Salford Safeguarding Children Partnership

Local Children's Safeguarding Practice Review
Nicholas
Executive Summary

Presented to the Salford Safeguarding Children Partnership on
The 12th of December 2022

Independent Author: Allison Sandiford

Contents

1. Introduction to the Review and Methodology

1.1. This Local Children's Safeguarding Practice Review was commissioned by the Salford Safeguarding Children Partnership (SSCP) following Rapid Review for National Panel submission.

1.2. The criteria were met as the local authority suspected that a young person (Nicholas) who had died, had been abused or neglected.

1.3. Nicholas aged 4 years, sadly died due to a serious incident whereby he was found faced down in a bath.

1.4. The report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant who gained experience in safeguarding whilst working for a police service. Since 2019 Allison has conducted serious case reviews and safeguarding practice reviews in both children's and adults safeguarding, and domestic homicide reviews.

1.5. Allison does not have any current links to Salford Safeguarding Children Partnership or any of its partner agencies.

1.6. A multi-agency review panel[1] met on the 22nd of June 2022. The panel agreed the scope of the review and the Terms of Reference[2]. Additional information was requested from the agencies involved to aid the review process.

1.7. The panel met on three further occasions to discuss the case and learning and to monitor the progress of the review. These meetings incorporated two practitioner learning events attended by professionals from the key agencies who had worked with Nicholas[3]. Contribution from the participants generated positive discussion around both good practice and areas of practice that could be developed and improved; this has formed the basis of this report.

1.8. It was agreed by panel members that the review would follow a question-based learning format in place of traditional recommendations. The questions developed during this Children's Safeguarding Practice Review process will drive Salford Safeguarding Children Partnership, and its partner agencies, to develop an action plan that will respond directly to the identified learning.

1.9. Panel members had an opportunity to review the final draft of the report and discuss the learning prior to presentation to the Salford Safeguarding Children Partnership.

2. Family Engagement

2.1. Family engagement is an important part of the review process. Discussion with family members about the support offered is hugely beneficial to identifying both good practice, and practice which can be improved upon.

[1] The panel consisted of representatives from Northern Care Alliance, Greater Manchester Police, Salford Safeguarding Children Partnership, Integrated Care System, Children's Social Care (Salford and from the Local Authority where Sarah had previously lived), Adult Social Care, Early Help, North West Ambulance Service.
[2] Refer to Appendix 1
[3] Adult Social Care, Early Help, Greater Manchester Police, Manchester Foundation Trust, Northern Care Alliance, North West Ambulance Service, Primary Care, Salford Children's Social Care, Together Housing, Children's Social Care from the Local Authority where Sarah had previously lived, Salford Safeguarding Children Partnership.

2.2. It has not been possible to speak with family members during the process of this review due to ongoing criminal investigations. The reviewer is happy to offer members of Nicholas' family the opportunity to meet when appropriate and will update them of the learning the process has identified.

3. Parallel Processes

3.1. At the time of writing this report, Nicholas' mother (hereafter referred to as Sarah) had been arrested for causing or allowing a child's death, and a criminal investigation was underway. The investigation had not concluded prior to the review process being completed. The review panel has agreed that the findings of the investigation are not expected to influence the learning identified.

3.2. Ordinarily, a Coroner's Inquest into a death is opened and then adjourned, pending any criminal trial, which takes precedence. It is the Coroner's prerogative to resume an inquest following a criminal trial.

4. Brief Summary of Events

4.1. Nicholas had been subject to a Pre-Birth Assessment in a different Local Authority. Sarah (aged 21 years at the time) had suffered previous trauma from her own father and had previously been under social care as a child. Sarah was missing midwifery appointments and was smoking and drinking. It was recorded that Sarah had no idea of the potential impact on the baby.

4.2. The Local Authority completed a referral to Early Help and the case was closed but Sarah missed some further ante-natal appointments. As a result, a further safeguarding referral was submitted, and an updated Pre-Birth Assessment was soon recommended.

4.3. The assessment process established that Sarah had moved to Salford[4] and therefore a Social Worker contacted Salford Children's Social Care to share the assessment. For reasons that cannot be confirmed, the assessment was not received by Salford.

4.4. On the 5th of December 2017, Children's Social Care in Salford received a referral after Sarah had contacted the NHS 111 Service informing them of missed appointments and not being registered with a GP practice.

4.5. On the 22nd of December 2017 Children's Social Care received a referral from Midwifery services after Sarah had attended an appointment with the community midwife and disclosed that she was low in mood ad had previously attempted suicide on two occasions, had a history of cannabis use, that her father had been abusive when she was a child, and that she was worried as she didn't know who the baby's father was.

4.6. Nicholas was allocated a Social Worker five weeks later - the day after his birth - Nicholas had been born in hospital by Emergency section at 35+3 weeks gestation.

4.7. On the 29th of January 2018 Nicholas was subject to a discharge planning meeting in which it was decided that Sarah would meet with the Mental Health team prior to discharge from the perinatal midwives, and Nicholas would be supported under the auspice of Child in Need.

[4] Nicholas' grandmother, Sarah's mother, already resided in Salford with Sarah's stepfather and their two children. There is a record of two domestic abuse incidents between Sarah and her mother dating from 2011 when Sarah was aged fifteen.

4.8. Upon discharge Nicholas and Sarah went to stay with a friend of Sarah's for a while before being placed in temporary homeless accommodation by the Council Housing Services. At this time, Sarah did not have her own tenancy.

4.9. Though the Child in Need process started well, and Sarah engaged with the Social Worker and Health Visitor, in time Sarah was not always available. Subsequently Nicholas was not always seen.

4.10. On the 1st of March 2018, Sarah having gained her own tenancy moved her and Nicholas into their home.

4.11. Around June/July 2018, Nicholas went to stay with a friend of Sarah's whilst Sarah reportedly attended a funeral abroad. It remains unknown how long Nicholas stayed with the friend but upon it becoming known that he was there, a Social Worker visited him and established that whilst there was evidence of bottles, milk, nappies and clean clothes, Nicholas was co-sleeping with the friend because he had no cot at the address.

4.12. Upon Sarah's return, safe sleep was discussed during a joint visit from Children's Social Care and Nicholas' Health Visitor. During this visit Sarah said that she felt she did not need any further support from the Social Worker, and it was agreed that Nicholas' Child in Need case would be closed - his support would return to the universal core programme.

4.13. Three days later Nicholas suffered a scalding whilst in the care of his grandmother. The injury was deemed to be accidental, but Nicholas suffered significant burns injury to his abdomen, bilateral thighs, perineum, and genitals. Nicholas stayed in hospital for one week due to infection. Nicholas was taken to an outpatient follow up appointment on the 27th of August 2018 but was not taken to appointments on the 14th and 28th of August 2018.

4.14. On the 12th and 15th of October 2018 Sarah took Nicholas to the Accident and Emergency Unit as he was suffering a cough and runny nose with noisy breathing at night. His scars were seen at this appointment and there were no concerns raised. Staff at the hospital learned that a man who Sarah referred to as her boyfriend, was sometimes staying at Nicholas' house.

4.15. On the 30th of November 2018 Sarah told her GP that she and a man who she referred to as a boyfriend of five months, were trying for a baby.

4.16. On the 7th of December 2018 Sarah told the Health Visitor that she and Nicholas were going abroad to the country of her birth until the 12th of January 2019.

4.17. Nicholas was not seen again by any professional until the 28th of March 2019 when he was taken for his 12-month vaccinations. Sarah did not report that there had been any medical concerns regarding Nicholas whilst he had been out of the country.

4.18. In May 2019 Sarah reportedly took Nicholas to London whilst she sorted out some legal papers. At the end of the month Nicholas demonstrated his walking skills to his Health Visitor but the Ages and Stages Questionnaire which was completed concluded that his communication, problem solving, and personal social was below expected levels.

4.19. In June 2019 Sarah reported that she was a victim of blackmail. This was dealt with by police from another force as the incident appears to have been related to Sarah's ex-partner who did not live in Salford.

4.20. In July 2019 the Health Visitor referred Nicholas to Bridge for a home safety assessment by an Early Help Practitioner. Sarah met the practitioner and agreed to a bathmat and cupboard locks

being provided. The home presented clean and tidy and there were no concerns. Sarah told the worker that she was separated from Nicholas' father who lived abroad but there were no issues.

4.21. In September 2019 during a phone call, Sarah told the Early Help Practitioner that she and Nicholas were going to her birth country again until May 2020. However, Nicholas was presented to his GP on the 14th of November 2019 regarding a keloid scar in his groin area evidencing that they were still in the United Kingdom at this point.

4.22. In April 2020 Sarah contacted the Housing Association to report that she and Nicholas were stuck abroad because of the Covid pandemic lockdown. Neither she nor Nicholas were seen by professionals again until Sarah collected her keys from the Housing Association office on the 15th of September 2021 (it is not known if Nicholas was with his mum on this occasion).

4.23. Nicholas was presented to the Accident and Emergency Unit on the 10th of October 2021 after Nicholas had consumed several vitamin jellies.

4.24. On the 27th of November 2021 Sarah left Nicholas in the care of an ex-partner. When Sarah attended the ex-partners address to collect Nicholas an argument started during which Sarah was pushed. Sarah reported the incident to the police. It is not known what Nicholas saw or heard but he was spoken to by a Police Officer who described him as being in good spirits.

4.25. In January 2022 Nicholas attended 'settle in' sessions at nursery.

4.26. On the 21st of February 2022 Sarah visited her GP Practice and reported feeling suicidal to reception. The Practice called 999 and Sarah followed this with a 999 call from herself. When later seen by the Mental Health Liaison Team, Sarah disclosed that she and Nicholas were staying with a friend due to having no heating, electricity, or food. Nicholas was not present during this consultation – he was reportedly staying at his grandmother's address.

4.27. The following month, Sarah left Nicholas without adult supervision, in the care of relatives aged 15 and 12 years. Sarah went to see a friend in a neighbouring property, with whom she drank alcohol and used illicit substances. Sarah returned the following morning.

4.28. The events that followed are subject to criminal investigation and thus will not be elaborated upon, but Nicholas was later found face down in the bath. Cardiopulmonary Resuscitation and advanced life support was administered to Nicholas by attending health professionals but was not effective.

4.29. Nicholas was unresponsive to treatment and sadly passed away.

5. Nicholas' Lived Experience of Events

5.1. It is very difficult to gain a true understanding of Nicholas' lived experience.

5.2. Contact between professionals and Nicholas has been inconsistent as Sarah has not always presented Nicholas to professionals for appointments and assessments. This is partly due to Sarah reportedly taking Nicholas out of the Salford area on occasion, and out the United Kingdom for periods of time on several occasions.

5.3. Nicholas was purportedly out of the United Kingdom from late 2019 until September 2021 when he was aged around 22 months to 3 years 8 months. Language development[5] explodes at this age. His vocabulary, understanding and communication will have flourished, but professionals were unable to meet with him, observe his development and/or gain a picture of his lived experience throughout this period. Nicholas was only back in the United Kingdom for five months before he tragically died.

5.4. This review has attempted to reflect upon what life was like for Nicholas. Some of this reflection is contained within the body of the report but it will begin with this overview:

As an unborn child, Nicholas was not provided with consistent and regular ante-natal care. He was fully reliant upon his mother who was facing her own challenges and not addressing her own health and care needs - she continued to smoke and drink despite the potential impact on Nicholas.

Nicholas was born in hospital by Emergency section at 35+3 weeks gestation due to a premature rupture of membranes. Nicholas wasn't very well for the first few days of his life and had to spend time away from his mum in the Special Care Baby Unit.

When Nicholas left the hospital with his mum, his mum was homeless and was placed, initially in homeless Bed and Breakfast accommodation and then other temporary accommodation by Council Housing Services before securing her own permanent home with a Registered Provider.

Because Nicholas' mum hadn't been expecting Nicholas to arrive early, she wasn't fully prepared for him, but Nicholas' grandfather[6] got Nicholas what he needed.

When Nicholas was around six weeks old, he and his mum got their own permanent home. Nicholas was still being supported at this time by his Social Worker and he now had a Health Visitor, but he was not always able to meet with them because his mum was not always available and didn't always respond to texts and messages. When Nicholas was seen by professionals, he was noted to be a happy child.

Nicholas and his mum developed a good bond but when Nicholas was five months old, she had to go away for a while, and he was left in the care of his mum's friend.

Besides his mum's friends, Nicholas had extended family around him in Salford. He had grandparents (grandmother and step-grandfather) and an uncle and aunt who were still children themselves. Nicholas often spent time at his grandparents' home. Nicholas also had a grandfather who lived close by, but this review has been unable to establish how much contact Nicholas and Sarah had with him.

When Nicholas was five months, he was badly burned and had to go to hospital. He had been staying with his grandma and she reported that she had been showering him in the bath, when the cold-water hose came off the shower and hot water scalded his tummy, thighs, and genitals. Nicholas had to stay in the hospital for a week because his burns got infected. Nicholas' burns required ongoing medical oversight, but Nicholas was not able to go to all the appointments because no one took him.

[5] Ages and stages (speechandlanguage.org.uk)
[6] The review has been unable to establish whether this was Sarah's father or stepfather.

Nicholas was closed to the Children's Social Worker around this time, but he still had a Health Visitor under Universal Services.

Though Nicholas didn't know his dad, there was a man who was now spending time in the house with Nicholas and his mum. Because Nicholas was so young, he was unable to tell anyone what it was like when the man came to stay.

Before Nicholas was one year old, he went to stay abroad with his mum for a couple of months. Nicholas was too young to be able to tell anyone back in England what his time away from the United Kingdom was like, or who he met, or who he stayed with. He went to stay abroad again just before he was two.

This time Nicholas had to stay abroad for almost two years because of the coronavirus. Whilst he was there, Nicholas missed some health appointments in the United Kingdom including some that were to look at a scar that had developed where he had been scalded. Nicholas also missed a chance to start of nursery.

Nicholas and his mum came back to Salford in September 2021. A couple of months later, Nicholas went to see a man who used to be a friend of his mums. His aunt went with him too. When his mum came to pick him up, his mum and the man argued, and the man pushed his mum. Afterwards the police came to see Nicholas and his mum.

Nicholas attended some sessions at nursery in January 2022 and was able to play and socialise with children his own age.

In February Nicholas' house got very cold and there wasn't much food. He and his mum went to stay with his mum's friend for a while, but his mum wasn't very happy. Sometimes Nicholas spent time at his grandma's house whilst his mum stayed with her friend.

One night Nicholas was left with relatives who were children themselves whilst his mum went out to see a neighbour. She didn't return until the following day when she went to bed.

The events that followed are subject to a criminal investigation and thus will not be elaborated upon, but Nicholas was later found, face down in bathwater. Nicholas was unresponsive to treatment and sadly passed away.

6. Consideration and Analysis of Key Practice Episodes

To enable the review to meet the Terms of Reference, professionals explored the following key practice episodes with the author. Practice episodes are periods of intervention that are deemed to be central to understanding the work undertaken with Nicholas and his family. The episodes do not form a complete history but are thought key from a practice perspective and summarise the significant professional involvements that informed the review.

Key Practice Episodes
Pre-Birth Assessment
Management of Child in Need
Professional Management and Response to the Scalding Incident
Professional Response to potential Domestic Abuse

Professional Management and Response to Mum's Suicidal Ideations.

Consideration of the key practice episodes highlighted principal issues and the following questions were formulated to guide the development of an action plan which will address the learning:

6.1. Key Practice Episode 1
Pre-Birth Assessment

6.1.1. In November 2017 Sarah was contacted by a Social Worker from the Multi-Agency Safeguarding Hub in the Local Authority where she had previously been living due to concerns regarding missed midwifery appointments.

6.1.2. Sarah informed that she had moved and was now staying between her mother's address in Salford and a hostel in Eccles. Consequently, following a telephone call with a Salford Children's Social Worker at the Bridge[7], the Multi-Agency Safeguarding Hub Social Worker emailed a Pre-Birth Assessment[8] to Salford that they had previously completed.

6.1.3. It has not been possible to locate or confirm whether the Bridge received the email but given that there were concerns for Sarah and unborn Nicholas, best practice would have seen a transfer meeting between the previous Local Authority and Salford.

6.1.4. On the 4th of December 2017 Sarah contacted the NHS 111 Service for advice and reported that she had missed her 20-week scan, was not registered with a GP, and was living in temporary accommodation. As a result, the Ambulance Service sent a Welfare Notice to the Adult Contact Team[9] reporting the concerns and Sarah attended hospital.

6.1.5. An Adult's Social Worker at the Contact Centre spoke to Sarah on the phone and with Sarah's consent subsequently referred Sarah to Children's Social Care.

6.1.6. The Bridge screening Social Worker passed the referral for assessment, but a Social Worker was not allocated to Nicholas until the day after Nicholas had been born. Consequently, the opportunity to complete a Pre-Birth Assessment in Salford had passed.

6.1.7. Whilst good practice was demonstrated post Nicholas' birth by a midwife on the post-natal ward who contacted the hospital that Sarah had initially booked with to obtain their information, without a Pre-Birth Assessment, Salford did not gain a full understanding of Sarah's lived experience, mental health, unmet needs, or parenting capacity. Instead following Nicholas' birth, professional focus was on unstable environment and housing issues as detailed by the screening Social Worker at the Bridge who passed the referral for assessment.

Question 1 for Salford Safeguarding Children Partnership:
How can partner agencies assure Salford Safeguarding Children Partnership of a robust transfer of information policy to be used when a person presents in Salford with safeguarding concerns from out of area, and when a person with safeguarding concerns moves to another area.

[7] All reports or enquiries concerning the welfare or safety of a child in Salford go straight to the Bridge Partnership,
[8] The presenting concerns identified had included Sarah booking in late at 13 weeks and 5 days gestation, reporting low mood and anxiety, residing temporarily in her friend's flat (sharing her friend's daughter's bedroom), alcohol use during pregnancy, low Body Mass Index, limited finances, history of abuse from her father, not able to confirm baby's father (two possible fathers), and a limited support network.
[9] The adult social care contact team is a single-entry point to streamline social care.

Consideration needs to be had of a national, uniformed, transfer information policy, and this learning should be brought to the attention of the National Child Safeguarding Practice Review Panel.

6.1.8. *As an unborn and a new-born Nicholas was totally dependent on others for his care. In the womb Nicholas needed his development to be monitored by health professionals, and Sarah's physical and emotional health to be checked to ensure that he was protected from the effects of any maternal mental ill health, physical violence, or abuse towards his mother, and maternal substance misuse.*

6.1.9. *As a new-born Nicholas needed Sarah to respond quickly to his physical and emotional needs, interact with him and observe that he was always safe, warm, and fed. Sarah's own early experiences may have impacted her ability to do this – the initial Pre-Birth Assessment had already deemed that without support Sarah may be unable to meet Nicholas' needs. In the absence of professionals in Salford gaining an understanding of Sarah's parenting abilities, Nicholas was vulnerable.*

6.2. Key Practice Episode 2

Management of Child in Need

6.2.1. Nicholas was subject to a discharge planning meeting after his birth at the hospital. This was good practice as it provided an opportunity for Sarah and Nicholas' information and circumstances to be shared multi-agency. However, it was established by frontline workers attending the learning event that whilst Children's Social Care, the ward midwife, and the community midwife were present at the meeting, the Health Visitor – the professional who would be a constant in Nicholas' life from 10-14 days old until school age, was not invited.

6.2.2. This omission was discussed at the learning event, and it was thought that a Health Visitor's attendance at discharge planning meetings of new-born babies was not being deemed necessary as the midwife would be present. However, it would appear that there is a gap in information sharing and handover discussions when a case transfers from a midwife to a health visitor that in this case was widened with the omission of the Health Visitor being at the discharge planning meeting.

Question 2 for Salford Safeguarding Children Partnership:
How can Salford Safeguarding Children Partnership be assured around discharge processes and the flow of information from all maternity services that support Salford women?

6.2.3. An action from the discharge planning meeting was for Sarah to attend an appointment with a psychiatrist and records show that Sarah met with a psychiatrist from Pennine Care ante-natal clinic prior to her and Nicholas being discharged from the hospital.

6.2.4. Unfortunately, this review has been unable to locate original documentation regarding this appointment, but professionals have reflected that a multi-agency update from the psychiatrist could have assisted the planning of support that Sarah would need to parent safely and effectively.

6.2.5. This omission of information sharing should be explored by Pennine Care and deliberated to ensure that any safeguarding concerns are being reported.

6.2.6. Also, at the discharge planning meeting, a decision was made to support Nicholas under the auspice of Child in Need and a children and families assessment commenced.

6.2.7. There is evidence of good support being offered to Sarah at this time but overall, whilst Sarah's immediate issues were addressed, a lack of thorough exploration and curiosity into Sarah's past experiences resulted in professionals failing to gain any understanding of how Sarah's history could affect her current and future behaviours or parenting capacity.

6.2.8. It is important to explore and address trauma correctly because many individuals who are living with trauma continue to feel unsafe, anxious and struggle to trust others. Therefore, trauma is often a barrier to an individual feeling safe enough to trust a person who has the potential to help.

6.2.9. Priority work regarding trauma informed practice is set to continue for practitioners in Salford with further training, workshops and events, and the recruitment of Trauma Responsive Practitioners.

6.2.10. Analysis of the Child in Need process for this review has been hindered because there is no official record of the Child in Need meetings, plan and/or actions.

6.2.11. A plan should have been co-produced between professionals and Sarah, and should have ideally included:

- the desired outcomes,
- who will do what, how and by when to mitigate any risks to Nicholas,
- the nature and frequency of professional contact,
- the frequency of Child in Need meetings, and
- a contingency plan in case actions were delayed, not implemented or there was a change in circumstances.

6.2.12. This plan should then have been shared, in writing, with Sarah and the professionals involved. The effect of no written plan being shared should not be underestimated. Without it neither professionals nor Sarah would have been clear about what needed to be done. And it would not have been possible to accurately measure the impact of the intervention being completed with Sarah and Nicholas.

6.2.13. This review has been unable to confirm the frequency or number of meetings that convened but has been informed that the meetings were undertaken when the Health Visitor and the Social Worker conducted joint visits. They did not include any other professionals who were working with Sarah and Nicholas, and it has now been recognised that housing and the Early Help Practitioner could have been included.

6.2.14. In addition, consideration could have been to include Nicholas' grandmother in the Child in Need process as she was a person who supported Sarah, and Nicholas spent time at her address in her care.

6.2.15. The review has been reassured that this informal situation could not happen now; meetings can no longer go unrecorded owing to Liquidlogic[10] which has been used in Salford since August 2021.

6.2.16. Good support was offered to Sarah with housing issues during the children and families assessment and the Child in Need process. In March 2018 Sarah had secured a tenancy. The home is referred to as clean but sparse. The sparseness could have been an indication of Sarah's financial problems. Given the known relationship between poverty and neglect it would have been good practice to have undertaken a Graded Care Profile.

6.2.17. Ofsted inspected Salford Children's Social Care Services soon after Nicholas' case had been closed in 2018 and found that the local authority's neglect tool was not being consistently used to good effect by social workers or partner agencies.

6.2.18. Subsequently identifying and addressing the unmet needs of children became a priority for Salford Safeguarding Children Partnership and the current Neglect Strategy was revised. In March 2019 practitioners were updated about the tool in a multi-agency workshop. And the Welfare Rights and Debt Advice Service provided practitioners with awareness training on the relationship between poverty and neglect.

6.2.19. Neither the children and families assessment, or the Child in Need process explored Sarah and Nicholas' culture - this review has not seen any reference to any professional, who encountered Sarah and Nicholas, striving to understand their culture. Yet, understanding someone's culture can help you better empathise with them and consider whether any changes are needed to support packages to ensure that a service user is not put a disadvantage.

6.2.20. It is not possible for a professional to learn of every culture, but there are generic skills to competence, such as - open-minded awareness of the differences that cultural background can produce. This should be regardless of whether a person is foreign born, or born in the United Kingdom, and should not be influenced by how long a person has lived in the United Kingdom and/or has sought to integrate.

Question 3 for Salford Safeguarding Children Partnership:
How can partner agencies assure Salford Safeguarding Children Partnership that work is being undertaken to remind and encourage professionals to practice an open-minded awareness of the differences that cultural background can produce.

6.2.21. A better understanding of Sarah's cultural background may have offered some insight into her engagement with Social Workers and health appointments. For example, did Sarah's cultural beliefs influence her decision-making process around attending follow up appointments for her mental health. This is significant given that culture can significantly impact various aspects of mental

[10] The Liquidlogic Children's Social Care System is a case management solution and supports all aspects of social work with children. It has been specifically developed by and for practitioners to support case management and record-keeping for children in need, looked after children, adoption, and child protection cases, as quickly and simply as possible. Liquidlogic configures workflow and workers cannot move on to the next stage of a process without first completing the previous stage. Consequently, a meeting must always be created, in timescale.

health including the perception of health and illness, treatment seeking behaviours and coping styles.

6.2.22. All professionals must be sensitive to the risk of intercultural misinterpretation in health and social care.

6.2.23. This review has established that information that was shared during the Child in Need intervention, was not always appropriately acted upon. On the 3rd of May 2018 an Early Help Practitioner undertook an unannounced visit, and the door was answered by a male who introduced himself as Nicholas' uncle. He said that Sarah was 'working away', and he was caring for Nicholas. The case worker asked the uncle why he wasn't in school, and he responded that school was shut. The case worker has reflected that at this point, given that Nicholas would have been just under 13 weeks of age and the uncle, 11 years old at this time, she could have demonstrated further professional curiosity and asked more questions of uncle about how often he cared for Nicholas, for how long, and why. But it was good practice that the worker logged the incident in supervision and that the concerns were then raised with Nicholas' Social Worker and Health Visitor.

6.2.24. The Social Worker spoke with Sarah the following day (when Sarah cancelled a Child in Need joint visit), but the issue was not addressed - it is possible that the Social Worker was not aware by this time. Following this, Sarah changed her telephone number and did not have any further contact with the Social Worker until the 17th of May 2018. There is nothing to evidence that the uncle caring for Nicholas was discussed on this occasion either.

6.2.25. The final decision to close Child in Need appears to have been made upon Sarah returning to the United Kingdom, when in August 2018, following a meeting between Sarah, the Social Worker and the Health Visitor, Sarah said she no longer felt as if she needed support. Whilst it is acknowledged that in the absence of child protection concerns, if a parent does not want to engage with services, there is little than can be done, no further multi-disciplinary discussion was had regarding closing Nicholas' case.

6.2.26. The other services involved with Nicholas were the housing association, the GP Practice, Greater Manchester Mental Health Primary Care, and practitioners from Early Help. Early Help were informed by email on the 17th of July 2018 that the family was to be closed to Children's Social Care and support would revert to Universal Services. The other services were not consulted or informed.

Question 4 for Salford Safeguarding Children Partnership:
How can Children's Social Care assure Salford Safeguarding Children Partnership that Child in Need processes are being followed and managed, and how can all partner agencies assure Salford Safeguarding Children Partnership that professionals from all agencies know when and how to escalate any concerns?

6.2.27. All professionals at the learning events for this case demonstrated a good theoretical understanding of professional curiosity. Yet it was not always recognised in practice around Sarah

and Nicholas. Had the professionals involved with Sarah and Nicholas demonstrated more professional curiosity there could have been more information fed into the Child in Need process.

6.2.28. For example, a lack of professional curiosity on the part of the housing officers involved, resulted in no contact being made with the Social Worker to seek more information once they knew a Social Worker was involved.

6.2.29. More professional curiosity to explore Sarah's finances by all professionals involved, could have ensured that she was being offered effective debt advice and money management advice as part of a multi-agency approach. It may also have encouraged Sarah to disclose other things as part of the conversations. For example, any potential exploitation[11] she was being subject to, and/or any substance abuse that was draining finances.

6.2.30. Continuous professional curiosity is an important skill that all professionals must develop.

6.2.31. *In his first few months, Nicholas was settling well into a routine. He was presenting as content and calm when seen by professionals but over time his contact with professionals decreased as his mum was not always available to present him for appointments.*

6.2.32. *Nicholas who had bonded well with Sarah, wasn't able to be with his mum for a period when he was only 5 months old. He had already lived in four houses since his birth, and he now found himself in the care of a friend of his mums at another house.*

6.2.33. *It was good that Nicholas was getting to know his extended family but sometimes he was left alone in the care of his uncle which wasn't safe as his uncle was a child himself. This put Nicholas at risk of injury to inadequate supervision.*

6.3. Key Practice Episode 3

Professional Management and Response to the Scalding Incident

6.3.1. In July 2018 Nicholas was brought to the Accident and Emergency Department at North Manchester General Hospital by his grandparents after he had sustained scalds from a hot shower.

6.3.2. The hospital referred Nicholas to Children's Social Care and Nicholas was transferred to Royal Manchester Children's Hospital specialist burns unit.

6.3.3. The consultant at the burns unit deemed the injury to be consistent with grandma's explanation (Grandma's initial explanation had appeared inconsistent but further exploration explained the irregularities) and to be accidental.

6.3.4. The Royal Manchester Children's Hospital did not make any referrals because the Consultant discussed his expert opinion with Children's Social Care, and it was agreed that a section 47 was not necessary.

[11] Trafficking was raised as a concern for Sarah at the Discharge Planning Meeting, but this review has been unable to establish how the concern arose and it was not explored in any subsequent assessment.

6.3.5. Practitioners at the learning event were concerned that this decision deviated from the Bruising Protocol for Immobile Babies and Children[12] which includes burns and scalds. But consideration of the protocol exposes that it is acceptable not to refer. However, the reason must be documented in detail alongside the names of the professionals taking this decision.

6.3.6. Such practice has recently been supported by government advisors who, although they have not reiterated that scalding should be included, have said that pre-mobile infant bruising should not automatically prompt section 47s[13]. The Child Safeguarding Practice Review Panel said it did not support policies that required section 47s or other interventions "without an initial appraisal of the circumstances of the presentation".

6.3.7. Instead, it proposed that there should be:

- a review by a health professional with appropriate expertise to assess the nature and presentation of the bruise and any associated injuries, and whether there is any evidence of a medical condition that could have caused or contributed to the bruising, or a plausible explanation for the bruising; and
- a multi-agency discussion, always including the health professional who examined the child, to consider any other information on the child and family, including known risks, and to jointly decide whether any further assessment, investigation or action is needed to support the family or protect the child.

6.3.8. The only multi-agency discussion regarding Nicholas was between the consultant and Children's Social Care. A multi-agency discussion involving other professionals who knew Nicholas and his family was not convened. But given the concerns that were known at this time regarding the problems engaging consistently with Sarah, and the history of Nicholas not being taken to scheduled health appointments, would have been beneficial to assess Nicholas' situation and on-going support.

6.3.9. Such a meeting would not have been convening to establish 'blame' for Nicholas' injury but for professionals to discuss how best Sarah and the family could be helped to keep Nicholas safe and to care for his injuries. It would have also offered an opportunity to discuss multi-agency whether given the incident, Child in Need should remain open for a further period.

6.3.10. This review has been assured that such meetings are now convening.

6.3.11. *Nicholas, at 6/7 months old was unable to verbalise his pain after the scalding injury. Following his discharge from hospital Nicholas was fully dependent upon Sarah and the other adults in his life, to care for his wounds and to present him at appointments for professional scrutiny. Good care of the burns was crucial. The skin would have taken many months to heal completely and left permanent scarring.*

6.3.12. *The psychological impact of the incident on Nicholas cannot be measured or understood.*

6.4. Key Practice Episode 4

Professional Response to potential Domestic Abuse

[12] 5.2.3 Bruising Protocol for Immobile Babies and Children (proceduresonline.com)
[13] Bruising in non-mobile infants (publishing.service.gov.uk)

6.4.1. In November 2017 Council Housing Services became aware during a homelessness assessment that Sarah had been a victim of stalking where she had previously lived. As mentioned, housing was not part of the Child in Need process, and partly as a result, no housing information was shared with other agencies. There was a missed opportunity to share this information when the Social Worker contacted housing by email at the end of January 2018.

6.4.2. Sarah was victim of blackmail in 2019 when she reported that someone was blackmailing her and threatening to post inappropriate photographs on social media. This incident was dealt with by Police from a different force as it was related to Sarah's ex-partner and his new girlfriend who did not live in Salford.

6.4.3. It is unclear whether this was considered in the context of domestic abuse or exploitation in the context of Sarah's extensive movements across the United Kingdom and overseas.

6.4.4. The next domestic abuse incident reported was in Salford on the 27th of November 2021. (This was the first reported incident in Salford since Sarah had been a child and two incidents had been reported between her and her mother.) On this occasion Sarah had an altercation with, and alleged that she was pushed by, her ex-partner who appeared to have a caring role in relation to Nicholas. Sarah had called at her ex-partner's house to collect Nicholas, but he had refused to allow her to take Nicholas home. This crime was assessed as standard risk.

6.4.5. This incident was not shared with Children's Social Care. Greater Manchester Police have confirmed that the criteria were not met as this was the first reported crime that Nicholas was linked to and was standard risk. Had this been the third incident at standard risk that Nicholas had been linked to, then it would have been referred.

6.4.6. However, expected practice should have seen an Operation Encompass notification being sent to the Health Visitor following this incident which would have provided the opportunity for the Health Visitor to explore the incident with Sarah and Nicholas further.

6.4.7. This review has been assured that the Greater Manchester Police Public Protection Governance Unit are currently developing training programmes to address the referral processes made by Greater Manchester Police to external agencies and the details of this review will be brought to their attention for the omission of the Operation Encompass notification to be addressed.

6.4.8. Later in February 2022 Sarah disclosed during an appointment with a mental health practitioner that she had always been 'looked after' by the men she had been in relationships with, and she had wanted for nothing. There is no evidence of these comments being explored in the potential context of domestic abuse, coercive relationships, and exploitation. There was a missed opportunity here to see Sarah alone (she presented with a friend) and explore her understanding of abuse. There was also a missed opportunity to contact the Health Visitor to share this information and the potential to check Nicholas was safe and well.

6.4.9. In the absence of the incidents/disclosures being shared multi-agency, the full picture as penned in this section of the report went unrecognised by the professionals working with Sarah and Nicholas.

6.4.10. *Nicholas was too young to tell anyone of any physical or verbal arguments he had seen or heard people have with his mum. He was unable to verbalise if he had been scared or if anyone visiting his mum had been verbally or physically violent towards him.*

6.4.11. *The males spending time in Nicholas' home with him, and his mum, remain unknown. Any potential risk they posed was unchecked.*

6.5. Key Practice Episode 5

Professional Management and Response to Mum's Suicidal Ideations

6.5.1. On the 22nd of February 2022 Sarah attended her GP Practice distressed and suicidal. Because the surgery did not have the capacity to review Sarah there and then, the practice contacted 999.

6.5.2. Sarah also called 999 herself. Sarah reported that she could not keep herself safe and wanted to jump off a building. She said that she wasn't a good mum and couldn't provide for her child. The clinician asked Sarah who was caring for Nicholas, and she advised that he was with his maternal grandmother.

6.5.3. The circumstances were deemed to be low risk. Sarah had told the clinician that she was not going to take any action, that Nicholas was safe with a relative and that Sarah was being supported by a friend.

6.5.4. The ambulance service sent a Welfare Notice to Adult Social Care reporting that Sarah had been taken to Salford Royal Hospital feeling suicidal regarding financial difficulties. It was acknowledged at the learning event that the ambulance service should also have sent a referral to Children's Social Care. The Clinician has since reflected that they considered that by raising a safeguarding concern for Sarah, the information would also be shared across to Children's Social Care. Feedback has now been given explaining that this is not the process and that a separate concern should have been raised for Nicholas in this situation.

6.5.5. The next service to learn of Sarah's suicidal ideations was the Emergency Department at the hospital. Professionals at the learning event discussed how this was a missed opportunity to further explore who was caring for Nicholas and to make a referral to Children's Social Care for assessment and support. The review has been informed that this is a process already embedded into training and therefore needs to be reinforced with staff. The review has been unable to establish the rationale as to why this was not done directly from the practitioners involved.

6.5.6. Sarah was then reviewed by the Mental Health Team at the hospital who discharged Sarah back to the care of her GP with a request to prescribe an antidepressant. Professionals at the learning event identified that the Mental Health team could have referred Sarah to Children's and Adult's Social Care given that she had disclosed during their consultation, having a child, experience of potentially controlling relationships, and having no heating, money, or food.

6.5.7. An internal three-day review undertaken by Greater Manchester Mental Health Safeguarding team identified the same and consequently held a reflective session with the practitioners involved and a learning event with the whole team in July 2022. The sessions raised the awareness of practitioners to recognise neglect and vulnerability, and safeguarding concerns when there is no immediate risk to either the patient or others.

6.5.8. Upon receipt of the ambulance referral, Children's Social Care were not notified. Practice should have seen a Social Worker at Adult Social Care, upon receiving the ambulance welfare notice - which noted concerns relating to Sarah's mental health and outlined that Sarah had a young child, sharing the information relating to the hospital attendance with Children's Social Care.

Question 5 for Salford Safeguarding Children Partnership:
How can Adult Social Care assure Salford Safeguarding Children Partnership that practitioners are aware that if an adult referred to Adult Social Care has a child; best practice is to liaise with Children's Social Care?

6.5.9. *Nicholas was four years old when Sarah reported experiencing suicidal ideations. Because his home was cold and there wasn't much food available, he and his mum went to stay in another house with a friend of his mums. Nicholas' mum was different to how she usually was. Nicholas could see that she was sad. Nicholas was sometimes taken to his grandma's house when his mum was very sad. Nicholas couldn't understand.*

7. Other Considerations

7.1. Drowning

7.1.1. There are concerns around the number of recent deaths due to drowning in the Greater Manchester area. Nicholas' case is different due to his age – professionals expected that a four-year-old child would be able to get out of the bath and alert family if he was distressed.

7.1.2. Work is ongoing in Salford by partners in relation to safeguarding babies and older children and water safety in and out of the home.

7.1.3. The number of incidents must be brought to the attention of the National Children's Safeguarding Practice Review Panel to assess whether this is a national interest.

7.2. The Effects of the Covid pandemic on the support offered to Nicholas

7.2.1. In November 2019 Nicholas was seen by the GP regarding a keloid scar. The following month, in December 2019 a coronavirus emerged which was swiftly labelled a pandemic. Every country was advised to take urgent action, and major disruption followed. In order to manage the impact of the virus and infection control, several adaptations to working practices had to be made and the United Kingdom Prime Minister announced a national lockdown on the 23rd of March 2020.

7.2.2. A month after the lockdown had begun, Sarah notified the housing association that she and Nicholas were stuck abroad with family and would have to remain there until flights to the United Kingdom resumed. It has not been possible to confirm the exact date that the family flew out of the United Kingdom.

7.2.3. The main effect of the Covid pandemic on Nicholas was that he went unseen by professionals in the United Kingdom for almost two years and during this time his health and education needs went unmet (in the United Kingdom).

8. Good Practice

The agency reports submitted to this review and the discussions around Nicholas, have highlighted examples of good practice[14] from professionals involved with her and her family. Including:

- There was good practice from the midwife on the post-natal ward who contacted the hospital where Sarah had initially booked to obtain information in relation to Sarah's antenatal care and did re-refer the case to Social Care.

- Northern Care Alliance records indicate regular contact between the Health Visitor and the Social Worker with both committed to keeping track of Sarah's whereabouts and both engaging in work with Sarah to support her in improving Nicholas' home circumstances.

- The Health Visitor was persistent in her attempts to contact Sarah

- Good practice of 111 to inform Adult Social Care of concerns of a possible vulnerable mother in December 2017.

- Adult Social Care displayed good practice in December 2017 by consulting with Sarah before closing the case, after ensuring that appropriate services were in place to support her.

- Nicholas was not registered at the GP Practice, albeit Sarah was, so it was good practice the surgery had offered to support him with his immunisation schedule despite not being a registered patient.

- Early Help Practitioners used all methods of communication to engage with Sarah, these included telephone, text, email, and unannounced visits. Updates were exchanged with the Social worker and Health Visitor.

9. Improving Systems and Practice

9.1. Developments Since the Scoping Period of the Review

Agencies have already made some important amendments to practice since the scoping period of this review. Some have been included in the body of this report. Other developments include:

9.1.1. Early Help involvement with Nicholas, crossed over a period of service re-structure. The practitioners allocated at the time had a focus in children aged 0-5 years, were not expected to complete an assessment and were intervention led only. This has now changed, and all Early Help Practitioners follow the new workflow including Early Help assessment for any request made for support. 4 weekly case supervisions are embedded and a clear escalation process in place. Also, at the time of the involvement, there were no clear expectations on 'child seen'. This has now changed as part of the Early Help service redesign and a clear 'child seen' guidance document has been created to support practice. Expectations are clear as to how often a child is seen, how their voice is captured and how this is recorded and discussed in case supervision, assessment, and reviews. Training and support is in place on a weekly basis on how practitioners can capture and record the voice of the child.

9.1.2. Manchester Foundation Trust have since reviewed and updated their own policies on Preventing and Managing Missed Health Appointments for Children and Young People (including unborn babies) and Adults at Risk of Abuse

[14] Good practice in this report includes both expected practice and what is done beyond what is expected.

9.2. Conclusion

9.2.1. Sarah's information was not effectively transferred from the Local Authority where she previously lived, to Salford during the Pre-Birth period. This led to Salford not having a full understanding of Sarah's parenting capacity and/or the potential risks to Nicholas stemming from Sarah's past experiences, mental health, and behaviours. Consequently, following Nicholas' birth, professional focus was on practical support and addressing an unstable environment and housing.

9.2.2. In January 2018 Nicholas was subject of a children and families assessment. There was a missed opportunity during this assessment process to start from Sarah's beginning and explore Sarah's and Nicholas' ethnicity and cultural background. Although not immediately obvious to professionals working with Sarah and Nicholas, this was significant, as a better understanding of Sarah's cultural background may have offered insight into Sarah's interpretation of support services, health interventions, abusive behaviours, and parenting. This would have helped professionals to tailor a support plan specific to Nicholas' needs, with Sarah's full co-operation.

9.2.3. An overall lack of thorough exploration and professional curiosity into Sarah's past experiences as a child, and an adult, resulted in professionals failing to gain any understanding of how Sarah's history could affect her current and future behaviours or parenting capacity.

9.2.4. The Child in Need process was poorly documented but reflection of the process with professionals has evidenced that not all the professionals working around Sarah and Nicholas were involved. Consequently, information was not effectively shared multi-agency. In addition, there is no official record of the Child in Need plan. It was not shared in writing with Sarah, or the professionals involved and without it neither professionals nor Sarah understood what needed to be done or were able to measure the impact of intervention.

9.2.5. Sarah often reported being away from home and consequently due to subsequent cancelled appointments and no access visits, Nicholas was seen less often. This made it increasingly difficult for professionals to gain an understanding of his lived experiences. This was further hindered because throughout the scoping period of this review, his information was not always shared effectively. Notably there was a missed opportunity to discuss Nicholas multi-agency when Nicholas suffered scalding.

9.2.6. When Nicholas was reportedly out of the country, he was totally hidden from professionals in the United Kingdom. Closing his Child in Need case further removed him from professional eyes.

9.2.7. Post Nicholas being closed to Children's Social Care, Children's Social Care should have been made aware when, in February 2022, Sarah experienced suicidal ideations. The omission of this communication prevented services being able to fully assess any potential risk to Nicholas at this time and understand how it was for him when his mum was unwell.

Appendix 1 - Terms of Reference

The panel agreed the following terms of reference:

1. How well did professionals understand the ethnicity and cultural background of the family?

2. What did professionals understand about mother's lived experience as a child and adult respectively and to what extent did this impact on her ability to parent? (Include alcohol, substances, Domestic Violence)

3. To what extent did professionals understand the Nicholas' lived experience, the relationships between the family members and significant others (what role did the extended family members play in Nicholas' life)?

4. How effective was information sharing across borders during the Pre-Birth Assessment period? How did this impact on the offer of support available to the mother when she moved to Salford?

5. How effective was safeguarding practice in Salford? (Focus on Pre-Birth Assessment period, Children and families assessment, Child Protection Processes in relation to the scalding incident in July 2018).

6. To what extent did agencies support the mother to engage with services? Did professionals understand the barriers to engagement at that time? Explore the escalation policies

7. Was Nicholas a hidden child to services given that he was not supported at a statutory threshold?

8. To what extent did the COVID-19 pandemic impact on multi-agency safeguarding practice?