 2009 and there were 4 A&E attendances due to incidents of self-harm or alcohol misuse during 2010 and 2011. Mother met father in 2011 at a very vulnerable point in her life- she was 25 years old, suffering from mental health difficulties and misusing alcohol, pregnant with her fourth child

³³ University of Warwick. "First ever study of serious case reviews of sudden unexpected infant deaths conducted: Domestic violence, mental health problems and substance misuse highlighted as factors." ScienceDaily. ScienceDaily, 26 July 2018. <www.sciencedaily.com/releases/2018/07/180726161055.htm>. Available at: <https://www.sciencedaily.com/releases/2018/07/180726161055.htm> (Accessed: 28.07.19)

³⁴ Bolton, Salford and Wigan LSCBs (2015) Bolton, Salford and Wigan Safe Sleeping Guidance. Available at: <https://safeguardingchildren.salford.gov.uk/professionals/policies-and-procedures/> (Accessed: 03.11.19)

and she wasn't caring for 3 previous children. There was significant evidence of the impacts on her of the ACEs she had experienced. Unresolved early trauma can impact on parenting capacity with a common reaction being parental dissociation within which parents are likely to ignore the emotional needs of their children and/or have difficulty in assessing risk in their partners³⁵.

184. Whilst practitioners strived to support mother in the care of her children born after the move to GMLA 2, the totality of her history and therefore the potential impacts of this on her parenting capacity and capacity to change do not appear to have been well understood. Not all the relevant historical information and evidence of concern had been shared by GMLA 1 and mother had been judged to be coping well after the birth of Poppy. Given her history, the use of a trauma based practice approach may have increased the possibility of mother feeling enabled and empowered to change her life circumstances and parenting skills. Trauma based practice is gradually being implemented within some UK public services e.g. within education with the organisation Trauma Informed Schools UK providing training and support and within some Mental Health Services including Young Minds.

185. The core principles of trauma informed practice are safety, trust, collaboration, choice and empowerment with services delivered in a manner which avoids inadvertently repeating unhealthy interpersonal dynamics in the helping relationship. Whilst trauma informed practice requires the use of emotional intelligence which is already understood to be important in establishing effective working relationships with vulnerable service users, it also requires that practitioners understand trauma in childhood is common and can impact on a person's psychosocial functioning throughout their lifetime. It requires practitioners to understand that presenting problems e.g. a service user who appears to mistrust authority are often indicators of previous trauma and interrelated emotional wounds and that these should be viewed as normal protective actions for that individual when they are feeling vulnerable as opposed to problematic behaviours. A response is required which conveys respect and compassion, honours self-determination and enables the rebuilding of healthy interpersonal skills and coping strategies³⁶.

186. At a national level, the Voluntary, Community and Social Enterprise (VCSE) Health and Wellbeing Alliance (a partnership between the Department of Health and Social Care, NHS England, Public Health England and 21 national voluntary sector organisations and consortiums) recently commissioned the development of a resource in respect to trauma informed practice with women. This builds on the 2018 Women's Mental Health Taskforce Report.

187. The new resource produced by the Centre for Mental Health and the Mental Health Foundation³⁷ highlights the 4 processes found by research to be fundamental to trauma informed care:

- Listening: enabling women to tell their own story in their own words,
- Understanding: receiving women and their stories with insight and empathy,
- Responding: offering women support that is timely, holistic and tailored to their individual needs,
- Checking: ensuring that services are listening, understanding and responding in a meaningful way.

188. This resource notes that, while there are challenges for organisations in adopting a trauma informed approach, these are not insurmountable, and that such care can prevent traumatisation and retraumatisation with research findings indicating the benefits of introducing such care outweigh the

³⁵ Community Care (2011) Effect of early trauma on parenting skills. Available at: <https://www.communitycare.co.uk/2011/09/15/effect-of-early-trauma-on-parenting-skills/> (Accessed:25. 05. 19)

³⁶ Levenson J (2017) Trauma Informed Social Work Practice. Social Work, Volume 62, Issue 2, pp 105-103. Available at: <https://academic.oup.com/sw/article/62/2/105/2937786> (Accessed:25. 05. 19)

³⁷ Mental Health Foundation (2019) Engaging with complexity: Providing effective trauma informed care for women. Available at: <https://www.mentalhealth.org.uk/news/new-resource-published-help-public-services-become-trauma-informed-support-womens-mental-health> (Accessed:25. 05. 19)

costs. A key organisational requirement in implementing trauma informed practice is effective staff support mechanisms including robust supervision processes.

Learning Point 8: It is important multi-agency practitioners are aware that trauma in childhood is common and of its negative impacts in an adult's life including on their ability to form positive relationships, parenting capacity and their capacity to change. The history of ACEs in a service user's life should be understood and inform care planning and provision. The use of trauma informed care supports the service user in forming effective working relationships with practitioners, increasing their resilience and in making the changes required to achieve a positive outcome. The provision of multi-agency training and availability of practice standards related to trauma informed care would enable practitioners to respond more effectively to these vulnerable parents.

Recommendation 1: SSCP to consider escalating the trauma informed practice learning to the GM Standards Board in order for that Board to consider implementing actions aimed at supporting the development of trauma informed approaches to practice across GM.

189. In conclusion, the emergence of trauma informed approaches to practice is in its early stages but has the potential to support agencies in responding more effectively to adults for whom the experience of ACEs poses long-term difficulties in their lives. This approach facilitates improved understanding of a service user's history and how these may impact on their parenting capacity and capacity to change.

5.2 KLOE 2 and KLOE 3. Impact of moving into another geographical area (GMLA 1 to GMLA 2 and GMLA 2 to Salford) upon assessment, planning and decision making. Impact of changes of social worker/professional and change of Local Authority.

190. Impacts of changes of Local Authority-transfer processes: There were 2 points in the review timeline at which the case was transferred across Local Authority boundaries and at both points mother was pregnant. The first transfer was from GMLA 1 to GMLA 2 at the beginning of August 2014 and just under 8 weeks prior to Poppy being born. Mother's previous 4 children were not in her care, with Adam and her fourth child residing formally in their grandmother's care since January, 2012 and her second and third children living with their father under a Residence Order since May, 2009.

191. GMLA 1 CSC had completed a pre-birth assessment prior to transferring the case to GMLA 2 CSC and forwarded this along with the referral. The relevant guidance in relation to the completion of pre-birth assessments is included in the GM Safeguarding Partnership procedures.³⁸ This guidance was last updated in November 2016, after the GMLA 1 assessment was completed, in light of a Court judgement following an application to remove a child at birth but it was not substantially changed. Section 11 relates to Allocation and Case Transfer within a Local Authority. The review has identified it does not clarify which Local Authority holds responsibility for the assessment if a mother moves across Local Authority boundaries during the pregnancy when the pre-birth assessment is due to commence or has commenced, provide guidance on how the case would be transferred or on the importance of challenge should such a transfer not be robust.

192. GMLA 1 CSC became aware of mother's fifth pregnancy at an early point in the pregnancy at the end of February 2014. The Pre-Birth Assessment guidance states this assessment should be completed within 45 days and will commence '*as early as possible when a viable pregnancy is identified but no later than 20 weeks into the pregnancy*'. Practitioner feedback was this is 45 working days or 9 weeks. Provided Poppy was born at full-term, mother would have been 20 weeks pregnant around the middle of May 2014.

³⁸ Greater Manchester Safeguarding Partnership on-line procedures- Pre-Birth Assessments. Available at: https://greatermanchesterscb.proceduresonline.com/chapters/p_pre_birth_assess.html (Accessed:25. 05. 19)

If the pre-birth assessment commenced at the latest point possible and lasted for 45 working days, the expected completion date would have been by the middle of July at the latest. The case was transferred to GMLA 2 CSC at the beginning of August. This posed challenges for GMLA 2 CSC in convening a Pre-birth Conference before 32 weeks gestation as required by the guidance. A Strategy Meeting was held in early September and the Pre-birth Conference just over 2 weeks later- Poppy was born 5 days after the Conference. Practice has since changed within GMLA 1 and all assessments are completed within expected timeframes unless a service manager has approved an amended timescale.

- 193.** Agencies had differing understandings of the date of mother's move to GMLA 2. The GMLA 1 CSC information did not specify a date, noting the case transferred after she moved. There was HV practitioner feedback that the involved Maternity Service had forwarded a Special Circumstances form to the GMLA 2 HV Service in the middle of March 2014. This was detailed and indicated mother was living with father in GMLA 2 at that point. If this was correct, it potentially posed challenges to multi-agency working with a differing Local Authority undertaking assessments to the one in which the family resided with local services providing universal services including health. However, the first CRC Case Manager understood in May that parents were living together but in GMLA 1.
- 194.** The Pre-Birth Assessment guidance states that a recommendation must be made regarding the need or not for both a Pre-birth Conference and a Pre-birth Legal Planning meeting. In this case, the pre-birth assessment recommended a Pre-birth Conference should be convened. GMLA 2 practitioner feedback was the assessment was brief considering the level of historic information held by GMLA 1 CSC, it did not come to a clear conclusion despite mother being clear she intended to continue her relationship with father and it did not clarify whether father was allowed at the home. It was acknowledged, with the benefit of hindsight, that the transfer process could have been challenged. GMLA 1 CSC was not represented at the Pre-birth Conference- this could have provided another opportunity for information to be shared. The acceptance by GMLA 2 CSC of the limited information and recommendation made without further consideration of initiating Care Proceedings resulted in *'the trajectory for case management in 2014 being set'*.
- 195.** The second transfer from GMLA 2 to Salford at the beginning of January 2018 was during mother's pregnancy with Baby MD and with CP Plans in place for Adam, Poppy and Luke. The guidance included within the GM Safeguarding Partnership Procedures for this case transfer was the North West Association of Directors of Children's Services (ADCS) Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure³⁹. This provides clear guidance and timescales aimed at ensuring the safe, efficient and consistent transfer of cases across Local Authority boundaries in North West England by Children's Services. It is aimed at case management of children subject to CP planning, including unborn children at the time of the transfer.
- 196.** The review has identified this procedure does not clarify actions required and by which Local Authority when an unborn baby has not yet been made subject to a CP Plan but siblings have. This did not pose any difficulties in this case, with mother understood to be only 14 weeks pregnant when the case was transferred- Salford CSC subsequently completed the required pre-birth assessment and convened the Pre-birth Conference. However, if such a case transferred across Local Authority boundaries when the pre-birth assessment was due to commence or had commenced, it would be important that the referring and receiving Local Authorities ensured its robust and timely completion was not compromised by the transfer process.

³⁹ North West ADCS. North West Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure. Available at: https://greatermanchesterscb.proceduresonline.com/pdfs/cpp_moving_across_la_pro_b.pdf (Accessed 23.05.19)

- 197.** In relation to involved partner agencies, the North West ADCS procedure requires Local Authorities to *'notify relevant partner agencies that the child has moved out of the area and the forwarding address'* when transferring a case out and also requires the receiving Local Authority to ensure *'information is shared to enable all relevant systems in Children's Services and in partner agencies are updated to include details of the child and their status'*. The safe transfer of cases also requires partner agencies to have robust single-agency systems and processes in place.
- 198.** Feedback from GMLA 2 practitioners and those in Salford was very positive with a shared perspective that the transfer process from GMLA 2 to Salford was very robust. The key positive factors highlighted were the presence of involved GMLA 2 practitioners who knew the family and case well at the Transfer-in Conference and the continued work by the GMLA 2 FSW with the family prior to the Salford Humankind Service becoming able to allocate a FW. Section 23 of the procedure states the *'allocated social worker or social work representative of the Responsible Local Authority must attend the Transfer-in Conference'*. The procedure is aimed at CSC case management, hence there is no reference to partner agency practitioners also attending and this will often be impractical. In this case, the transfer was across GMLA boundaries, it was possible and feedback was it supported a safe and effective transfer. The Salford CSC SW present at the Transfer-in Conference was allocated to the case and remained the involved SW up to the date of the incident.
- 199.** The current procedure (Section 7) states the receiving Local Authority should request the following from the referring Authority: copies of the Continuous Assessment, CP Plan, minutes of the ICPC, Child Protection Review Conferences, all Core Group minutes and any other relevant assessments or information, including the Section 47 Child Protection Enquiry.
- 200.** The procedure was last updated in March 2017 and was to be reviewed again on completion of this review. The Salford SQU summary report highlighted a need to agree best practice across North West Local Authorities in respect of the documents and assessments required to prevent *'start again syndrome'* when cases are transferred including consideration of the need for the provision of an updated assessment by the responsible Local Authority requesting the Transfer-in Conference to ensure a clear level of risk and protective factors is understood by the receiving Local Authority.
- 201.** The Transfer-in Conference was convened promptly. The ADCS procedure states that the receiving Local Authority determines whether CP Plans are necessary. Currently, where they are deemed necessary, the date of the Transfer-in Conference becomes a new start date in respect of CP planning with the duration of such planning in the transferring Local Authority not counting towards the overall length of time children have been subject to CP Plans.
- 202.** The Salford SQU summary report proposed that where a child has been subject to a CP Plan and that planning continues with a receiving Local Authority after a family moves across Local Authority boundaries, the previous length of time should be included to ensure the duration of the CP planning is understood. This would support an improved understanding of the impact of the CP planning across the duration including about both the progress being made and the impacts on outcomes for the child/ren. This change to practice would prevent the previous period of CP planning becoming *'lost'* and assist in addressing the issue of avoidant parents who move across Local Authority boundaries when they feel authorities may take action such as removing their children. There was evidence in this case of parents doing this- they indicated they wanted to move back to GMLA 1 at the point of the case being escalated to GMLA 2 CSC in June, 2017.

Learning Point 9: This review has demonstrated the contributing factors to and outcomes of both an ineffective and very effective case transfer across GMLA boundaries. The importance of ensuring all information including that related to significant historical risk factors and parental ACEs follows a family

when their case is transferred has been highlighted by this case and is key learning from this review. Without a good understanding of the history, a '*start again*' approach is likely as seen in this case following the first transfer across GMLA boundaries. The review has also demonstrated that expected practice has evolved to ensure consistently effective case transfers by the involved GMLAs and the available regional guidance requires review and update to reflect this current good practice and ensure its consistency across the region.

Recommendation 2: The North West ADCS Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure and the GM Pre-Birth Assessment guidance should be reviewed and updated in light of the learning from this review. SSCP to:

- endorse the recommendation and request the Greater Manchester Policy & Procedures Group considers this and determines the actions required to meet it;
- be assured the North West ADCS Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure and the GM Pre-Birth Assessment guidance have been reviewed and updated and that they concur in relation to the management of case transfers for unborn babies.

- 203.** The current procedure (Section 9) highlights the need for the SW in the receiving Authority to read the records held by the referring Authority. Practitioner feedback was that this expectation is met through attending the referring Authority to read their files and supports the newly allocated SW in understanding all information held by the referring Authority including historical information. However, there remains the potential for historical information to get lost where a family moves more than once across Local Authority boundaries as in this case.
- 204.** For a complex case to transfer effectively across Local Authority boundaries, the records held by involved partner agencies must also be transferred promptly. Within this case, GMP was the only agency that provided interventions to the family for the duration of the review timeline. As the transfers were only across GM Local Authority boundaries, GMP held all the information about the family and Police interventions on their systems supporting consistent practice despite the family's moves. The domestic abuse incidents were attended and recorded, appropriate referrals were made to CSC and ICPCs were attended. Had the family moved outside of GM, the GMP understanding would have been challenged had another force become involved recording on different systems.
- 205.** Effective case transfers for complex and transient families are reliant on all relevant information being transferred each time a family moves across Local Authority boundaries to ensure key including historical information continues to be well understood.

Learning Point 10: Effective case transfers for complex and transient families are reliant on all relevant information being transferred each time a family moves across Local Authority boundaries. It is important that the systems and processes in place for such case transfers by all involved partner agencies are timely and robust.

- 206. In conclusion,** there were 2 transfers across Local Authority boundaries, the first of which fell under the remit of the GM Pre-Birth Assessment guidance and the second under the North West Transfer and Notification of Children Subject of Child Protection Plans across Local Authority Boundaries procedure. The review has identified learning relating to both these documents including the lack of guidance for cases which transfer either when a pre-birth assessment is about to or has commenced.
- 207.** Overall, the first transfer from GMLA 1 to GMLA 2 was not robust but was not challenged at the time. It does not appear GMLA 2 CSC was informed of the extent of mother's ACEs and mental health challenges or of father's history of alcohol misuse. The understanding by GMLA 2 CSC of the placements of mother's

4 children not in her care was incorrect. Overall, the second transfer from GMLA 2 to Salford was very robust. By that time, the GMLA 2 CSC interventions which commenced in July 2017 had clarified there were multiple risk factors in the case and CP planning had commenced. However, the understanding of the placements of mother's children not in her care was also incorrect with Salford CSC understanding they were in her care up to around 2014 whereas the concerns about mother's parenting capacity dated back to 2009 when her second and third children commenced living with their birth father.

Learning Point 11: This review has highlighted the challenges posed by the circumstances of siblings not in parental care being poorly understood including important historical information about mother's parenting capacity and capacity to change becoming '*lost*'. Access to the private law papers at an early stage would support a good understanding of the concerns about parental difficulties and assessment of parenting capacity and capacity to change.

- 208.** Practice within GMLA 1 has changed significantly since August 2014 including in relation to both pre-birth assessments and case transfers. The current GMLA 1 CSC processes ensure that cases are not transferred prior to a robust plan being in place and the transfer point would be at a Case Conference with both the GMLA 1 and receiving CSC SW present. These are also the current practice expectations within GMLA 2 and Salford. The proposal to agree best practice across North West Local Authorities in respect of the documents and assessments required to prevent '*start again syndrome*' would ensure consistently effective transfers of complex cases across the region. The proposal to include the length of time CP planning was in place in the referring Authority within the overall length of such planning would support an improved understanding of whether this process was impacting positively on outcomes for the children in a sufficiently timely manner. The review has also identified learning in respect of the GM Pre-Birth Assessment guidance
- 209. *Impacts of changes of Local Authority-use of written agreements:*** Over the timeline of this review, written/working agreements were put in place by CSC in each of the Local Authority areas. GMLA 1 CSC used an agreement in December 2011 signed by mother agreeing not to let father have contact with her fourth child which was not adhered to. GMLA 2 CSC put in place a second written agreement signed by both parents in September 2014 which included father was not allowed to stay at the house overnight until assessments were completed. At that time, father was engaging with ongoing assessments and it was understood parents had complied with this written agreement.
- 210.** At the Transfer-in Conference in January 2018, Salford CSC put in place a third written agreement stating father was not allowed any contact with the children prior to the completion of a risk assessment in light of his criminal violent history. A fourth written agreement was provisionally developed at the Initial Pre-Proceedings meeting in June and then signed by mother at the Pre-discharge Planning meeting after Baby MD's birth. This included a requirement for mother not to allow father in the home or have any contact with Baby MD prior to a risk assessment of him being completed. Subsequently, he was found at the home on the date of the incident. There was evidence therefore of 3 out of the 4 agreements put in place not having been adhered to.
- 211.** Practitioners understood at the time that mother did want to end her relationship with father and her verbal assurances of not having contact with him were accepted. Practitioner feedback at the RPE was that, having reflected on the case, a likely hypothesis was parents never actually ended their relationship, that father was always around and that mother possibly informed him of new addresses. The review has not clarified whether mother signing and then not adhering to the first written agreement in GMLA 1 was known to GMLA 2 and then Salford CSC. If it wasn't, there was an understanding parents had adhered to the agreement put in place by GMLA 2 CSC and that mother was adhering to the first agreement put in place by Salford CSC in January 2018 up to the beginning of May when a domestic abuse incident was reported and father was found at the home.

- 212.** The use of written agreements in domestic abuse cases is problematic given the complexity of the issues faced by victims. Whilst they may provide some assurance to practitioners when there is no evidence they aren't being adhered to, there are many reasons why mothers are unable to actually do this. Mothers will often sign an agreement because they fear the consequences of not doing so and perceive they have no option but to sign it. However, they may then be unable to adhere to it for a number of reasons including fear of the perpetrator, experiencing coercive control or the emotional impacts of ongoing domestic abuse. The perspective provided by maternal grandmother was that mother did sign the agreements due to fearing she would lose her children if not but was then unable to adhere to them. Mother provided the following perspective *'the written agreements I was asked to sign were right and I had to sign them because of my worries about my children being removed if I didn't. I couldn't not sign them'*.
- 213.** A Joint Targeted Area Inspection in Salford in October 2016 included a deep dive focus on the response to children living with domestic abuse. The report identified practitioner's views of the capacity of victims and perpetrators to comply with written/working agreements may be unrealistic. Salford CSC has undertaken work in respect of the use of written agreements including policy development. The overarching findings of 6 such inspections including that in Salford was published in September 2017⁴⁰. An identified issue in cases involving coercive control was there being no evidence that the use of written agreements was effective and that this was unsurprising when the perpetrator was not the focus of the agreement.
- 214. In conclusion**, whilst the use of requirements for mother to deny father to have contact within the written/working agreements in this case may have provided some assurance to practitioners, they were not effective in reducing the risk or preventing further incidents. The perspectives of mother and grandmother were that mother felt she had no choice but to sign these despite mother knowing her relationship with father had not ended. The learning from this review accords with the 2017 JTAI findings.
- 215. Impact of changes of social worker/professional and change of Local Authority:** the move from GMLA 1 to GMLA 2 resulted in new practitioners having to establish working relationships with parents without a full understanding of the historical concerns. The GMLA 2 CSC summary report acknowledges there were a number of SWs who had involvement with the family between August 2014 and January 2018 as the case was opened and closed. However, the allocation of the case to a new SW at the beginning of August 2017 proved positive with the agency summary report noting *'a level of challenge and questioning of mother which had not been present previously with an analysis of the information leading on to next steps'*. There were 3 HVs involved in GMLA 2 overall with the initial HV leaving the service and the case being re-allocated after a period of no concerns. There were 2 CGM CRC Case Managers involved. Practitioner feedback was that mother expressed frustration at having to retell her story to different people.
- 216.** After the move to Salford, there was consistency overall in the practitioners involved prior to the incident. The potential for information to be lost during the robust case transfer to Salford had been minimised. Positive practice was also seen with the GMLA 2 CSC FSW continuing to support the family after the move to Salford until the Humankind FW became involved. Practitioner feedback was this was not common practice but was very beneficial in this case with family support continuously provided despite

⁴⁰ Ofsted (2017) The multi-agency response to children living with domestic abuse. Prevent, protect and repair. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/680671/JTAI_domestic_abuse_18_Sept_2017.pdf (Accessed: 21.07.19)

the case transfer. This also afforded a continuity in 1 key professional for a period of time after the case transferred.

- 217.** Due to the family being moved to a new home within a fourth GMLA shortly after Baby MD's birth, community Midwifery care transferred from St. Mary's to the NHSFT in that area. Conflicting perspectives were provided about the information understood by these Community Midwives. Whilst there was a perspective, they were not made aware of key information including the name of the allocated SW, their home visiting pattern was in accordance with that agreed at the Pre-birth Conference with an increased number of visits and the family not being discharged until the maximum 28 days after birth.
- 218.** Despite the changes, there was evidence mother could establish good working relationships with a number of practitioners including the GMLA 2 HV to whom she disclosed her difficult childhood and the Humankind FW who gained a thorough understanding of mother's challenges. Changes to managers providing supervision to SWs in both GMLA 2 and Salford posed challenges with practitioner feedback of there being a '*start again approach*' to case guidance which Salford CSC was to address. Supervision in GMLA 2 was noted to be action as opposed to outcome focused and improvement action was planned.

Learning Point 12: The provision of consistent, reflective and outcome focused supervision by all agencies is vital as an integral component of the intervention in complex cases. A change of supervisor requires careful management to ensure practitioners are well supported and that cases are not allowed to '*drift*'.

- 219. In conclusion,** this was a complex case requiring extensive multi-agency involvement resulting in a number of practitioners working with the family in each of the Local Authority areas. This number was increased due to agencies having to reallocate the case within GMLA 2. It also increased substantially due to the transfers across 2 GMLA boundaries. The effective transfer process from GMLA 2 to Salford ensured that the Salford practitioners understood the case well and avoided a '*start again*' approach in a case where the level of risk was high. The involved Salford practitioners positively remained the same which supported effective multi-agency safeguarding interventions.

5.3 KLOE 4: Role of agencies in risk assessment, planning and decision making.

- 220. Risk assessments:** Following the move to GMLA 2, father did engage with a risk assessment undertaken by a SW in November 2014. After the domestic abuse incidents in December 2015 and March 2016, there was no evidence father engaged with agencies apart from his limited compliance with his CRC Case Manager after his conviction for Common Assault and Criminal Damage in April 2016. A key issue in the case was the lack of engagement by father in further required risk assessments resulting in the level of risk he continued to pose being poorly understood. After his initial period of engagement following the family's move to GMLA 2, he became a '*hidden male*⁴¹'. Practitioner feedback was that the valuable information collated by the CRC Service between May 2014 and February 2015 and then between April 2016 and April 2017 could have supported improved practice given the detailed risk assessment tool used by that service.
- 221.** The outcome of the 2 risk assessments were both that father posed a medium risk of serious harm i.e. if he was convicted again the risk of that incident causing serious harm was medium. The first assessment in May 2014 indicated that '*those at risk were mother, his unborn child, other children and the public. Risk factors included alcohol use, poor emotional self-control, relationship issues and failure to comply with professionals including CSC*'. The outcome of the second risk assessment in April 2016 was largely the

⁴¹ NSPCC "Hidden men: learning from case reviews, summary of risk factors and learning for improved practice around "hidden men". Available at: <https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/hidden-men/> (Accessed: 03.11.19)

same with this also including as a risk factor '*children at risk of witnessing domestic abuse or being caught in the crossfire*'.

- 222.** The risk rating of medium indicated there were identifiable indicators of serious harm, that father had the potential to cause such harm but was unlikely to do so unless there was a change of circumstances such as alcohol/substance misuse, relationship breakdown or loss of accommodation. This CRC Service also had a very good understanding of father's lack of compliance with him failing to meet the requirements of his Court Orders. The first CRC risk assessment informed decision making at the Pre-birth Conference for Poppy; however, the service wasn't represented at the Review Conference 3 months later.
- 223.** Whilst the second involved CRC Case Manager was proactive in contacting GMLA 2 CSC and partner agencies during the second period of intervention, referrals made to CSC in May 2016 and March 2017 did not progress. A CSC Children and Families Assessment was undertaken in response to the first referral and the case then closed with feedback given to the CRC Case Manager by a SW towards the end of June that no concerns were raised by practitioners. Feedback provided after the second referral was that there was an EH Plan in place, mother was understood to be allowing father to visit and stay over but had informed the MASS EH Support Worker he was not living at the property and that practitioners had not identified concerns. The information held about the second period of CRC intervention appears to have been '*lost*' and, by the time concerns escalated at the end of June 2017, this service was no longer involved.

Good Practice 7: The CRC Case Manager was proactive in identifying and responding to potential safeguarding concerns for the children. These interventions included obtaining additional information from the GMP PPIU, making 2 referrals to CSC, making telephone contact with CSC to discuss the need for a referral after identifying there was a new baby at the home and making contact with the HV Service to discuss the Case Worker's concerns.

- 224. In conclusion,** whilst agencies struggled to engage father in assessment processes, valuable risk information was known to a key adult service which could have informed understanding and case planning including victim safety planning. The fact that a service user is not engaging with required assessments in itself is a further risk factor and the impacts of this on the overall level of risk should be considered. A positive development referenced in paragraph 129 of this review relates to the 2015 changes to managing applications to vary or discharge a Restraining Order which are referenced in the current GMP Domestic Abuse policy. The changes include a request by the CPS for GMP to undertake a joint risk assessment with CSC prior to the application being considered.

Learning Point 13: Obtaining relevant information from previously involved key adult services including Probation supports the understanding of risk in complex cases.
In this case, the CRC Case Manager held both valuable risk information in respect of father and also information about his lack of compliance during 2 periods of intervention including with domestic abuse and alcohol abuse interventions.
The Joint Targeted Area Inspection in Salford (October 2016) report highlighted the important role of Probation Services (CRC and NPS) and that this is not well understood by partner agencies.

- 225. Assessment and management of the toxic trio:** The issue of risk information becoming '*lost*' has already been discussed. There were significant time lapses between some of the domestic abuse incidents with 4 occurring in GMLA 1 (between September 2011 and February 2012), 4 in GMLA 2 (December 2015, March 2016 and then August and September 2017) and 1 incident in Salford in May 2018. Similarly, whilst 3 incidents of mother having been intoxicated were known to GMLA 1 with the last incident occurring in April 2011, there was then no further evidence this was an issue for mother until

March 2016. The last incident of self-harm in GMLA 1 had been in 2010 after which the first such incident in GMLA 2 occurred in July 2017.

- 226. Assessment and management of domestic abuse incidents:** there was some concern expressed by practitioners that mother lacked insight into the impacts of the domestic abuse and that she at times minimised these. It was understood she had lived in a context domestic abuse herself as a child and it was known she had experienced ongoing domestic abuse from previous partners and then from father over a number of years. There was evidence that mother either couldn't or didn't want some incidents to be reported or acted on although she did at times contact GMP herself. The significant incident in March 2016 which resulted in father being charged with Common Assault and Criminal Damage was reported by mother's friend with mother herself not wanting to press charges. A likely hypothesis would therefore be that mother experienced many more incidents than practitioners were aware of.
- 227.** The challenges for women who want to end an abusive relationship are many and can include fear, lack of self-confidence, intimidation, loyalty and lack of support. Whilst involved practitioners strove to provide supportive interventions, mother had limited family support at times with practitioners understanding grandmother was not supportive if she knew father was around. Mother told practitioners she was not in a relationship with father on a number of occasions after the incident in March 2016 and practitioners were reassured by this. However, the review has identified mother commenced living with father towards the end of 2011 at the start of their relationship until he was imprisoned in February 2012 and then lived with him again from the point of his release in June 2013 until CSC became aware of her pregnancy with unborn Poppy in February 2014. Both parents were saying they wanted to live together at that time and applied successfully for the Restraining Order to be discharged. They were then known to be living together from around December 2014 up to the date of the significant domestic abuse incident in March 2016. Therefore, their history indicated they would live together. Mother's perspective on the relationship was *'I knew everyone was trying to help and support me but I couldn't tell them about my worries and what was happening because they thought the relationship was over. I couldn't end the relationship because I couldn't see how I could do that. I was too scared of what he would do if I did end it.'*
- 228.** The management of the early domestic abuse incidents in GMLA 1 isn't understood and practice has changed since that time. The 4 domestic abuse incidents which occurred between March 2016 and May 2018 were each discussed in line with expected practice at either the MASS in GMLA 2 or at a Strategy Meeting in Salford. GMP completed DASH risk assessments with mother and father was arrested on each occasion. Information reviewed evidences robust information sharing by GMP with partner agencies after incidents. The HV in GMLA 2 was proactive in undertaking visits to discuss incidents with mother. The outcome of the DASH risk assessments for the 3 incidents whilst mother resided in GMLA 2 were medium, however the outcome for the incident in Salford was standard. GMP feedback following review was this incident could also have been risk assessed as medium given the couple's domestic abuse history which could have prompted consideration of a MARAC referral at the Strategy Meeting.
- 229.** It is difficult to understand the decision not to escalate the case from EH by GMLA 2 CSC after the significant incident in March 2016 which resulted in father being charged and subsequently convicted of Common Assault. Father had previously been charged with S47 Assault in October 2011 and then charged and convicted of S47 Assault in February 2012. Whilst there had been no reported domestic abuse incidents between February 2012 and the verbal incident in December 2015, father had been in prison between February 2012 and June 2013 preventing any incidents occurring over that 16-month period and he had been convicted of Common Assault (against a third-party) in May 2014. Both parents were intoxicated at the time of the March 2016 incident, hence there was evidence the 2 key risk factors which were the focus of the CP and CIN planning between September 2014 and May 2015 had not been satisfactorily addressed. A contributory factor in the case not being escalated by CSC may have been insufficient understanding of the 4 incidents which occurred in GMLA 1.

- 230.** The incident was subject to prompt multi-agency discussion at the MASS with a clear multi-agency plan agreed. Practitioner feedback from the education EH Plan lead was there had been a delay in allocation of the case to a SW after the incident which had been challenged at a subsequent meeting. The rationale for the delay was clarified by CSC- the case was allocated to a SW who then had a period of sickness absence resulting in the case having to be reallocated. This would have delayed completion of the CSC actions agreed at the MASS. A CSC Children and Families assessment had been completed before the end of June with feedback about its outcome having been provided by a SW to the CRC Case Manager. The case was then closed to CSC and the EH Plan also ceased in the middle of June due to practitioners understanding its outcomes had been largely achieved. One possible MASS outcome was for this EH Plan to be made more stringent. Given the history of the parental relationship and the significance of the incident, EH was no longer the appropriate level of intervention.
- 231.** The review has clarified that a CRC perspective would inform discussions at the MASS when this agency is or has recently been involved. In this case, the first CRC Case Manager had closed father's case 13 months previously in February 2015. However, the second CRC Case Manager became involved in April 2016 following father's conviction. This agency held significant information about father which, given the timeframes of their involvement, didn't inform multi-agency decision making at the MASS.
- 232.** Given the very significant domestic abuse history in the parental relationship in addition to this incident during which both parents were intoxicated and father was charged with Common Assault, a decision at the MASS to escalate the case to CIN or CP planning at this point would have supported more effective case management including assessments and interventions in relation to parental alcohol misuse. This was the first evidence of parental alcohol misuse identified within GMLA 2. Case escalation at this point would also have enabled the valuable information held by the second CRC Case Manager to inform multi-agency safeguarding practice. The CRC Case Manager made the first referral to CSC in May 2016 due to father's conviction for Common Assault which was not progressed.

Learning Point 14: Multi-agency decision making processes to agree a plan quickly following a significant domestic abuse incident is good practice. It is also a challenging area and decision making including the most appropriate level of intervention should be informed by a good understanding of the history of the parental relationship and previous incidents including whether these led to convictions.

- 233.** Practice in relation to the management of domestic abuse continues to evolve. A number of Local Authorities including GMLA 1 are considering or have implemented the Safer & Together⁴² model. This is a child centred model which aims to keep children safe and together with the non-offending parent whilst also intervening with the perpetrator of the abuse. The model provides a suite of tools and interventions designed to help child welfare professionals become domestic violence informed. Within GMLA 2, the Council is undertaking a programme of work aimed at reducing family conflict including the delivery of an evidence-based, dedicated training programme entitled '*how to argue better*'⁴³
- 234.** There was evidence of safety planning being undertaken with mother. After Adam returned to the family home in 2015, there were 5 reported domestic abuse incidents. Section 3- safety planning- in the GM Safeguarding Partnership procedure on Domestic Violence and Abuse⁴⁴ highlights that a child's

⁴² Safe & Together Institute. Available at: <https://safeandtogetherinstitute.com/about-us/about-the-model/> (Accessed: 25.07.19)

⁴³ Oneplusone How to Argue Better training- a programme designed to help practitioners raise parental awareness of the impact of their conflicts on their children and to give them skills to tackle their disagreements in a healthy way. Available at: <https://www.oneplusone.space/how-to-argue-better> (Accessed: 25.07.19)

⁴⁴ Greater Manchester Safeguarding Partnership on-line procedures- Domestic Violence and Abuse. Available at: https://greatermanchesterscb.proceduresonline.com/chapters/p_dom_abu.html (Accessed: 09.09.19)

perspective should be obtained through direct communication. It also clarifies that support to keep themselves safe can be provided most effectively through them having their own safety plan.

Learning Point 15: A key intervention in domestic abuse cases is safety planning with the victim of the abuse. Direct communication with children living in the home to obtain their perspectives is also important. The development of a separate safety plan with a child once this is age appropriate can further support them in keeping themselves safe. This may include establishing: how to remain safe during an incident, where they can go to use a telephone and who they can talk to.

- 235. In conclusion,** the review has identified that the majority of reported domestic abuse incidents were effectively managed. There was one incident for which the GMP DASH risk assessment outcome might have been medium as opposed to standard. Escalation of the case to CIN or CP planning after the significant March 2016 incident could have provided a potential turning point in this case, an opportunity to address the domestic and alcohol abuse concerns and an opportunity to utilise the information known to and expertise of the CRC Case Manager.
- 236.** The MASS was being piloted in GMLA 2- this process ensured timely discussion and agreement on required actions by partner agencies. Following implementation of GMP district teams instead of the central PPIU in April 2019, multi-agency partners in each district were to determine the most appropriate response mechanism to domestic abuse incidents.
- 237. *Assessment and management of mother's alcohol misuse:*** mother's history of alcohol misuse was understood by GMLA 1 CSC. During her residence in GMLA 2 and Salford, whilst practitioners were aware mother had a history of alcohol misuse, she denied this was an issue and there was little evidence to the contrary with an exception being the domestic abuse incident in March 2016. During the first period of CP planning within GMLA 2, it was understood both parents had addressed their alcohol misuse issues. There had been no interventions to support them in doing this and it could be hypothesised it would have been extremely difficult for them to succeed. After the March 2016 domestic abuse incident, the only further evidence available to support decision making was a neighbour raising concerns about possible substance misuse in September 2017 and the SW identified beer bottles in the rubbish bin in June 2018. In September 2017, this information supported escalation of the case. In June 2018, it supported the understanding of the increasing level of risk in the case.
- 238.** A further challenge for practitioners in understanding the risks posed by parental alcohol use was that the practitioners supporting mother and the children had no contact with father after March 2016. Feedback from maternal grandmother was that *'while father did drink alcohol, mother also had a long-standing alcohol problem and drank regularly'*. This information was unknown to practitioners. Mother's perspective was *'I do like a drink but don't have a drink problem'*. There was some practitioner feedback that the issues of domestic abuse and mother's relationship with father may have been the focus of discussions and that the possibility of ongoing alcohol misuse by mother might not have been sufficiently considered.

Learning Point 16: This case has highlighted the following practice issues which should inform agency processes including risk assessments, care planning and supervision:

- the importance of understanding parental histories including ACEs in relation to parenting capacity and capacity to change;
- the fact that there is no current evidence of previous significant risk factors should not provide assurance these risks have been resolved. Evidence should also be sought which proves these risk factors are no longer an issue such as positive changes made by parents which are sustained over time;
- whilst a victim of domestic abuse may say the relationship has ended, there is a need to consider the likelihood of that given the history of the relationship including coercive control, evidence of it continuing

over time such as further pregnancies, support mechanisms available to the victim and the fact that a victim may fear the consequences of admitting it hasn't ended;

- including requirements for a victim of domestic abuse to have no contact with the perpetrator within a written/working agreement is inappropriate;
- the possibility of manipulation by parents and disguised compliance which, in domestic abuse cases, might occur for a number of reasons including a victim's fear of the perpetrator or of the consequences of not complying.

239. In conclusion, the management of possible parental alcohol misuse when parents deny this is an issue and evidence to the contrary is not available is challenging. The review has identified that evidence which became available in September 2017 and June 2018 informed the level of risk and was acted on appropriately. The review has not identified that a formal assessment of mother's alcohol use was undertaken. A referral to the local Substance Misuse Service had been made in light of the increasing concerns in Salford and an appointment offered for the middle of August 2018. A practice development within GMLA 2 has been the use of '*scram bracelets*' as a mode for testing parents in the antenatal and post-natal period for alcohol use within Pre-proceedings.

240. Assessment and management of mother's mental health: Historically, in 2009, an entry in the GP records noted mother had a history of anxiety, depression and self-harm. Whilst mother resided in GMLA 1, she attended A&E on 2 occasions in 2010 following incidents of self-harm, attended A&E on 1 occasion in 2010 whilst intoxicated and again on 1 occasion in April 2011. There was then limited evidence of mother's mental health difficulties in GMLA 2 prior to mother attending A&E in July 2017 following a self-harm incident. Positive practice was seen after this incident with the SW contacting the GP Practice and the HV to ensure support was in place for mother. Mother's mental health difficulties were referenced in the concerns leading to the case subsequently being escalated.

Good Practice 8: The newly allocated SW contacted both mother's GP and the HV to ensure there was appropriate support in place for her after mother's attendance at A&E following an incident of self-harm.

241. Mother disclosed her history of self-harming to the HV shortly before her move to Salford and a referral was made for counselling. After mother moved to Salford, she informed the new HV during a home visit in January 2018 that she had suffered from depression as a teenager but not since and that she suffered from anxiety but managed this. At mother's booking appointment with Maternity Services in March, she said she had been depressed in the past but had stopped taking medication 8 months earlier. Supporting mother to access relevant services in relation to her mental health was one element of the Humankind FW's plan of work with the family.

242. In conclusion, mother had a significant history of mental health difficulties prior to her move to GMLA 2 after which there was limited available evidence that this issue posed a significant risk or that it impacted on her parenting capacity. There was evidence that, after the self-harm incident in July 2017, mother's mental health difficulties were understood and contributed to the assessment of risk in the case.

SECTION 6: CONCLUSION.

243. This is an overarching conclusion with the analyses in Section 5 each having been concluded. This was a complex family in which there had been long-standing domestic abuse within the parental relationship, histories of alcohol misuse for both parents and a maternal history of mental health difficulties. Case management was complicated further by 2 moves across GMLA boundaries which resulted in key information becoming '*lost*' during the first transfer. Practitioners strove to support mother and the children and the review has highlighted 8 instances of good practice. The review has been informed by the valuable participation of mother, maternal grandmother and mother's eldest child.

- 244.** Practitioners endeavoured to work in partnership with mother who, from March 2016 onwards, said on a number of occasions father wasn't living at the home or that they were no longer in a relationship. Practitioners wanted her to succeed and supported her in the belief she had made positive changes. The review has identified evidence of the relationship not ever having ended and that the risks posed by father's alcohol misuse and violent behaviours continued. With the benefit of hindsight, the review has identified practitioners were attempting to work in partnership with parents who were non-compliant and deliberately manipulative. It may well have been the case that mother's fear of father resulted in these behaviours on her part and that the impacts of the ACEs she had experienced impacted on her ability to make required changes including ending the relationship. However, the overall impact of the non-compliance and manipulation was that practitioners were unaware of the reality of life in the family home.
- 245.** The review has identified 2 key areas of learning. The first relates to the importance of identifying parental ACEs and recognising how these may impact on parental abilities to respond positively to agency interventions and achieve good outcomes. Recommendation 1 has been made in response to this learning.
- 246.** The second relates to the importance of consistently effective management of the transfer of complex cases by CSC Services across Local Authority boundaries. Whilst this area of practice has developed significantly since the review timeline, the proposed work to agree best practice and to implement that through a review and update of the North West ADCS Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure is required. The findings of this review should inform that work. The review has also identified learning in relation to the GM Pre-Birth Assessment guidance. Recommendation 2 has been made in response to this learning.
- 247.** Sixteen Learning Points have been identified and included within the review. These should be considered by the relevant strategic group/s where appropriate and by the involved agencies. Implementation plans should be developed by agencies aimed at ensuring required action to improve safeguarding practice further is taken. Recommendation 3 has been made in response to this learning.

SECTION 7: SSCP RECOMMENDATIONS.

Recommendation 1: SSCP to consider escalating the trauma informed practice learning to the GM Standards Board in order for that Board to consider implementing actions aimed at supporting the development of trauma informed approaches to practice across GM.

Recommendation 2: The North West ADCS Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure and the GM Pre-Birth Assessment guidance should be reviewed and updated in light of the learning from this review. SSCP to:

- endorse the recommendation and request the Greater Manchester Policy & Procedures Group considers this and determines the actions required to meet it;
- be assured the North West ADCS Notification and Transfer of Children Subject of Child Protection Plans across Local Authority Boundaries Procedure and the GM Pre-Birth Assessment guidance have been reviewed and updated and that they concur in relation to the management of case transfers for unborn babies.

Recommendation 3: The SSCP to be assured its multi-agency partners have considered the relevant learning points and developed implementation plans in order to support safeguarding practice when working with complex families with multiple risk factors.

APPENDIX 1: COLLATED LEARNING POINTS AND GOOD PRACTICE.

Learning Point 1	<p>Achieving quoracy at Review Case Conferences is required for effective multi-agency decision making but can be challenging if a limited number of agencies are actively involved. A decision can be made to proceed with the Conference provided all relevant reports and information are available. GMP may not be represented at Review Case Conferences, however the report and recommendation provided should always inform decision making.</p> <p>Seeking a further GMP perspective when there are conflicting opinions as to whether or not a CP Plan should cease supports effective multi-agency decision making with GMP, as a key safeguarding agency, having attended the ICPC and able to provide an informed further perspective.</p>
Learning Point 2	<p>It is not uncommon for children who have lived with relatives under private law arrangements to return to their parent/s' care. If concerns about such a move are raised with CSC by an agency or the involved relatives, careful consideration on a case by case basis is required particularly when there are current or have been recent safeguarding concerns relating to the parent/s.</p> <p>Considerations as to the action required by CSC should be informed by a good understanding of Orders previously issued and their current legal status. In cases where CSC was involved with the family when Orders were issued, and particularly when an Order informed CSC decision making as in this case, relevant information should be obtained. Access to the private law papers at an early stage would support a good understanding of the concerns about parental difficulties and assessment of a parent's capacity to change.</p> <p>This additional information would support a robust CSC response and decision making including about the assessments required. It is important the risk and protective factors for the returning children and any children already in parents' care are identified including whether vulnerable parents are likely to be able to effectively meet the needs of all the children.</p> <p>All agencies should have systems and processes in place to ensure the circumstances of such children returning to parental care are understood and correctly recorded to inform effective care planning.</p>
Learning Point 3	<p>When a child becomes subject to a CP Plan, the category of abuse should be determined by the evidence presented to the ICPC and the views of practitioners in attendance. The category should reflect the primary area of concern identified at the Conference.</p> <p>For the duration of the CP Plan, the category of abuse should be formally reviewed within each Review Conference.</p>
Learning Point 4	<p>It is important that the GM Pre-birth Assessment process including the recommended timescales are followed to facilitate effective and timely care planning.</p>
Learning Point 5	<p>Significant information provided prior to a baby being registered at a GP Practice will be held on mother's records initially. Expected practice is for this information to then be saved onto the baby's own record which is generated once the baby is registered with the Practice. It is important that all Practices have the required systems and processes in place to meet this expectation.</p>
Learning Point 6	<p>The individual patient records held by GP Practices contain both information generated by the Practice and information shared by other health services and</p>

	<p>partner agencies. Family members living at the same address are linked on Practice systems supporting an understanding of information held about a family unit including key safeguarding information.</p> <p>The GP records provide the evidence base for GP decision making in relation to meeting statutory safeguarding responsibilities. The formal sharing of Maternity Service Special Circumstances forms with GP Practices ensures Maternity Service concerns inform this evidence base. This process would also support a shared understanding of the concerns across the Maternity Service, GP Practice and HV Service and facilitate effective information sharing between these key health services.</p>
Learning Point 7	Recent research findings have clarified that SUDIs now occur largely in association with social deprivation and modifiable risk factors and that more consideration is needed on how best to support such vulnerable families. It is important that CDOPs and Public Health maintain a strategic focus on this issue which includes the exploration of more effective interventions to support this challenging area of practice.
Learning Point 8	It is important multi-agency practitioners are aware that trauma in childhood is common and of its negative impacts in an adult's life including on their ability to form positive relationships, parenting capacity and their capacity to change. The history of ACEs in a service user's life should be understood and inform care planning and provision. The use of trauma informed care supports the service user in forming effective working relationships with practitioners, increasing their resilience and in making the changes required to achieve a positive outcome. The provision of multi-agency training and availability of practice standards related to trauma informed care would enable practitioners to respond more effectively to these vulnerable parents.
Learning Point 9	This review has demonstrated the contributing factors to and outcomes of both an ineffective and very effective case transfer across GMLA boundaries. The importance of ensuring all information including that related to significant historical risk factors and parental ACEs follows a family when their case is transferred has been highlighted by this case and is key learning from this review. Without a good understanding of the history, a ' <i>start again</i> ' approach is likely as seen in this case following the first transfer across GMLA boundaries. The review has also demonstrated that expected practice has evolved to ensure consistently effective case transfers by the involved GMLAs and the available regional guidance requires review and update to reflect this current good practice and ensure its consistency across the region.
Learning Point 10	Effective case transfers for complex and transient families are reliant on all relevant information being transferred each time a family moves across Local Authority boundaries. It is important that the systems and processes in place for such case transfers by all involved partner agencies are timely and robust.
Learning Point 11	This review has highlighted the challenges posed by the circumstances of siblings not in parental care being poorly understood including important historical information about mother's parenting capacity and capacity to change becoming ' <i>lost</i> '. Access to the private law papers at an early stage would support a good understanding of the concerns about parental difficulties and assessment of parenting capacity and capacity to change.

Learning Point 12	The provision of consistent, reflective and outcome focused supervision by all agencies is vital as an integral component of the intervention in complex cases. A change of supervisor requires careful management to ensure practitioners are well supported and that cases are not allowed to 'drift'.
Learning Point 13	Obtaining relevant information from previously involved key adult services including Probation supports the understanding of risk in complex cases. In this case, the CRC Case Manager held both valuable risk information in respect of father and also information about his lack of compliance during 2 periods of intervention including with domestic abuse and alcohol abuse interventions. The Joint Targeted Area Inspection in Salford (October 2016) report highlighted the important role of Probation Services (CRC and NPS) and that this is not well understood by partner agencies.
Learning Point 14	Multi-agency decision making processes to agree a plan quickly following a significant domestic abuse incident is good practice. It is also a challenging area and decision making including the most appropriate level of intervention should be informed by a good understanding of the history of the parental relationship and previous incidents including whether these led to convictions.
Learning Point 15	A key intervention in domestic abuse cases is safety planning with the victim of the abuse. Direct communication with children living in the home to obtain their perspectives is also important. The development of a separate safety plan with a child once this is age appropriate can further support them in keeping themselves safe. This may include establishing: how to remain safe during an incident, where they can go to use a telephone and who they can talk to.
Learning Point 16	This case has highlighted the following practice issues which should inform agency processes including risk assessments, care planning and supervision: -the importance of understanding parental histories including ACEs in relation to parenting capacity and capacity to change; -the fact that there is no current evidence of previous significant risk factors should not provide assurance these risks have been resolved. Evidence should also be sought which proves these risk factors are no longer an issue such as positive changes made by parents which are sustained over time; -whilst a victim of domestic abuse may say the relationship has ended, there is a need to consider the likelihood of that given the history of the relationship including coercive control, evidence of it continuing over time such as further pregnancies, support mechanisms available to the victim and the fact that a victim may fear the consequences of admitting it hasn't ended; -including requirements for a victim of domestic abuse to have no contact with the perpetrator within a written/working agreement is inappropriate; the possibility of manipulation by parents and disguised compliance which, in domestic abuse cases, might occur for a number of reasons including a victim's fear of the perpetrator or of the consequences of not complying.
Good Practice 1	The newly allocated HV was proactive in visiting the home to discuss the 2 new domestic abuse incidents with mother.
Good Practice 2	The education EH Plan lead was proactive in collating the safeguarding concerns including the impacts on the children to effectively escalate the case to CSC and in

	ensuring their concerns about the case were raised including verbal challenge of the SW decision not to convene an ICPC after the July 2017 Strategy Meeting.
Good Practice 3	After the Strategy Meeting held in October 2017, involved GMLA 2 practitioners were clear about the level of risk in the case and proactive in supporting mother up to the point of the case being transferred to Salford. Positive practice was also seen with these practitioners taking action to ensure there was a very robust and effective case transfer. These actions included prioritising attendance at the Transfer-in Conference and the continued involvement of the GMLA 2 FSW until a Salford Humankind FW was allocated, enabling continuity of family support for mother and the children at a difficult time.
Good Practice 4	The GMP Officers who attended this incident identified there were vulnerable children in the home and were then proactive in ensuring the identity of the intoxicated man was clarified. On reviewing the incident, the PPIU took further action to ensure this significant information was shared effectively with CSC by making a referral. The PPIU had taken the same action following GMP attendance at the home in October 2017.
Good Practice 5	The review has identified a number of instances of good practice in relation to professional curiosity and healthy scepticism during the review timeline. These included the CRC Case Manager being sceptical about father's assertions he was not in contact with mother, GMP Officers observing evidence of father living at the home, research by GMP Officers attending a further incident to identify the intoxicated man found at the home and the SW identifying beer cans in the rubbish bin.
Good Practice 6	There was a prompt response and good communication between hospital and community Maternity Services after mother missed 2 hospital appointments in April with Community Midwives attending the home on the day after the second missed appointment. The discharge summary from St. Mary's Maternity Hospital to the GP Practice was detailed and provided key required safeguarding information including the main risk issue and the name of the allocated SW.
Good Practice 7	The CRC Case Manager was proactive in identifying and responding to potential safeguarding concerns for the children. These interventions included obtaining additional information from the GMP PPIU, making 2 referrals to CSC, making telephone contact with CSC to discuss the need for a referral after identifying there was a new baby at the home and making contact with the HV Service to discuss the Case Worker's concerns.
Good Practice 8	The newly allocated SW contacted both mother's GP and the HV to ensure there was appropriate support in place for her after mother's attendance at A&E following an incident of self-harm.

APPENDIX 2: THE INDEPENDENT REVIEWERS.

Melanie Hartley became an independent safeguarding consultant in August 2016 following her retirement from the NHS after 41 years of service. She holds an MA in Child Welfare and Protection (Huddersfield) and firmly believes that effective multi-agency working is vital if vulnerable children and adults are to be adequately safeguarded. The case review process is a key component in this work. It ensures that multi-agency lessons are learnt and that actions are implemented leading to improvements in multi-agency safeguarding practice. Melanie's professional background is also in nursing (nurse, health visitor), including 20 years' frontline experience as a health visitor, working with complex and vulnerable families and 10 years' specialist safeguarding experience (named nurse safeguarding children, designated nurse for safeguarding children/children looked after and the head of safeguarding including safeguarding adult responsibilities). These roles required the development of expert skills and knowledge in all areas of multi-agency operational and strategic safeguarding work. Melanie has been involved in the production and quality assurance process for numerous single and multi-agency case reviews. She has significant experience of leading and chairing a Safeguarding Board's case review panel which enhanced her experience in case review methodologies and practitioner involvement. This is her tenth review as an independent reviewer. In preparation, Melanie has undertaken relevant training and fully participated in and shadowed a serious case review process undertaken by another independent safeguarding reviewer. She has not been employed by any organisation aligned to this review.

Jane Carwardine became an independent safeguarding consultant in April 2015 during which time she has completed over 16 case reviews (serious case reviews, concise practice reviews, thematic reviews). Jane holds an MA in Child Care Law and Practice (Keele) and a BA Honours in Health Studies (Bolton). Her professional background is in nursing (nurse, health visitor and midwife, now lapsed) with 42 years NHS experience. She has undertaken a range of NHS strategic, provider and commissioning management roles. Jane had 15 years dedicated specialist safeguarding experience prior to her current role, in a variety of NHS leadership roles including; senior and line management functions, named nurse role, designated nurse for safeguarding (including adults and children) and head of safeguarding. Examples of her previous safeguarding experience includes; supporting the completion of serious case reviews, leading on multi-agency safeguarding learning and development, assuring the quality effectiveness of safeguarding activity, complex case management, the development of multi-agency teams, developing supervision systems, development and leadership of safeguarding advisory teams, membership on safeguarding boards, chairing safeguarding sub-groups, and providing advice to a range of strategic boards. She has worked intensively to improve the quality effectiveness of the case review process. She has previously represented the Royal College of Nursing (RCN) on the Royal College of Paediatrics and Child Health (RCPCH) Child Protection Committee and been involved in the completion of RCPCH invited reviews. She has not been employed by any organisation aligned to this review.