



Combined Serious Case Review and
NHS England Mental Health Homicide Review
Re Child D

An Independent Review undertaken on behalf of
Stockport Safeguarding Children Board
and
NHS England

Contents Page

1	Introduction	1
2	Family Perspectives	5
3	Background and family history	8
4	Chronology of significant events	9
5	Review of children social care engagement with the family	12
6	Review of health visiting engagement with the family	18
7	Review of midwifery engagement with the family	20
8	Review of the National Probation Service and the Community Rehabilitation Company engagement with the family	22
9	Review of Greater Manchester Police engagement with the family	24
10	Review of GP's engagement with the family	27
11	Review of mental health service engagement with the father	29
12	Multi- agency analysis and learning	43
	Appendices	
	a. Framework for Review	48
	b. TOR for NHS Review	55
	c. Biographies	57
	d. Glossary	58

Introduction

1.1. On Wednesday 29th July 2015, following a 999 call from the father, Child D was taken to the local hospital and pronounced dead on arrival. The Child had sustained non-accidental injuries; the father was arrested and subsequently convicted of murder.

1.2. The circumstances were such that consideration needed to be given to both the serious case review¹ and the Mental Health Homicide Review² criteria. The approach taken to this review delivers the combined requirements of a serious case review and the National Serious Incident framework². The Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005 has now been superseded by the Serious Incident Framework but the principles of an independent investigation remain the same. The framework for this review and the terms of reference for the Mental Health Review are given in full in Appendices A and B.

1.3. The Chair of Stockport Safeguarding Children Board took the decision to convene a serious case review in Sept 2015 and commissioned an independent author. NHS England, North Region commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, in order to carry out an independent review into the care and treatment of the Child D's father. The Verita team authored Chapter 11 of this report.

1.4. A serious case review considers multi-agency working and reviews practice in order to identify learning and contribute to improvement. The purpose of the independent mental health review is to discover what led to an adverse event and to audit the standard of care provided to the individual. While the reviews may not identify root causes or find aspects of the provision of healthcare or multi-agency practice that directly caused an incident, they will often find things that could have been done better.

1.5. The findings from both reviews have been combined into this single report. The criminal investigation into the circumstances of Child D's death following the death in July 2015 and subsequent court proceedings has been concluded. A coroner's inquest is on-going.

Approach

¹ Working Together to Safeguard Children 2015

² Mental Health Homicide Reviews <https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incident-framework-upd2.pdf>

1.6. The combined team consisted of Jane Booth, Independent Social Care Consultant; Chris Brougham, Director of Verita; Gemma Caprio, Senior Consultant; and Dr Mostafa Mohanna, Consultant Psychiatrist. Dr Mohanna provided expert advice and undertook a review of Child D father's clinical records. From now on the review team will be referred to as 'we'. Our biographies are at Appendix C.

1.7. The time span covered by the review was of a period where the father was mostly living with the mother in Stockport, but in addition to a summary of local agency involvement with the family, we also received information about the father's engagement with the Cheshire and Wirral Partnership NHS Trust, MerseyCare NHS Trust and Liverpool Children's Social Care. A chronology of significant events was provided, as was a copy of the Pennine Care NHS Foundation Trust, Mental Health internal report.

1.8. The Verita team reviewed documentary evidence including:

- National guidance;
- Pennine Care NHS Foundation Trust policies and procedures;
- Child D's father's clinical records.

1.9. We jointly interviewed practitioners from relevant agencies:

- 3 social workers from Stockport Metropolitan Borough Council (SMBC) children's social care ;
- A team manager from SMBC children's social care;
- An independent reviewing officer from SMBC safeguarding children unit who had previously been the team manager;
- A General Practitioner (GP);
- 3 police officers from Greater Manchester Police;
- A probation officer from the National Probation Service;
- 3 midwives and an assistant midwife from Stockport NHS Foundation Trust ;
- A health visitor and health visiting manager from Stockport NHS Foundation Trust ;
- A care co-ordinator from the Pennine Care Foundation Trust Community Mental Health Team;
- A mental health practitioner from the Pennine Care Foundation Trust Home Treatment Team;

1.10. In addition, we met with the child's mother, father and maternal grandmother. We wish to acknowledge the contribution they have made and appreciate that sharing their experience of multi-agency working with us in such distressing circumstances was not easy. Their views are summarised in section two of this report.

1.11 The Verita Team also quality assured the Pennine Care Foundation Trust Mental Health internal investigation report. The team only interviewed staff if the

information could not be identified from the report or any transcripts. The Verita team also analysed issues that were considered not adequately addressed by Pennine Care NHS Foundation Trust internal investigation team.

1.12 As part of the Serious case review process we were specifically asked to address the following:

- The quality and robustness of assessments completed;
- Information sharing and the effectiveness of communication pathways and timeliness, particularly with mental health services;
- The effectiveness of team around the child meetings in effectively coordinating services for the family;
- Discharge planning from hospital to include 'did not attend' appointments, monitoring of medication and support;
- The role of 'tolerance' in managing cases;
- The role of manager supervision;
- Diagnoses of mental health - the extent to which the impact of mental health has an effect on parenting.

Predictability and Preventability

1.13 In the course of this review we have considered whether Child D's death was predictable and or preventable.

1.14 We have used a test,³ based on Verita's established test developed in conjunction with Capsticks legal firm, which considers that a homicide would have been predictable if there was evidence from the perpetrator's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

1.15 Similarly, a homicide would have been considered preventable if there was evidence that professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but did not take the steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done to prevent any tragedy.

1.16 In her pre-sentence report in April 2015, the National Probation Service pre-sentence report author made a clear assessment of risk. She reflected on the father's history, previous convictions and the circumstances which appeared to lead to a risk of future outbursts. She described his behaviour to have been at times "potentially dangerous, risk taking, reckless anti-social behaviour in order to put his own needs over the welfare and safety of victims". She concluded that these were linked to the father's inability to manage his emotional well-being, thinking and behaviour following an altercation of some kind. It is not clear to what extent this analysis was known by other professionals and there is no reference to it in the subsequent social work assessment.

³ Based on Verita's established test developed in Conjunction with Capsticks legal firm.

1.17 The offences referred to in the pre-sentence report took place when the father was reportedly keeping his appointments and taking his medication – both seen as protective factors. The pre-sentence report author had recommended a community sentence during which a programme of work was planned to address the issues identified, but the Court did not accept the recommendation and the outcome of the case was a discharge. Consequently the work did not take place. This meant the underlying issues were not addressed and in these circumstances, it would seem that the likelihood of further outbursts of violent behaviour could reasonably be expected.

1.18 There was however no evidence from the father's words or actions at the time that could have alerted professionals to a specific risk to his child or that he might be at risk of becoming violent imminently. Professionals were working with the family under the team around the child process. While this does not have the formal rigour of the child protection system, the reality of contact with the family is unlikely to have been any different if the child protection process had been in place.

1.19 There was no evidence in the father's behaviour as a parent, which would have justified taking legal proceedings and either removing him from contact with the child or taking the child into care. It is more likely that a fuller understanding of the risk would have led to a child protection plan but the child would have still been in the full-time care of both parents.

1.20 While further outbursts of non-specific violent behaviour may have been predictable on the basis of past behaviour, a specific threat to the child was not predictable and therefore not preventable.

1.21 While this report has identified a number of areas where practice could be improved, it has also found some examples of good practice:

- The mother's GP recognised her vulnerability and flagged both her record and that of her child in respect of risk of domestic abuse.
- The social worker made a number of visits jointly with other professionals.
- The father was seen by the forensic medical examiner when in custody and given helpline information prior to release.
- The pre-sentence report author recommended a further period of supervision despite a relatively minor offence as she was concerned that the original issues of risk had not been addressed due to the father's non-compliance.
- All bar one professional reported they had good access to supervision and support in managing child protection cases.

1.22 Recommendations are made where necessary.

2 Family Perspectives

2.1 During the course of this review we met with the mother, the father and maternal grandmother of Child D to discuss their experience of working with the agencies.

2.2 The child's mother told us that she felt that she had to some extent been pressured into accepting involvement with services via the Common Assessment Framework (CAF) because of her history as a care leaver⁴. She was fearful of criticism and concerned that if she did not comply her child might be removed. Nonetheless, she told us she had felt well supported by the social worker who completed the pre-birth assessment and felt that he acknowledged the parents' strengths, but was frank about consequences if things did not go as planned.

2.3 She described how her relationship with the father had developed and how concerns about his history were shared with her. She described the support she received after his assault on her in April 2014, and how children's social care had supported her in getting a restraining order. She did not confirm the father's statement that he had returned to the family home in the late summer of 2014 and that they hid this from agencies.

2.4 The mother had relatively little involvement with the mental health services, but felt that the father was not given enough access to counselling nor sufficient opportunity to talk about the issues he had about his own father's death. Although she was administering his medication, she received no advice as a carer. She told us she was not involved in any mental health risk assessment and felt that relevant information was not shared with her. She acknowledged that to an extent she had not wanted to get involved, and preferred the father to deal with his mental health issues without her needing to be included. At times she felt out of her depth and unsafe.

2.5 Following the incident where the father was arrested and charged with breach of the restraining order, she describes being confused by the police decision to bail him to her mother's address a few doors from her home. She feels the police should have discussed this decision with the family.

2.6 The mother did not think the common assessment framework and team around the child process was necessary, but accepted this when expecting her first child for fear of the consequences of not doing so. She did understand why a risk assessment needed to be done when the father wanted to return to the household during the period when the restraining order was in place. With hindsight she feels let down. She feels that it was unrealistic to expect she would recognise a risk that was not seen by the professionals. While the mother had a generally good relationship with the health visitor, she sometimes found the meetings difficult and when the issues about rough handling and safe sleeping practices were raised in the team around the child meeting she felt criticised. She did not feel the issues of concern should have been brought up and she felt they were not justified.

2.7 The maternal grandmother told us that, although she provided support to her daughter, and for a period offered accommodation to the father, she felt relevant information had not been shared with her. When concerns were first raised about the father's history she told us that she was not given detail, and she feels she should

⁴ See Glossary for Care Leaver

have been in order to offer support to her daughter. She feels her daughter was well able to care for her children and only needed agencies to be involved when the father became part of her household.

2.8 She felt the father should have had more access to a psychiatrist and that he knew when he was unwell and had asked for help. Nonetheless, she told us the social worker would ask from time to time how she felt the couple were doing, and she was always able to be positive. She was aware of the concern expressed by the midwife about rough handling of the first child and felt it was unfair. Her own observations at the time were that the father would never do anything to harm the child.

2.9 Following the arrest for the breach of the restraining order, the maternal grandmother told us that she had no contact from the police about the fathers' bail conditions despite it being a requirement for him to live at her address. Although police procedures require contact to be made, she states that this did not happen and he informed her of the condition when he had been released and given transport back to the address. Contrary to the father's account she states that the requirement was complied with and that he spent a lot of time in the house. She observed him to be agitated and unwell much of the time, and does not feel he was getting the treatment he needed.

2.10 The father told us he felt he had been let down by the agencies from as far back as when he was living Liverpool. He stated that he had been refused support because of a serious drug habit and that this had resulted in him becoming homeless. He felt he had benefitted from engagement with a support worker in Liverpool who met with him fortnightly and involved him in activities such as cycling and walking. He had hoped this support might be available in Stockport, but it was not. He felt he should have been offered more support when his father died in 2013 and that arrangements for transfer of his care, when he moved to Stockport, were not good.

2.11 There was a period when he moved to several different addresses and found difficulty getting his medication. He recounted being "in a bad way" at the mother's and he registered with a GP who made a referral to local mental health services. He told us he wanted, but was never offered, counselling. He told us that he had stopped taking drugs by simply withdrawing and with some encouragement from his father. He told us that in the months prior to Child D's death; he had been spending time upstairs alone and had been shoplifting alcohol so that he could drink without his partner knowing. Apart from one conversation with the GP the issue of alcohol had not been discussed with professionals.

2.12 The father shared the mother's view of the positive support offered by the social worker who completed the pre-birth assessment, but felt he could not be open with him when he felt his mental health was deteriorating. He said his experience in Liverpool had left him with difficulties in trusting professionals. He reflected on the issue raised by the midwife at the team around the child meeting and said her concerns were not justified. He said he did not have a good relationship with the health visitor and felt she was criticising and patronising him.

2.13 The father told us that he knew when he was unwell and just wanted help which he feels he did not receive.

3 Background and Family History

3.1 Child D's mother has a long history of involvement with children's social care and is reported to have had a "difficult childhood" from quite an early age, resulting in concerns about emotional and behavioural development. A number of adverse childhood experiences are recorded and, along with her siblings, she was subject of a child protection plan and became "looked after". She remained in care until she reached adulthood. She was supported with the transition from foster care to independent living, but did visit her GP during this period with symptoms of anxiety and depression.

3.2 Child D's father was brought up in a different area and does not appear to have had significant involvement with children's services as a child. He was known to mental health services, having been transferred into adult mental health services from the Child and Adolescent Mental Health Service in 2009. The history in respect of his mental health is set out in detail in Section 11 of this report. Records refer to an extensive history of anti-social behaviour, a history of assaults, setting fires, and many episodes of self-harm and threats of violence to others. He came to the attention of children social care in 2010 when aged 18. He was at the time living with his parents and a nephew, aged 9 years. Initial concerns involved an incident of "inappropriate physical chastisement" of his nephew. Although there was no prosecution in respect of this incident, concerns relating to the potential risk he posed to the nephew contributed to the decision by the local authority to remove the child into care.

3.3 A number of incidents of concern are recorded between 2010 and 2012 and records refer to a prior diagnosis of bi-polar disorder and attention deficit hyperactivity disorder. During this period Child D's father states he was drinking heavily and had a serious addiction to illegal drugs.

3.4 The couple commenced an online relationship in 2010. Both describe becoming good friends before they had even met. This progressed to an "in person" relationship around May 2013. The couple had two children together.

4. Chronology of Significant Events

4.1 The couple's first child was born in March 2014. During the pregnancy children's social care records indicate that there was an incident of domestic abuse which was not reported to the police. Following the birth of the first child there was a second incident. Child D's father phoned the police alleging he had been assaulted by Child D's mother. The outcome, however was that there was evidence of assault on Child D's mother and he was convicted of assault. He left the family home and a restraining order was put in place. An assessment was completed by children's social care and the case closed to children's social care as the couple were no longer living together. The health visitor agreed to co-ordinate future support as lead professional. Child D's mother was informed that, in view of the previous domestic abuse and history of concerns in Liverpool, children's social care would have significant concerns if she were to resume her relationship with the father.

4.2 Child D's father was prosecuted for the offence of assault referred to in 4.1 above and made subject of a community sentence supervised by the Community Rehabilitation Company.

4.3 Over the few weeks following the separation, a number of referrals were received alleging that there were issues around the care of the couple's first child. These were investigated and not substantiated. Some were raised by the father. Other referrals were anonymous and Child D's mother believed these were also instigated by Child D's father. She stated he was also placing threats on Facebook but this was not seen to be the case when checked. Child D's father made approaches to children's social care seeking contact with his child. During this period the mother became anxious that her child might be removed into care.

4.4 Child D's father states that some time before October 2014 he moved back in with his partner and their daughter, although this is denied by the mother. Late October 2014 the health visitor observed the child's mother to have a black eye which was said to have resulted from an accident in the home. Shortly after this the paternal grandmother contacted the Community Rehabilitation Company. She had received a letter addressed to Child D's father giving final warning about non-compliance with the community order. She advised that he had returned to live with his previous partner and their child. She also reported that he had recently returned home with a broken finger, broken glasses and multiple bruises. The Community Rehabilitation Company informed children's social care and the police that they believed the father had returned to the family home. The father was arrested at the home for breach of the restraining order and bailed to live with the maternal grandmother, a few doors away from the family home.

4.5 In discussion with the family members they all appear to have been surprised by this but give different versions of what followed. Child D's father states that the police made no checks but accepted the address without question. The maternal grandmother says no checks were made with her but states he did stay there. The mother states she had been told he could not stay with her until a risk assessment had been completed and so did not; the father states he almost immediately returned to the family home.

4.6 The couple told the social worker that they wanted to live together and both wanted the restraining order removed. Child D's mother subsequently made an application to have the restraining order removed.

4.7 Child D's father appeared in court for the breach of the restraining order and received a conditional discharge. This was contrary to the recommendation of the National Probation Service's probation officer who had prepared a pre-sentence report for the court and recommended a further period of supervision. The reason for this recommendation was that the father had failed to engage with the planned work to address domestic abuse and the probation officer felt this should be re-attempted.

4.8 Child D's father confirmed to the social worker and the Community Rehabilitation Company's probation officer who was responsible for his supervision that he had been living at the family home for the previous 3 or 4 months, and a social work assessment was commenced. The mother however continued to deny this when she spoke to professionals, and the father also subsequently reverted to saying he was not living there (although he now says he was). The social work manager recorded in December 2014 that the assessment would likely lead to an initial child protection conference being called. A few days later the social worker was contacted by a member of the mental health crisis team, who reported that the father had sought support. The mental health practitioner also reported that he felt the father did not pose a risk if he accessed support and continued to take his medication.

4.9 When the assessment was complete the social worker recorded in the assessment record that there had been a discussion with an independent reviewing officer. Such a discussion is part of routine process. The independent reviewing officer is recorded as agreeing that the case should be managed as a team around the child case and a child protection conference would not be required, and that the team around the child should include health, children's social care and mental health professionals. A key issue was the understanding that the mental health professional did not feel Child D's father was a threat or a risk as long as he continued to access support and take his medication.

4.10 From January 2015 there were an increasing number of incidents involving the Child D's father's behaviour. A number of hospital attendances were also recorded and involved a number of different hospitals.

4.11 On the 1st January 2015 Child D's father was arrested for a breach of the restraining order and for brandishing a knife. The police record states that a friend had challenged the father as he knew he was not supposed to be living in the family home. The father later presented at the Accident and Emergency Department in Manchester with a stab wound to his arm. Later in January the mother was confirmed to be pregnant with Child D and a pre-birth assessment was commenced with regards the unborn child.

4.12 In March 2015 Child D's father attended the local hospital saying he was hearing voices and had been throwing things around the home. He was discharged

home and “cause for concern” notified to children’s social care. Two days later the father reported a burglary to the police, stating that his TV had been taken. He subsequently reported that it had been returned.

4.13 On 30th March 2015 Child D’s father was arrested for criminal damage. He had “jumped” in front of car causing damage to the windscreen. Although he later stated that he was attempting suicide, he denied he still felt suicidal to the officer who attended and was arrested for criminal damage. Although he had informed the police about his psychiatric history, no information was passed to other agencies. Two days later he went to the GP and recounted this event as an attempt at suicide. He was subsequently admitted to a psychiatric unit and remained there for three days. The social worker phoned the consultant psychiatrist after his discharge and it was confirmed the hospital had not been aware that a pre-birth assessment was in progress until then.

4.14 On 23rd April the health visitor discussed Child D’s father’s recent hospital admission and Child D’s mother told her she was pleased that he had gone to the hospital as she had not felt safe. The following day a 999 call was made from the house but on attendance no concerns were noted by the police.

4.15 During May and June records indicate that Child D’s father was in frequent contact with mental health services and reporting conflicting states of mind. At times he reported that he did not feel safe and needed to be in hospital, and at other times, sometimes within hours, reported things had settled down and he was fine. He referred to an escalation of hallucinations and was offered appointments on an urgent basis, but then did not always attend.

4.16 In mid-June Child D’s father was the victim of threats by a known offender and although he reported this to the police, he then refused to make a statement.

4.17 Child D was born mid-July and the father later reported that he had had an “out of body experience” at the time of the birth and had seen himself dropping the child. This was later related to the mental health practitioner in slightly different terms. A week later he said he was experiencing “fleeting hallucinations”.

4.18 During a post-natal visit the midwife recorded having seen Child D’s father handling the older child roughly. This information was shared at the next team around the child meeting and both parents were upset by this and denied this had happened in the way described. The health visitor also used the opportunity of the meeting to reiterate advice around not shaking babies, as the father had not been at home when this routine advice was given previously. Some members of the team around the child meeting felt that the father reacted negatively and clearly felt there was an implicit criticism of him.

4.19 The incident which resulted in the child’s death occurred the following day.

5. Review of Children's Social Care engagement with the Family

5.1 Child D's mother had been known to Stockport children's social care both as a child and as a care leaver. She had been in care from the age of thirteen and was noted to have suffered from depression and anxiety. Services were provided via a team around the child process when she became pregnant, though it is noted that the mother was not entirely welcoming of this approach and felt she was being discriminated against because of her history in care. She did however sign her consent for this process. The team around the child process was established with the health visitor as the lead professional, having been set up at the request of the leaving care social worker.

5.2 In mid-April 2014 children's social care received a referral concerning a potential risk posed by Child D's father as a result of a history of concern following what was described as inappropriate chastisement of his nephew. Appropriate enquiries were made and an assessment commenced. During the course of the assessment an incident of domestic abuse was reported and resulted in the child D's father leaving the family home and being charged with assault. He was subsequently convicted of the offence and made subject of a restraining order.

5.3 Enquiries are recorded as having identified "multiple risk factors" including information about an assault on Child D's father's nephew (a child), and in respect of his mental health history and drug use. The history included information that although his birth family had appeared to be cooperative and willing to ensure he did not have on-going contact with the nephew, these agreements were not kept and the child had been removed into care due to the level of risk. The assessment was completed mid-May 2014. The assessment concluded that as the father was no longer believed to be in contact with the family that no further action or support was required. It was noted that, should he return further children's social care involvement would be necessary.

5.4 During June and July 2014 there were a number of contacts between Child D's father and children's social care. He expressed concerns and made a number of allegations about the care of his child and was anxious to make arrangements for contact. A number of visits, including some out of office hours, were made to the family home and no concerns were recorded. At this time the mother of Child D expressed fears that children's social care would remove her child into care.

5.5 In early July the case was closed to children's social care and there was no further contact until a referral was received in November 2014 from the Community Rehabilitation Company who believed the father was now living back in the family home. Further enquiries identified that he had been arrested at the house in breach of the restraining order. The mother told the social worker that they wanted to be together and she wanted the restraining order to be lifted. She was informed that he should not be allowed to live with the family until risk had been assessed, and an assessment commenced. Child D's father was bailed to live at the maternal grandmother's house a few doors away.

5.6 During the course of the assessment the mother was seen to have a black eye which she said had been the result of an accidental fall in the home. The social work record identified a number of risk factors:

- The father had not completed remedial work re earlier domestic abuse incident.
- The maternal grandmother was not seen as a protective factor.
- The mother had permitted the father's return to the family home despite children's social care having told her this should not happen without a further assessment.
- The father's mental health was not seen as a risk as it was believed he was keeping his appointments and taking his medication.

5.7 The social work manager recorded that although further work needed to be done the case was likely to progress to an initial child protection conference. On the same date the father was open with the social worker and Community Rehabilitation Company's probation officer about the fact that he had been living in the family home for the last three or four months.

5.8 In December 2014, the record made by the manager (prior to completion of the assessment) includes a decision to hold a child protection conference in relation to the older child. The subsequent summary from children's social care assessment refers to the couple being "given the chance" to work and engage with services and the manager authorised this assessment. Later records also quote the mother as using this phrase in a team around the child meeting; the meeting included the social worker and health visitor and midwife.

5.9 In accordance with practice the social worker had a consultation with an independent reviewing officer to discuss the outcome of the assessment and the need for a child protection conference. Although this conversation was not recorded at the time it was reflected in the assessment documentation. It has not been possible to discuss the thinking behind this as the independent reviewing officer has not been identified. However, the assessment documentation indicates that the advice was that the case should continue to be managed within the team around the child framework rather than the child protection system.

5.10 In December 2014 there was contact between the social worker and mental health worker. The social worker was informed about the father's recent contact with the mental health crisis team, and that the risk assessment was that he was not seen as a risk as long as he maintained contact and took his medication. Despite the independent reviewing officer recommendation that the mental health worker be involved, there is no record of an invitation to join the team around the child process.

5.11 In January 2015 the social worker was informed by the police of the arrest of father on New Year's Eve involving an attempted assault with a knife. It is not clear whether this was discussed with the couple.

5.12 The same month the social worker was informed that the mother was pregnant. She had also applied to the court for the restraining order to be lifted. A pre-birth assessment was commenced and was completed in April 2015, a little outside the 45-day procedural requirement.

5.13 In March 2015 the social worker was informed that the father had attended the accident and emergency department saying he had been hearing voices and had been throwing things around in the family home. The social worker followed this up with a visit. The mother reported that all was well and she would ask the father to leave if he withdrew from the support he was being offered. She reported he was keeping his appointments and taking his medication.

5.14 The social worker was notified of the father's hospital admission in April 2015 and followed up with a phone call to the unit. He spoke to the consultant psychiatrist who had been involved in his care and was informed that the father had already been discharged. The consultant psychiatrist also indicated that he had not known children's social care were in the process of completing a pre-birth assessment. The social worker followed up with a joint home visit with the mental health worker. Both parents were seen on that visit.

5.15 Also in April the social worker was informed by the police of the incident when the father reported a burglary. On the bottom of the report there was also a reference to the earlier event with the car. Again the social worker followed this up with a visit.

5.16 In the final analysis and recommendation section of the assessment the social worker recorded the following:

"The couple are aware that over the period until the birth in early July 2015 their relationship, their ability to keep baby safe and the potential risk from the Father's mental health will be closely monitored. If there are any major deviations from the care plan the Social worker will consult safeguarding and arrange a Child Protection Conference; everyone involved in the case understands this."

5.17 Slightly at odds with this statement, which reflects active concern, the outcome of the pre-birth assessment was that the team around the child process would continue for the older child and that the unborn baby would be included in that, and that it would be led by children's social care for a period of monitoring post birth. There were no further concerns identified. Children's social services were to remain involved in the team around the child process post birth to monitor the potential impact of a new baby on the father's mental health and medications etc. and consideration to step-down at that point.

5.18 In the discussions with the couple and between professionals, this translated into a confident statement by the social worker that the case would be closed once the baby was born. This expectation had in essence been carried forward from the period prior to the pregnancy with Child D. At that time there were few concerns and the case had been on the point of being stepped down. The pregnancy intervened and the plan then became to step the case down once the child was born.

5.19 The social worker was notified of Child D's birth and two weeks later a team around the child meeting was held. Both the parents and professionals came to this meeting with an understanding that the outcome would be for children's social care to close the case and for future support to be provided by a continuation of the team around the child at a lower level with the health visitor in the lead. This was indeed the

outcome. This was subsequently described by the health visitor and midwife as a tense meeting although this was not the social worker's view.

5.20 During the discussion Child D's father stated that he did not have the same feelings for the new baby as for the first child. In the subsequent discussion he was told it was not appropriate to have a favourite.

5.21 The midwife had observed what she considered to be rough handling of the oldest child by Child D's father, and reported this at this meeting. She had seen the father place the child quite roughly in the high chair and then put a dummy into her mouth in what she considered to be a forceful manner. Additionally, the health visitor used the opportunity to remind the father of the advice on the importance of not shaking babies as he had not been at home when this routine advice had been given. Both parents reacted negatively to this and both told us they felt they were being accused of being bad parents. The mental health worker had not been invited to this team around the child meeting, and no information had been sought from the mental health team.

5.22 Notwithstanding some issues of concern, the meeting concluded as planned with a decision for children's social care to step down from involvement. All parties present were in agreement with this plan. The social worker was informed of Child D's death the following day.

Analysis and Conclusions

Disguised Compliance

5.23 The work with this family was provided within the team around the child process. This requires consent from the parents and although consent was given in this case, it is clear that this was with some reluctance on the mother's part. She complied because of the fear of consequences should she refuse. At the back of her mind there seems throughout to have been a fear her child/children might be removed. There was no indication that the possible implications of this were considered.

5.24 Because the restraining order was in place and the couple understood the need to complete a risk assessment, it seems to have been assumed that the requirement for the father not to live in the family home would be complied with. The mother knew what was expected of her and was therefore unlikely to be open if going against those expectations. Such situations create the climate in which disguised compliance thrives.

5.25 Similarly, the father's assumed compliance in keeping appointments and taking his medication was seen as a protective factor. No formal arrangements had been established to monitor this. The reality was that the father was not keeping his appointments and had concerns about taking some of his medication. He also knew what was expected and did not disclose his non-compliance. He had a history of alcohol and drug abuse and the mother had expressed concerns about his gambling,

but his assurances that these were no longer problematic were accepted. No-one questioned how he found the personal resilience to deal with these matters unaided.

Service Provision and Policy Compliance

5.26 Appropriate services were provided to Child D's mother as a care leaver, and assessments were completed around the time of the first child's birth and after the first reported incident of domestic abuse. These were well-informed and resulted in appropriate responses.

5.27 Support was provided via the team around the child process and was effective prior to the father's return. Effectiveness of the team around the child process is addressed in Section 12.

5.28 A re-assessment and a pre-birth assessment followed in response to the father's proposed return to the household and to the pregnancy. This was appropriate and complied with policy.

5.29 The quality of assessments, the role of the manager in supervision, the sharing of information and multi-agency working, the efficacy of the team around the child meetings, communication and engagement with mental health services and the availability of domestic abuse programmes for perpetrators are discussed in section 12.

5.30 When asked about the context within which support to the family was planned and delivered, both social workers and managers reported compliance with supervision policies and procedures.

5.31 Case records were not fully up to date and some key information had not been recorded.

5.32 The allocated social workers were appropriately experienced and qualified.

Risk of Confirmation Bias

5.33 It is difficult to see the rationale behind the shift in thinking in this case. Throughout the completion of the second assessment there is clearly an expectation that this would lead to a child protection conference. It is also clear that the mother's perspective, (and her words), is about being "given a chance". At some point this seems to have also become the social worker's perspective, and the decision about next steps, which should have been taken at the team around the child meeting, was pre-empted by confident statements prior to the meeting. Confirmation bias is a phenomenon whereby a view is adopted and any evidence which undermines that view is overlooked, denied or cast in a positive light. This may provide a possible explanation for the apparent acceptance of positive self-reporting on the parents' part with little challenge.

5.34 The opportunity for considered reflection is an important element of professional supervision and good supervision often also provides for professional challenge which guards against the risk of bias.

Recommendations

5.35 Children's social care have identified a number of key actions and developed an action plan to address them. This includes:

- audit of existing cases where there is a pre- birth assessment;
- presentations to staff around the quality of assessment including:
 - robust analysis of historical information;
 - the safeguarding response to domestic abuse;
 - development of hypothesis and analysis is clearly evidenced in recording and assessment;
- recording of consultations with an independent reviewing officer;
- improvements to the handover process between staff when workers change
- improvements in staff induction.

The Safeguarding Children Unit has developed a separate action plan which includes:

- steps being taken to update the child protection conference consultation process and recording;
- raising awareness to improve the interface between social workers and mental health practitioners.

5.36 In view of this no recommendations are made in respect of these areas.

A number of recommendations for Stockport Safeguarding Children Board which appear later in this report will, however, impact on all agencies.

6. Review of Health Visiting Service's engagement with the family

6.1 The health visiting service had become involved with the family prior to the birth of the first child. They were aware that the team around the child process was in place and of the mother's history as a care leaver. The health visitor met the father on her second visit and he informed her of his mental health history.

6.2 The health visitor received routine notification of the domestic abuse incident in April 2014 and followed up with a visit. The mother told her there had been an earlier incident when she was pregnant, and also told her about Child D's father's history of abuse of his nephew.

6.3 Nothing of further significance is recorded until October 2014 when the health visitor observed the mother had a black eye during a visit. The mother said that she had fallen over her slippers and that the father was still not living with her. This explanation was accepted.

6.4 Three weeks later the health visitor was informed by the social worker that the father was being allowed back in the home, although the restraining order was still in place. It is now known that he had been living there for some time.

6.5 The health visitor received notification of the mother's second pregnancy and was also made aware of the father's hospital admission in March 2015. She followed this up in her next visit and the mother told her she was glad that the father had spent some time in hospital as she had not felt safe. This does not appear to have been discussed in the subsequent team around the child meeting.

6.6 After Child D's birth, the health visitor made the routine primary visit and gave advice with regards home safety, safe sleep, risks around shaken babies in line with policy. The father was not present.

6.7 The health visitor attended the team around the child meeting on 27th July 2015. She had been in contact with the social worker and was aware of the plan for children's social care to withdraw following the birth of the child. She was happy to take on the role of lead professional at this point. She reiterated the advice concerning shaking babies in the meeting as the father had been absent when she gave the advice at home and recognised that he did not respond well to this.

Conclusions

6.8 The health visitor fulfilled her role in accordance with policies and procedures. She was responsive to notifications from other agencies and followed these up with visits. She put herself forward to act as lead professional with the family when children's social care was planning to withdraw.

6.9 The role of the manager in supervision, the sharing of information and multi-agency working, the efficacy of the team around the child meetings, communication and engagement with mental health services are discussed in Section 12.

Recommendations

6.10 The Stockport NHS Foundation Trust has identified key actions and developed an action plan which includes:

- increasing the confidence of staff in addressing risk with parents;
- development work around confident engagement in the team around the child process;
- review of the current supervision model.

In view of this no recommendations are made in respect of these areas. A number of recommendations for Stockport Safeguarding Children Board which appear later in this report will, however, impact on all agencies.

7. Review of the Midwifery Service's engagement with the family

7.1 A number of different midwives and an assistant midwife were involved with the mother during her pregnancy. Although the midwives were not able to offer continuity of care, one of them had supported the mother during her first pregnancy. During the pregnancy with Child D, apart from a few missed appointments, there were no concerns about the pregnancy and the father accompanied the mother to a number of appointments. Records of involvement are limited as the postnatal records, which are held by the mother, have not been returned.

7.2 The work for the day is allocated across the midwifery team via a team diary and we were told that if a midwife makes a visit on her way in to office she may not have had any background information other than a note of the task to be completed. Each mother has a "named midwife" who does have the detailed history but, as happened in this case, midwives making postnatal visits will not always have full information. For example, it is not clear whether the history of domestic abuse was known to those conducting the postnatal visits.

7.3 The assistant midwife had the most postnatal contact with the family as her role was to offer support in the home. She had not had access to the hospital discharge summary sheets when she made a visit five days after Child D's birth, but had read notes in the team diary and was aware of the team around the child process and the reasons for this. The named midwife was not able to attend the team around the child meeting and asked a colleague to attend. She told her colleague that she had observed the father handling the older child roughly, and asked her to mention this. The assistant midwife also attended the team around the child meeting, and was aware of the plan for children's social care to withdraw at this point.

Conclusions

7.4 The midwifery service was delivered in line with policy and procedures. Antenatal care followed a routine course, other than the midwife's involvement in the team around the child meetings.

7.5 Postnatal care was provided by a number of different midwives, not all of whom had good knowledge of the background. We were told that continuity of care is not possible to achieve due to the inevitable unpredictability of the workload on any given day. Whilst this may be inevitable, it means good systems need to be in place to ensure essential information informs the midwife's engagement with the family.

7.6 The quality of assessments, the role of the manager in supervision, the sharing of information and multi-agency working, the efficacy of the team around the child meetings, communication, and engagement with mental health services are discussed in Section 12.

Recommendations

7.7 The Stockport NHS Foundation Trust has identified key actions and developed an action plan which includes:

- improvements in continuity of care with improvements in assessment and communication;
- the development of a system for an electronic record to be kept where there is likelihood of the patient hand-held record being lost;
- confident engagement in the team around the child process and improve understanding around risk and vulnerability particularly where mental health is vulnerability.

7.8 In view of this no recommendations are made in respect of these areas. A number of recommendations for Stockport Safeguarding Children Board which appear later in this report will, however, impact on all agencies.

8. Review of the National Probation Service and the Community Rehabilitation Company engagement with the family

8.1 Child D's father was known to both the National Probation Service and the Community Rehabilitation Company covering the Stockport area and, as he was moving around at the time, he also had some contact with services in Blackpool and Liverpool.

8.2 A pre-sentence report was prepared by the National Probation Service in June 2014 following the assault on Child D's mother. The officer preparing the report had liaised with the Stockport social worker but had been unable to gain any information from Merseyside police as to any history of violence. The father himself provided information about the previous assault on his nephew. The officer used an approved risk assessment tool which resulted in an assessment of medium risk of re-offending. Because the father had no previous convictions, and had mental health problems, he was not eligible for the domestic abuse programme. It was agreed that, if a community order was made, an individual domestic abuse toolkit would be used.

8.3 A six-month community order was imposed and managed by the Liverpool Community Rehabilitation Company. Child D's father was at various addresses during this time resulting in some confusion as to which area was responsible. There were some difficulties in transfer of responsibility as the father moved around. Officers were, however, pro-active in seeking to maintain contact and alert to potential risks relating to the father's history. They sought to make contact appropriately with children's social care and notified them when they became aware that the father was back living with the family. One joint visit was made with the social worker but involvement in the team around the child does not seem to have been discussed. Overall the father's compliance with the order was patchy and steps were taken to pursue this with him, including a final warning around non-compliance and was returned to court for a breach of the order. He did not complete the programme designed to address domestic abuse issues. For this breach he was fined by Liverpool Magistrates court and the order was continued.

8.4 A further pre-sentence report was prepared by the National Probation Service in May 2015 in respect of the criminal damage charge following the father having thrown himself in front of a car. A thorough assessment was completed and identified the relevant history and assessed risk. The probation officer identified five incidents in his history which involved abusive behaviour in a domestic context. She also considered the extent of non-compliance with both the restraining order and previous community order. The assessment of risk of harm was at medium risk, as was the risk of reoffending. She sought to make contact with children's social care but reported that this was problematic, with messages left and no response. The officer identified that engagement with the previous order had been poor and recommended that an intensive contact order be imposed so that the risk areas could be addressed. The court did not accept this recommendation and imposed a conditional discharge.

Conclusions

8.5 The National Probation Service and Community Rehabilitation Company were pro-active in seeking to engage with the father and to secure compliance. Recognised assessment tools were used and pre-sentence reports were thorough.

8.6 The quality of assessments, the role of the manager in supervision, the sharing of information and multi-agency working, the efficacy of the team around the child meetings, communication and engagement with mental health services and the lack of domestic abuse programmes for perpetrators are discussed in Section 12.

Recommendations

8.7 There are no recommendations made for either the National Probation Service or Community Rehabilitation Company.

9. Review of Greater Manchester Police's engagement with the family

9.1 The police were called a number of times to deal with incidents in the home when the mother was a child living with her own mother. Liverpool police had had involvement with the father when he was living with his parents. They had dealt with the incident with the concerns re the nephew and also an assault on the paternal grandmother. There were a number of incidents of potential breach of the peace and drug use. They also dealt with incidents where the father was threatening to harm him or others.

9.2 From April 2014 Greater Manchester Police had involvement on a number of occasions, after the parents had become a couple. In April 2014 the father was arrested following an incident of domestic abuse. This resulted in him leaving the family home, being convicted of assault, and being made subject of a restraining order.

9.3 Following on from this, there were seven entries made on the records relating to the dispute between the couple after the assault or in respect of checks as to the father's whereabouts.

9.4 In November 2014 the father was arrested in the family home and charged with breach of the restraining order. He was bailed to live at the maternal grandmother's address – a few doors from the family home. The record indicates that she had agreed to ensure no contact between the parents. The parents and maternal grandmother all deny they were consulted about this arrangement.

9.5 In January 2015 there was an argument between the father and a family friend who had apparently taken issue with the fact that he was living at the family home despite the restraining order. This resulted in an incident in the street and the father threatening him with a knife. He was arrested and subsequently charged with breach of the restraining order. The mother told the police she was in the process of getting the restraining order removed. The police sent notifications to both health and children's social care. The father later presented himself at the accident and emergency department and was treated for a stab wound on his arm.

9.6 In mid-March 2015, Greater Manchester Police dealt with a report by Child D's father of a burglary and theft of a television, which was later said to have been a joke. The mental health records indicate that at this time the father attended accident and emergency department with a cut hand, and told them he had smashed the television.

9.7 A week later Greater Manchester Police were called out by a motorist who reported that the father had jumped out in front of his car, causing damage to the windscreen. This was dealt with as a traffic incident and a number of different officers were involved in the various stages of the process. The officer attending the scene could not recall whether the father had told her that he had wanted to kill himself but does remember him saying that it was a foolish response to a domestic argument and he apologised. She did not feel the situation needed to be dealt with as a mental health case. The father was transported to the police station by another officer and interviewed by a third.

9.8 While in custody the father was seen by the forensic medical examiner that assessed him as fit to be processed, and the suicide risk was assessed as standard.

On discharge from the cells the father was provided with an advice leaflet and mental health helpline numbers, but it is not clear whether any alternative to charge was considered and no referral was made to adult services or children's social care. Officers dealing with incident appear to have had no information beyond that provided by the father.

9.9 Greater Manchester Police had no further involvement until Child D's death.

Conclusions

9.10 Individual officers attending incidents appear to be unlikely to have any background information or access to previous records of offences or call outs. They described the process to us and the need for them to be able to make a quick assessment of what they are presented with and how best to respond. In this case incidents were not straightforward:

- The original domestic abuse incident started out as an allegation that the father had been assaulted, but resulted in evidence that, in fact, the Mother had been assaulted;
- The threatening of the man with a knife became a breach of the restraining order;
- The reported burglary was withdrawn and said to have been a joke;
- The attempted suicide by jumping in front of a car resulted in arrest for criminal damage.

9.11 Without any context it is a challenge for an officer to make sense of what is presented and to draw any inferences re mental health issues.

9.12 Some incidents did result in notification to children's social care after the event, but not all, and there were no notifications to adult mental health services. Assumptions were made that there was no injury following the car incident and no medical examination, although the impact had been sufficient to crack the windscreen, and the driver reported the father as being propelled a couple of metres. No injuries were noted after the attempted stabbing but Child D's father later took himself to A&E with a stab wound to his arm. The attempted suicide resulted in the forensic medical examiner assessing the father and giving him helpline information, but no alternative to charge appears to have been considered.

9.13 There is no record of the thinking around the decision to bail the father to the maternal grandmother's address; given the family home was only a few doors away. The record does imply a conversation with the maternal grandmother, but this is not clear and is disputed by the family.

Recommendations

9.14 Greater Manchester Police have identified key actions and developed an action plan which includes:

- improved training for front-line police officers around mental health issues.
- assessment and monitoring of vulnerable prisoners.
- Review of arrangements for determining the suitability of bail addresses.

In view of this no recommendations are made in respect of these areas. A number of recommendations for Stockport Safeguarding Children Board which appear later in this report will, however, impact on all agencies.

10. Review of the GPs' engagement with the family

10.1 Two GPs' had relevant involvement with the parents during the period under review. Child D's mother and first child were registered together, and Child D's father consulted her GP occasionally when he needed emergency medication. The mother's GP had been involved since 2013 and was familiar with the mother's history.

10.2 There was routine contact with health visitors working with the practice, and in April 2014 the health visitor informed the GP that she had received a notification following an incident of domestic abuse. The GP ensured that there had been a notification made to children's social care and added an alert to both the mother's and first child's medical notes.

10.3 The first child was brought to the GP on a number of occasions during 2014-2015. These were for routine childhood ailments though happened at a slightly greater frequency than is usual. The GP felt this reflected fairly anxious parenting but was not concerned. The GP was aware of the team around the child process but was never invited to attend. Had the GP been invited, it is unlikely that practice commitments would have made it possible for her to go. Although the GP did get routine notifications and had good communication with the health visitor, there was no involvement in the pre-birth assessment.

10.4 The mother's GP practice saw the father on four occasions during 2013-2014 as a temporary patient when he was seeking medication. He was usually given a month's supply. In March 2014 he was told he would need to register with the practice if this was to continue. In fact, he went on to register with a different practice. It is not clear why he chose to use a different practice but this did prevent either GP from having a whole family perspective.

10.5 When the father registered with a Stockport practice in November 2014 he told the GP he had been sent by the social worker and that he needed a referral for counselling. He told the GP about the previous assault on his partner and the restraining order. He provided a history of his mental health and reported himself to be "feeling terrible" – worse since his father's death. He reported concerns about his medication, a concern which he felt had also contributed to his own father's death. The GP performed alcohol screening and the father reported he was drinking alcohol only two or three times per month at around four units, with an occasional tally of eight units or more, perhaps once a month. This is the only record of the father discussing the use of alcohol with a professional. The GP made a mental health referral the same day and faxed it through as urgent.

10.6 In December 2014 the father made further contact as he was concerned about his medication. The GP had received routine notification of hospital attendances. In March 2015 there was an escalation of contact and a call to the emergency number. During this call the father reported that he was not handling stress well, and was described as in a panic. This was resolved via telephone contact only.

10.7 The father attended the GP on 2nd April 2015 and his presentation was described by the GP as "very odd". He was very stressed and said he believed his mental state was deteriorating. He told the GP about the incident when he threw

himself in front of the car and said that he still wanted to kill himself. He was crying and expressing concern for his partner and daughter, and wanted to be well for their sake. He reported hallucinations and said he had seen himself strangling himself. The GP observed his speech to be pressured. An urgent referral was made to the local psychiatric resource. Five days later he returned to the GP practice wanting a variation to his medication. He was observed to be less agitated and his speech was normal.

10.8 The GP described contact with the Home Treatment Team and with children's social care as being very limited but reported this was often the case, particularly with patients who were fathers rather than mothers. There was no involvement in the team around the child process.

Conclusions

10.9 The GPs were responsive to the levels of need presented by the parents.

10.10 The mothers' GP was pro-active in ensuring the risk of harm was flagged on both the mother and first child's records. She ensured specific information had been shared with children's social care and was in good communication with the health visitor. Appropriate advice was given to the father about the need to register with a local GP rather than keep asking for prescriptions. The father's GP made appropriate referrals into mental health services.

10.11 Involvement in the team around the child and general information sharing is discussed in Chapter 12

Recommendations

10.12 There are no recommendations made for the GPs.

11. Review of Mental Health Service engagement with the Child D's father

Overview of the treatment and care of Child D's father from December 2014 until the time of the incident.

11.1 There is an overall chronology of events in section 4 of this report. We provide an overview here, however, to remind the reader of the sequence of events surrounding Child D's father.

11.2 The Verita team quality assured the Mental Health Trust's internal investigation report. The team only interviewed staff if the information could not be identified from the report or any transcripts. The Verita team also analysed issues that were considered not adequately addressed by Pennine Care NHS Foundation Trust's internal investigation team.

11.3 Child D's father had been in receipt of adult mental health services from the age of 17. He received services from the child and adolescence services and the early intervention team in Lancaster. He also attended the attention deficit hyperactivity disorder out-patient clinic at Cheshire and Wirral Partnership NHS Foundation Trust.

11.4 Child D's father was referred to the Stockport access and crisis team at Pennine Care NHS Foundation Trust by his GP on 17 December 2014. He was assessed by a mental health practitioner. He was also prescribed antipsychotic medication by a psychiatrist. The psychiatrist didn't see Child D's father to assess him but he did review his records before prescribing the medication. This is usual practice within the access and crisis team. He was discharged in February 2015 and was given an out-patient appointment with a consultant psychiatrist for April 2015.

11.5 In March 2015 Child D's father smashed a television and injured his hand. He attended A&E but declined a full assessment so was discharged. Two days later he jumped in front of a car and hit the windscreen. The police were involved but he was not taken to A&E.

11.6 On 2 April 2015 Child D's father's GP referred him back to the access and crisis team. He was reviewed by a mental health practitioner, and admitted to hospital for a relapse of a bipolar disorder. He was reviewed by a psychiatrist whilst in hospital and discharged two days later. A discharge plan was put in place. This included being followed up by the home treatment team.

11.7 At the end of April, Child D's father was referred to the community mental health team for monitoring and referred for psychological therapy.

11.8 On 2nd May 2015, Child D's father attended a planned appointment with the home treatment team. He had been arguing with this partner and reported feeling volatile and unpredictable. He requested admission to hospital but there were no beds available. He said he would stay at his partner's Mother's house as she would make sure he was safe there. The following day, Child D's father reported that he had returned home and the situation with his partner had settled. The agreed plan was for the home treatment team to contact the community mental health team on 5th May to establish if Child D's father had been allocated an assessor yet.

11.9 On 3rd May 2015, Child D's father telephoned the home treatment team. He reported again that he needed to come into hospital as he was struggling to cope. He agreed to attend hospital at 1.30pm for an assessment. He later called back to advise he needed to dry his clothes first and would call again to arrange to attend the hospital.

11.10 Child D's father did not contact the home treatment team as previously arranged so the home treatment team called him to assess his mental state. He did not sound distressed. He reported that he had split up with his partner and he needed to leave the house. He was advised there were still no beds available and this was likely to be the case until Tuesday due to the bank holiday weekend. He reported he could keep himself safe and would contact Stockport Homes or the Salvation Army.

11.11 On 7 May, a letter was hand delivered to Child D's father with an appointment date of 11 May for a joint meeting with the community mental health team and home treatment team. His care was then transferred to the community mental health team where he continued to be seen until the time of the incident.

11.12 Child D's father was last reviewed by the community mental health team on 23rd July 2015 before the incident on 29th July 2015.

11.13 Child D's father frequently asked for medication reviews. He did not engage with services very well, often missing appointments and being out when home visits were planned.

How Child D's father's diagnoses were formulated

11.14 In this section we consider if Child D's father's diagnoses of bipolar affective disorder and attention deficit hyperactivity disorder were appropriately formulated and evidenced by those responsible for his care. This is one of the areas that Pennine Care NHS Foundation Trust internal investigation team did not explore in detail.

11.15 Formulating an accurate diagnosis is important because it largely determines the type of care and treatment that is required. In psychiatry, diagnosis is based mainly on clinical grounds by interpreting an individual presentation (history and examination). A diagnostic formulation, bringing together all relevant information, is valuable in mental health, not least because it shapes the care and treatment provided to that particular individual. Factors such as physical health, emotional development and social environment, which may impact on mental health presentation and treatment, are incorporated in a good formulation.

11.16 In this case, the diagnoses appear to have been made before Child D's father was in receipt of care from Pennine Care NHS Foundation Trust. It is not clear from the documentary evidence that we received when the diagnoses were made, or by whom.

11.17 When Child D's father was assessed in December 2014, the mental health practitioner accepted without question, that he was experiencing true auditory hallucinations (as opposed to him himself thinking such thoughts, as is common in personality disorders). There is no evidence that questions were asked as to what exactly Child D's father was experiencing. Here, as with previous mental health

professionals, the mental health practitioner accepted from the start the idea that his experiences could be wholly explained in terms of illness, of which the voices are a part.

11.18 In the December 2014 assessment the mental health practitioner concluded:

“Priority was for Child D’s father to be seen by a consultant as he reported that his mental health was deteriorating and he felt that he needed to resume antipsychotic medication.”

11.19 The mental health practitioner was led by Child D’s father. He stated that his mental health was deteriorating, and that he needed to be back on Amisulpride 300mg twice daily.

11.20 Two days after Child D’s father’s assessment, the mental health practitioner, in response to him phoning with some urgency for medication (and specifically Amisulpride 300mg twice daily), talked over the phone to the consultant psychiatrist who, without having ever seen Child D’s father, agreed to prescribe what he had asked for. Child D’s father assessed himself as becoming more mentally ill and needing medication urgently – a specific drug at a specific dose.

11.21 When Child D’s father talked about his self-harming, he stated that these were not in the context of voices or command hallucinations. It would have been important to explore why, when it came to self-harming, voices played no part but when it came to harming others or not taking his medication, this was in response to voices.

11.22 Child D’s father was admitted to hospital on 5th April 2015, after stating he did not feel safe, that he might harm himself. He was diagnosed as relapse of bipolar disorder.

11.23 The next day there was no evidence that Child D’s father was experiencing psychosis or low mood. Over the next two days several entries are written in the clinical records stating the absence of any symptomatology. On 7th April 2015 Child D’s father requested to be reviewed by the inpatient consultant psychiatrist. He wanted to leave the ward as he felt he was better and wanted to get back home. As he was not detainable, he was discharged at his request on 7th April 2015. He remained under the care of the home treatment team.

11.24 This stay in hospital was an excellent opportunity to study the father’s presentation in more detail and come to some better understanding of his diagnosis.

11.25 Given the presentation that led to the admission proved not to be a relapse of the bipolar illness, attempts should have been made to understand better the causes. There was no evidence in the child father’s clinical records to show that attempts were made to find out about any alcohol, drugs, or difficulties in his relationships. Clinical staff could have tried to find out about his social life, how he spent his time and what sort of people he was spending his time with. At the very least, the discharge letter should have emphasised that, when Child D’s father was feeling at his worst and wanting admission to keep safe and keep others safe, he was not in fact suffering from any identifiable symptoms of bipolar disorder or of attention deficit hyperactivity

disorder. This might have encouraged professionals involved in the case after this admission to look elsewhere for the difficulties presented by Child D's father.

11.26 A letter dated 9th July 2014 by a consultant psychiatrist from Cheshire and Wirral Partnership NHS Foundation Trust in the early intervention in psychosis team to the child father's GP advised that he was discharged from the early intervention service (and from all other secondary care mental health services) because he was not engaging with the services. He had been his consultant for three years, from early 2011 until his discharge. One crucial point in this letter is the diagnosis: The consultant psychiatrist referred to possible bipolar mood problems, elaborating further in the body of the letter that Child D's father's mood swings "did not present as classically hypomanic or depressive episodes". He referred to Child D's father's complaints as being against the background of "significant cocaine use". This was dated July 2014, only six months before he was in receipt of services by Pennine Care NHS Foundation Trust. Documentary evidence indicates that staff assumed that the diagnosis of bipolar disorder had been definitely made and that illicit drug use was no longer an issue. There was no evidence that staff had questioned him about how he had managed to stop a long standing drug problem or probe more about his symptoms of bipolar disorder.

11.27 The mental health practitioner referred Child D's father to a psychiatrist and an appointment was made for 17th April 2015. Unfortunately, he did not attend this appointment or three subsequent appointments. The next appointment was scheduled for 17th August 2015.

Conclusion

11.28 Health professionals knew very little about Child D's father apart from his diagnosed conditions, his various symptoms and his medication. Obtaining records from previous mental health services and finding out more about him would have better enabled the clinical staff to be confident that he had the correct diagnoses and devise a robust care plan to meet his needs.

11.29 Child D's father would have benefitted from seeing a psychiatrist on a regular basis, because a psychiatrist may have revisited his diagnosis, got involved in clinical decision making and may have recommended other forms of treatment.

11.30 A more assertive approach to his disengagement from care and treatment may have led to a better understanding of his presentation and led to discussions about his diagnoses, treatment and care.

Recommendations to improve services

11.31 Pennine Care NHS Foundation Trust in their internal investigation identified that Child D's father:

- was not assertively questioned about his presentation and the impact of this on his risks and ability to parent;
- requested a medication review but this was not discussed with a doctor by the home treatment team or community mental health team; and
- was not engaging with services and a more assertive approach was indicated to complete the community mental health team assessment.

11.32 Pennine Care NHS Foundation Trust has also advised us that there is an 11-week maximum waiting time between the time of referral and being seen. All referrals are now triaged by the access & crisis teams so service users are seen much more quickly than maximum waiting time.

11.33 Pennine Care NHS Foundation Trust internal investigation made the following recommendations.

- When a service user requests a medication review, practitioners will assess the need for this, clearly document whether a review is indicated or not and ensure that appropriate action is taken.
- More information on past mental health and risk history should be sought when a patient has a previous history with another service.
- Where patients are not engaging with services, practitioners will escalate this to a team manager and a plan will be agreed.

11.34 Pennine Care NHS Foundation Trust has developed an action plan outlining steps of how these recommendations are being taken forward. Pennine Care NHS Foundation Trust has also shown evidence of how the recommendations are being put in place and are making good progress. In view of this, we do not make any further recommendations.

The Care Programme Approach and Care Planning

11.35 The care programme approach is the framework that underpins mental health care for all service users in specialist mental health settings. It was introduced in 1990 as the approach for the care of people with mental health needs in England. This is one of the areas that Pennine Care NHS Foundation Trust internal investigation team did not explore in detail.

11.36 The care programme approach is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs.

11.37 The care programme approach is designed for people identified as suffering with a severe and enduring mental illness with complex mental health needs, posing a significant level of risk and requiring multi-disciplinary input and inter-agency involvement.

11.38 Pennine Care NHS Foundation Trust policy for the care programme approach outlines that service users with the following characteristics would meet care programme approach criteria:

- Complex mental health needs;

- Severe and enduring mental illness;
- Multi-agency input;
- Significant levels of risk;
- Moderate degree of clinical complexity; and
- Potentially difficult to engage.

11.39 Pennine Care NHS Foundation Trust's care programme approach policy states that non care programme approach is designed for people with a low or moderate risk of harm to themselves or others. They would be identified as having a severe and enduring mental illness with low level maintenance and monitoring needs, e.g.

- Depot administration.
- Lower level of need (maintenance and monitoring).
- Severe and enduring mental illness.
- Single statutory agency input in addition to GP.
- Low degree of clinical complexity.
- Low to moderate level of risk.
- Actively engages with services and treatment.

11.40 Trust policy goes on to state that even if service users do not meet the criteria for care programme approach support, they should still receive an assessment of needs, a care plan and reviews. These assessments and reviews should also consider whether the service user should be transferred to care programme approach in order to support their needs.

Conclusion

11.41 In this case Child D's father met the criteria for care programme approach. He was assessed, allocated a care coordinator and a care plan was completed by the home treatment team on 30th April 2015.

Risk Assessment and Management

11.42 In this section we focus on the adequacy of risk assessments and risk management plans including specifically the risk that Child D's father may have posed to others including children.

11.43 Pennine Care NHS Foundation Trust risk assessment policy states that each service user will have completed risk assessment covering the following areas:

- Risk of suicide and/or harm to self;
- Risk of self-neglect;
- Vulnerability to exploitation or abuse by others; and
- Risk of harm to others (including children)

11.44 We reviewed Child D's father's records and found that he was assessed and a risk history was taken. His records show that he had previously attempted to hang himself and had taken an overdose. He also had a history of violence. In April 2014 he assaulted his then partner and mother of his child. He told staff that he did this when he was under considerable stress. He reported that he had never previously harmed another person, but he had previously experienced command hallucinations

telling him to harm others. He denied having these command hallucinations at the time of the assessment. At this point he was being monitored by children's social care and was barred from having unsupervised contact with his ex-partner and child.

11.45 The risk assessment also highlighted that Child D's father had a history of drug and alcohol abuse, but he told staff that he no longer used drugs.

11.46 His history indicated that he was more likely to attempt suicide when his mood deteriorated. At the time of the risk assessment he denied thoughts of self-harm, suicide or thoughts of harming others.

11.47 A risk management plan was put in place. This included:

- referring him to a consultant for antipsychotic medication;
- liaising with the child and family social worker;
- plans to refer him to a consultant.

11.48 Other risk assessments were undertaken in April 2015, prior to Child D's father being discharged from hospital and in May 2015.

Conclusion

11.49 Risk assessments were carried out and updated in light of events known by services - for example an accusation of theft against Child D's father by his mother and brandishing a knife at a party. As discussed in the last chapter of this report, much more probing could have taken place to find out more information. The services could have attempted to obtain information about Child D's father's past mental health and risk history from Cheshire and Wirral Partnership NHS Foundation Trust. More could have been done to assertively question him about his presentation, his history and ability to parent. These omissions are important because a robust risk management plan can only be put in place if it is based on an accurate and detailed risk history.

Recommendations for improving services

11.50 Pennine Care NHS Foundation Trust internal investigation recognised that Child D's father was not assertively questioned about his presentation and the impact of this on his risks and ability to parent. The discharge risk assessment completed by ward staff and shared with the home treatment team as part of the referral had limited information. The risk summary and formulation, service user/care perspective and safeguarding sections were not completed.

11.51 Pennine Care NHS Foundation Trust internal investigation recommended:

- The South Division set up a pathway workshop to review the quality of information shared with the community teams by inpatient services to identify expected standards. The outcome of the workshop will be shared with North Division adult service managers.

11.52 Pennine Care NHS Foundation Trust has developed an action plan outlining steps of how this recommendation is being taken forward. Pennine Care NHS Foundation Trust has also shown evidence of how the recommendation is being put in place. We make a further recommendation in relation to risk assessment in addition to the recommendation made by Pennine Care NHS Foundation Trust:

Recommendation 1 Pennine Care NHS Foundation Trust should ensure that all staff keep accurate contemporaneous records in line with Pennine Care NHS Foundation Trust record management policy to ensure that all relevant information is seen and shared when necessary.

Safeguarding

11.53 In this section of the report we focus on safeguarding and whether Child D's father was assessed to see if he was a risk of harm to others, including children. Like all other NHS bodies, Pennine Care NHS Foundation Trust has a statutory duty to ensure that arrangements are in place to safeguard and promote the welfare of children and young people.

11.54 In December 2014, the social worker told the mental health practitioner that Child D's father had an order against him restricting him from residing with his partner and his child because he previously assaulted his partner. The social worker requested to be kept updated on any developments by email. There was no record of a detailed discussion between the social worker and the mental health practitioner about this incident, the level of harm that Child D's father caused, the reasons for the restraining order, why he couldn't see his child and whether this incident happened when he was mentally unwell.

11.55 In April 2015, a joint visit was undertaken by a home treatment team practitioner and the social worker. They noted that Child D's father was well groomed. He was able to focus on the conversation, although his speech was a little pressured. Child D's father reported that he was feeling more settled, though hearing the occasional voice and having occasional visual hallucinations. He was not concerned about these. Child D's father did not feel his medication was having the desired effect and so requested a review by his consultant psychiatrist. There is no record showing whether or not staff considered speaking separately to his partner, who was pregnant at the time, to see if they could find out about the impact of him on her and the child and how she was coping.

11.56 In May 2015 a student nurse from the community mental health team contact the social worker. The reason for this call has not been established. The social worker reported that he had no concerns regarding the Child D's father and his family. The plan for children's social care was to withdraw their involvement after the new baby was born.

11.57 The care coordinator carried out a home visit on 26th June 2015. Child D's father was clearly at home because the care co-ordinator heard him and his partner

shouting, and the baby crying, but he did not answer the door. Given Child D's father's history, further action should have been taken to check on the welfare of baby and his partner who was pregnant at the time. This visit was discussed at a zoning meeting on 29th June 2015 but no action plan was decided or advice given by the chair of the meeting. The issue was not raised at the multi-disciplinary meeting on 30th June 2015.

11.58 On 16th July 2015 Child D's father reported to the care coordinator that he had an 'out of body' experience where he saw himself handing his baby to somebody else, who dropped her. The care co-ordinator recorded this in the clinical notes but there is no evidence to show that this issue was discussed with anybody or escalated.

11.59 The care co-ordinator (who was an agency nurse) told us during an interview that she had not received safeguarding training, although she attended a course in a previous role and another course within Pennine Care NHS Foundation Trust after the incident.

11.60 The home treatment team mental health practitioner told us during his interview that he was up to date with safeguarding training. We were provided with evidence to support this from Pennine Care NHS Foundation Trust.

Conclusion

11.61 Pennine Care NHS Foundation Trust fell short in meeting their statutory responsibilities in relation to safeguarding children. In addition, there was no recognition of the importance of domestic abuse and the impact of this. There was limited contact with children's social care. There is no evidence in the records to show that any proactive attempts from mental health services were made to request or clarify if any team around the child meetings were taking place and request involvement in these. Team around the child meetings can be called by any agency that has concerns about a child or young person with additional needs that they feel may require a response from more than one agency, but without requiring statutory intervention.

11.62 It is generally accepted that working alongside other agencies is extremely effective for improving outcomes for children, due to the cross cutting themes that organisations are able to share information and raising concerns that agencies can increase the likelihood of protecting children from harm. In this case, staff missed opportunities to further probe into the life of Child D's father or to hold formal multiagency meetings with relevant agencies where information could be received and shared.

Recommendations for improving services

11.63 The Pennine Care NHS Foundation Trust internal investigation report highlighted that Pennine Care NHS Foundation Trust had safeguarding issues. These were:

- Child D's father's care was adult focused and staff did not recognise or consistently act on child safeguarding concerns;

- There was limited contact to or from children's social care, including no proactive attempts to establish if team around the child meetings were taking place and to request involvement in these;
- Important information relevant to safeguarding was not fed back to meetings, (e.g. when he reported that he had an 'out of body' experience where he saw himself handing his baby to somebody else who dropped her), this was not discussed with anybody or escalated further;
- There was no consideration of the impact of Child D's father on his partner who was pregnant, looking after a small child and acting as a carer for Child D's father;
- No documentation was in place to indicate that the children's social care social work team were informed on discharge from hospital; and
- During an attempt to visit Child D's father, it was recorded he was at home but not answering the door and the baby was heard crying. Due to his history, further action should have been taken to check on the welfare of the baby and the child's pregnant mother. The visit was discussed at a zoning meeting on 29th June 2015 but no action plan or advice provided by the chair. The issue was not raised at the multidisciplinary meeting on 30th June 2015.

11.64 Pennine Care NHS Foundation Trust internal investigation report set out the following recommendations:

- Services will maintain liaison with appropriate professionals such as a children social care social worker, midwife and health visitor at the earliest opportunity where child safeguarding issues are identified.
- Staff will liaise with the safeguarding named nurse for advice and support where child safeguarding concerns are known and where child and family services are involved.
- Guidance has been put in place that all clients in red and amber (ACT) are now discussed at each zoning meeting. All clients where child safeguarding concerns are known will remain in the red zone and discussed at each meeting.
- Child safeguarding issues to be discussed at both community mental health team zoning and multi-disciplinary meetings. The chair will ensure that an action plan is in place to address these concerns.

11.65 In addition to Pennine Care NHS Foundation Trust internal investigation recommendations, we recommend:

Recommendation 2 Pennine Care NHS Foundation Trust should ensure that all staff working for Pennine Care NHS Foundation Trust (including agency staff) are competent in safeguarding so they are able to fulfil their responsibilities under the statutory framework.

Recommendation 3 Pennine Care NHS Foundation Trust should use existing systems and processes within Pennine Care NHS Foundation Trust such as induction, probation periods, supervision and annual appraisal systems to provide assurance that staff are competent in safeguarding.

Involving Carers

11.67 Pennine Care NHS Foundation Trust care programme approach policy recognises the role of carers in supporting people with mental illness. Both Pennine Care NHS Foundation Trust and local authority have a responsibility regarding carers. The local authority has a statutory duty to ensure all carers are offered an assessment. Pennine Care NHS Foundation Trust policy does not document a formal / standardised process, as each local authority has a different process.

11.68 The care programme approach policy states wherever possible carers should be:

- Involved in the care planning process;
- Provided with the information they need to give care effectively & safely; and
- Offered a carer's needs assessment.

11.69 Evidence shows that the child's mother was not recognised as a carer. This was despite the fact that staff were aware that the child's mother was administering the Child D's father's medication and monitoring his mental state. This is an important omission as the child's mother might have needed education plus practical and psychological support to care for him.

Conclusion

11.70 Pennine Care NHS Foundation Trust did not fulfil their responsibilities in relation to ensuring that a carer's need assessment took place.

Recommendation for improving services

11.71 Pennine Care NHS Foundation Trust internal investigation report highlighted that there was no consideration of the impact of Child D's father on his partner who was pregnant, looking after a small child and acting as a carer for him. Despite this finding, Pennine Care NHS Foundation Trust did not make a recommendation. We therefore recommend that:

Recommendation 4 Pennine Care NHS Foundation Trust should ensure that all carers are offered a carer's needs assessment in line with Trust and local authority policy.

Bed Management and Record Keeping

11.72 In this section we focus on the issue of bed management and the record keeping of key decisions about whether or not admission to hospital is necessary.

11.73 The Pennine Care NHS Foundation Trust record management policy states that accurate contemporaneous record-keeping is needed regardless of which media they are held i.e. paper or electronic. Accurate records would have been an important way of sharing information about Child D's father and the way in which he presented.

11.74 Child D's father telephoned the home treatment team in May 2015 and reported that he needed to come into hospital as he was struggling to cope. The home treatment team discussed the lack of a local bed with him.

11.75 The mental health practitioner from the home treatment team told us during his interview that he felt Child D's father did not require admission to hospital and the lack of available beds was not the deciding factor for the non-admission. Trust documentation, however, indicated that the lack of a local bed appeared to influence the decision not to admit him.

Conclusion

11.76 There is no record in Child D's father's records explaining why the mental health practitioner thought an admission to hospital was not needed.

Recommendations for improving services

11.77 Pennine Care NHS Foundation Trust has already highlighted issues in relation to bed management in their internal investigation. They have made the following recommendations:

- The importance of clarity when completing documentation will be discussed with the practitioner.
- There is a clear process in place for obtaining a bed when admission is deemed appropriate. The lack of a local bed is not a reason not to seek a bed elsewhere as per the bed management protocol. The lack of a local bed should not be shared with a patient as a reason not to admit.
- Documentation standards and the importance of not discussing bed availability with services users to be addressed with the practitioner in supervision.

11.78 We have made a recommendation earlier in our report about record keeping so we do not repeat it here.

Information Sharing

11.79 In this section we concentrate on the issue of information sharing and whether information was appropriately shared.

Zoning Meeting:

11.80 A zoning meeting is a team meeting held to discuss and share any risks and any ongoing issues regarding service users. The minimum expected frequency of zoning meetings for service users is allocated according to their care programme approach status. The zoning categories are red, amber, amber and green (as used by the access and crisis team).

11.81 We were told that all team managers were sent a copy of the draft working zoning policy when the access and crisis team and community mental health team were redesigned, but the purpose of the meeting appears unclear. Evidence shows

that the Child D's father was discussed at the meeting, his risk was shared, and a record of these were made. However, no management plan was put in place for him.

Conclusion

11.82 The purpose and remit of the zoning meeting was unclear resulting in no management plan.

11.83 Pennine Care NHS Foundation Trust internal investigation states that:

- *A review of the sector 2 community mental health team zoning meeting has taken place. In addition, guidance is now in place so that all clients in red and amber are now discussed at each meeting. The chair/lead of the meeting will ensure that there is an action plan in place for any concerns raised during the zoning / multi-disciplinary meeting. Any concerns will be discussed at both zoning and multi-disciplinary meetings and the discussion / action plan recorded accurately within the case notes.*

11.84 We are confident that these changes will make the purpose and remit of the zoning meeting clearer. Pennine Care NHS Foundation Trust action plan shows evidence that these actions are in place so we do not make any further recommendations.

Communication with the GP

11.85 We considered why the GP did not receive a letter from Pennine Care NHS Foundation Trust explaining that Child D's father had not attended outpatient appointments. Pennine Care NHS Foundation Trust explained to us that a letter should be generated and sent to the service user's GP if they have not attended an outpatient but on this occasion the system failed. We also examined the issue about no discharge letter being sent from Pennine Care NHS Foundation Trust to Child D's father's GP. On 17th December 2014, his GP referred him to the Stockport access team. As previously discussed within the report, he was under the care of the access team until 7th February 2015. The access team discharged him from their care as he was awaiting an outpatient appointment with the consultant psychiatrist.

11.86 Pennine Care NHS Foundation Trust internal investigation recognised that no discharge letter had been sent to Child D's father's GP when he was discharged from the access team.

Conclusion

11.87 This was a missed opportunity to share important information about Child D's father with his GP.

11.88 Pennine Care NHS Foundation Trust made the following recommendation:

- A new process will be implemented to ensure a letter is sent to a patient's GP when they are discharged from the access team.

11.89 Pennine Care NHS Foundation Trust action plan demonstrates that GP template letters have been devised to make it easier for staff to write to GP following discharge. Further work needs to be carried out though to put a failsafe solution in place so that a discharge letter is always sent to the GP and that GP are always informed of the non-attendance of appointments. We therefore recommend that:

Recommendation 5 The team manager should ensure that there is a process in place for ensuring that GP letters are sent following discharge and that this is audited on a six monthly basis.

12. Multi-Agency Analysis and Learning and Recommendations

12.1 In the terms of reference set out in a framework document for the Serious case review element of this review the author was asked to explore the following specific areas:

- The quality of assessments completed;
- The role of manager supervision;
- The sharing of information and multi-agency working;
- The efficacy of team around the child meetings;
- Communication with and engagement of mental health services; and
- The lack of domestic abuse programmes for perpetrators.

The quality of assessments completed

12.2 Assessment of various kinds and at various times were completed in this case, some by the National Probation Service, some by mental health services, and some by children's social care. The quality of the assessments completed by mental health services is covered in Section 11.

12.3 Officers completing the National Probation Service pre-sentence reports used a recognised risk assessment tool. They did seek to obtain information from other agencies and the pre-sentence reports contained history, analysis and appropriate recommendations.

12.4 The Community Rehabilitation Company staff delivering the community order also completed risk assessments though had more difficulty contacting partner agencies.

12.5 There were several assessments completed by children's social care but the two crucial ones were the last two; the one commenced when the father sought to return to the household after the incident of abuse, and the one subsequently completed as the pre-birth assessment. There are a number of issues with both the quality of assessment and the outcome.

12.6 The assessment process did not appropriately involve all relevant agencies. Although in each instance the social worker was in contact with some agencies, consultation with all relevant agencies was inadequate, and the assessment was informed by what the social worker understood to be their views second-hand. As a result, there was no direct input from mental health services, the police or GPs.

12.7 Because the father's compliance with his mental health treatment was seen a protective factor, the omission of direct information which would have revealed that he was not attending all appointments, was significant.

12.8 Agencies, other than the father's GP, were not aware of the father's use of alcohol so any potential impact on either the effectiveness of his medication or on his behaviour was not considered.

12.9 The pre-birth assessment suffered from an insufficiently robust approach in challenging the parents around compliance. It did recognise and outline the risks. The parents self-reporting on compliance of the father with mental health appointments and medication were accepted without challenge.

12.10 Decision making in response to the assessments was confused. The initial line manager, when recording a decision prior to completion of the pre-birth assessment, was clear that a child protection conference was appropriate; a later consultation between the social worker and an unidentified independent reviewing officer resulted in a recommendation for a different course; and the plan was then confirmed as being to continue to manage the case within team around the child meetings. Following the pre-birth assessment Community Rehabilitation Company continued to be the lead agency in respect of the team around the child pending the birth of the baby at which point there was expected to be no further need for children's social care to be involved.

12.11 The plan was shared with the team around the child which consisted of the social worker, health visitor and midwife (and a family support worker latterly) but not more widely, and although any agency can request a child protection conference, there was no challenge. Both the health visitor and midwife told us they recognised the birth of a new baby as a time when families might be more vulnerable but there was no challenge to the plan.

12.12 The social worker had spoken with the community mental health worker and had done joint visits. He had been reassured by the statement that any risk could be managed by compliance with appointments and the taking of medication. He took this to mean there was compliance and that he would be notified if there was not, though this was never agreed and there appears to have been a degree of misunderstanding.

Multi-agency recommendation

12.12 Improvements around assessment are largely addressed in the single agency action plans. However, there was no evidence that multi-agency practice was informed by any understanding of the possibility of disguised compliance. The possible risk of confirmation bias was similarly not considered.

Recommendation 1: That Stockport Safeguarding Children Board assesses the impact of relevant training currently provided in respect of disguised compliance and the possible impact of bias.

The role of Manager Supervision

12.13 All professionals other than the police reported that they had access to supervision in accordance with policy and procedures. Other than in children's social care, there is no evidence of specific management challenge in respect of this case.

12.13 The health visitor and midwives had access to both line management and specialist safeguarding supervision.

12.14 The two managers in children's social care were provided supervision in line with policy and procedures. However they described poor handover when the new

manager came into post. The initial manager had supervised the case when held by a former social worker and knew the history well. She was clear initially that a child protection conference to consider the assessment would be required. She told us she managed the social worker's caseload and monitored his work.

12.15 When the second manager was appointed both confirmed that there was little opportunity for a full hand-over, and although this was planned it did not take place. The new manager was an internal appointment and an experienced professional who had previously been a senior practitioner. She had monthly supervision herself and induction was built into her personal development plan. She recalls working long hours to try and complete all her tasks. She told us that when she took on her new role the social worker had a slightly lower caseload than average and she sought to remedy this. She recalls signing off the pre-birth assessment and, with hindsight recognises it was of poor quality. She described experiencing considerable pressure of work at the time, recalls she was working late and the completion date was slightly overdue. These factors may have contributed to a tolerance of a less than good piece of work. She recalls being told of the plan to step the case down and endorsing this. She did not challenge the social worker on the shift in direction away from child protection during the assessment.

Multi agency recommendation

Recommendation 2 That Stockport Safeguarding Children Board challenge agencies through its Section 11 safeguarding audit to provide evidence that reflective supervision is available to those working in child protection and is effective.

The sharing of information and multi-agency working:

12.16 There is a mixed picture in respect of information sharing. Issues in respect of the mental health services are discussed in detail in section 11.

12.17 Police engagement was significant but disjointed over a number of separate incidents. Some information was shared and some not. Because this case was being managed as team around the child rather than child protection, the police were not invited to meetings and no-one took an overview of all the information held.

12.18 The GPs were not engaged as part of the team around the child. The mother's GP did have regular communication with the health visitor and did take steps to ensure some information had been shared, but generally neither GP was asked for, or provided routine information. The father's GP recognised the risk of self-harm but it is not clear to what extent risk to others was considered. The GP made appropriate referrals to mental health services but did not routinely alert children's social care.

12.19 The Community Rehabilitation Company were pro-active in sharing information and immediately notified both the police and children's social care when they had reason to believe the father had returned to live at the family home. No information was sought from them.

12.20 The health visitor and the midwifery service were active in communicating with each other and with the GP and the social worker. The health visitor routinely updated the social worker and was very responsive when receiving information in following up

any concerns in a visit. The concern about rough handling was notified to children's social care the next day at the team around the child meeting.

12.21 The social workers generally kept the members of the team around the child updated. The social worker who completed the pre-birth assessment and supported the family up to the point of the incident, spoke with colleagues on the phone and made a number of joint visits.

12.22 Although communication was not with the full multi-agency network, the health visitor, midwife and mental health worker were all in touch with the social worker. What was missing was an agreement that any alert would be given in respect of missed appointments and any clear understanding as to what might be important from individual perspectives. Had the case progressed via a child protection conference to a child protection plan, there would have been a formal framework for information sharing with independent oversight.

Multi agency recommendation

Recommendation 3 That Stockport Safeguarding Children Board ensures all agencies provide guidance to staff around the importance of routine exchange of information and specifically around areas identified as protective factors and tests the effectiveness of such guidance.

The efficacy of Team around the Child Meetings

12.23 There is a practice issue about consent when the team around the child was first initiated. The mother felt she had no choice but to consent.

12.24 The purpose of the team around the child is to promote the well-being of the child through, in this case, support to the mother as a single parent with a care leaver background, and the team around the child process was appropriate and effective. When the father joined the household it continued to operate with the core membership of the social worker, health visitor and the parents, and reviewed the assessment which was completed following the assault on the mother.

12.25 When it became clear the couple wished to be together this should have prompted a review of membership and both mental health services and the Community Rehabilitation Company should have been asked to join. When the mother became pregnant the midwife did join.

12.26 Unlike the child protection system, there is no administrative process to support the team around the child system. It is entirely reliant on the lead professional, in this case the social worker, to identify who should be invited and send invitations. Professionals told us that generally dates would be fixed in meetings so if someone sent apologies they might not get the next date.

The purpose is to provide support and work with the family through coordination and information sharing. This is reliant on the right agencies being a part of the process. This was not achieved in this case.

Multi agency recommendation

Recommendation 4 That Stockport Safeguarding Children Board has access to audit methods to gain assurance that the team around the child is effective and that key professionals are fully involved. Outcomes need to be clearly evidenced.

Communication with and engagement of mental health services

12.27 This matter is considered in detail in section 11. Overall communication across agencies with the mental health services was poor and there was no representation in the team around the child process.

Multi agency Recommendations

Recommendation 5 – see Recommendation 4 – An audit should also examine mental health engagement and poor communication across agencies where there are mental health issues in particular, to ensure poor mental health engagement in team around the child process is not systemic.

The lack of Domestic Abuse programmes for perpetrators

12.28 Following conviction in respect of the assault on the mother the National Probation Service pre-sentence report author identified a need for the father to address issues of domestic abuse. As he had no prior convictions and in view of his mental health problems he did not qualify for the treatment programme. Nonetheless arrangements were made for one to one sessions to be delivered as part of the community order. Unfortunately, the father failed to comply. When he reappeared in court the officer made a further recommendation for an order which would have enabled this but the court did not follow the recommendation.

12.29 The issue in this case does not appear to have been the lack of provision but one of compliance on the part of the father and no recommendations are made.

Appendix A – Framework for Review

Framework of Review in respect of:

1. **Serious Case Review on Child D and for the**
2. **Independent Investigations under HSG (94) 27/ Serious Incident Framework 2015 in respect of Child D.**

Due to the circumstances of this case, two statutory reviews namely a Serious Case Review (SCR) and a Mental Health Serious Incident Independent Investigation are required. The statutory requirements and recommended methodologies for these two reviews have both common ground and differing elements and requirements. Two independent authors have been appointed. Every effort will be made to complete the two reviews together and, as far as is possible, produce a single integrated report.

The Framework below (Framework 1) is a framework for the serious case review commissioned by Stockport Safeguarding Children Board in July 2015. It is a document to act as a guide to the review. It may be subject to a change in the light of new information subject to agreement by the SCR Panel.

Framework 1 Serious Case Review

1.	<p>Purpose of the Review</p> <p>Stockport Safeguarding Children Board is committed to a culture of continuous learning and improvement across the partner organisations that make up Stockport Safeguarding Children Board.</p> <p>The review into the learning from Child D has been commissioned by Stockport Safeguarding Children Board. The purpose of the review is to learn all we can from the experience of Child D.</p> <p>The Stockport Safeguarding Children Board will seek to ensure that the serious case review will be conducted in a way which:</p> <ol style="list-style-type: none">1. Recognises the complex circumstances in which professionals work together to safeguard children2. Seeks to understand how practitioners interacted with the children and parents and with each other and the interplay of the difficulties and problems presented by the family and the practitioner expertise and resources. It will seek to identify the underlying reasons that led individuals and organisations to act as they did; identifying the contributory factors that influenced key events and decision making.3. Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than relying on hindsight analysis.4. Is transparent about the way data is collected and analysed and makes use of relevant research and case evidence to inform the findings. (<i>Working Together to Safeguard Children 2015, p74</i>) <p>The SCR aspects will be conducted using a hybrid approach which combines elements of a systems based approach but retains some of the traditional methods of an investigative approach to ensure that key events or decisions are identified. It will consider the practice that took place during the time period</p>
----	--

	<p>under review in the light of general practice, procedure requirements and expectation at the time. The review will seek to give all parties time to reflect on practice.</p> <p>The NHS Independent Review will run alongside this review. That review will draw on internal investigations within identified services. Separate terms of reference for that review are attached to this document. The two reviews will seek to complement each other where possible.</p> <p>Stockport Safeguarding Children Board has commissioned an Independent Reviewer, to carry out the review. The Independent Reviewer will be supported in this task by the review managers: Stockport Safeguarding Children Board Performance and Development Manager, who is independent of all agencies involved in the review and the Head of Safeguarding and Learning, who is independent of all agencies involved in the review. The review managers will chair any meetings that are required as a result of this review.</p>
2	<p>Scope of the Review - Time period under review</p> <p>The timescale of the SCR is review is from 13th July 2012, when the Child D's father came to the attention of children's social care to the 29th July 2015. This date covers the period of the mental health diagnosis of Child D's father, the birth of the first child and the period of agency involvement prior to Child D's death on 29th July 2015.</p>
3.	<p>Issues to be examined for the SCR (Key lines of Enquiry)</p> <p>Preliminary themes identified at SCR panel set up meeting:</p> <ul style="list-style-type: none"> • The quality and robustness of assessments completed; • Information sharing and the effectiveness of communication pathways and timeliness, particularly with mental health services ; • The effectiveness of team around the child meetings in effectively coordinating services for the family; • Discharge planning from hospital to include did not attend, monitoring of medication and support; • The role of 'tolerance' in managing cases; • The role of manager supervision; • Diagnoses of mental health - the extent to which the impact of mental health has an effect on parenting.
4.	<p>Methodology to be used and the reasons</p> <p>The method chosen for this review is a hybrid methodology - i.e. a review using elements of a systems review alongside features of an investigative review such as gathering of chronologies. Individual management reports are not required unless the decision of the SCR panel is that they are required for specified reasons.</p> <p>In conjunction with the serious case review there is a requirement for an NHS England Mental Health Review. A mental health expert will be appointed to complete that review and will sit on the serious case review panel. The purpose of this is to offer expert guidance on practice, and process and specialist knowledge about mental health. Where conversations with practitioners will be completed jointly.</p>

All agencies are asked to commit to the SCR methodology and to enable practitioner's to have time to take part in conversations. It is not possible to be certain what time commitment will be required or where the key lines of inquiry will lead to.

It is anticipated that the review will include the following:

- A timeline of events / chronology
- Meeting with the SCR panel of senior managers as appropriate
- Meetings with practitioners either in a group or through individual conversations where appropriate
- Efforts will be made to meet with the family to seek their views and support them to provide information
- Contribution from any other significant person/people who knew Child D if applicable

Serious Case Review Panel Meetings

Initial set-up meeting with the SCR panel on 29th September 2015. This first meeting will seek to plan the review in a collaborative manner to make the most of the opportunity to learn. The set up meeting will also agree how many meetings of the SCR panel need to be held and the frequency.

This panel will be made up of senior representatives of agencies who were involved in the care planning for Child D.

The Review Panel will consist of the following:
(SMBC -Stockport Metropolitan Borough Council)

- Head of Service - SMBC Children Social Care
- Service Manager - SMBC Children Social Care
- Designated Nurse - Stockport Clinical Commissioning Group
- Named Nurse - Stockport NHS Foundation Trust
- Head of Midwifery Services - Stockport NHS Foundation Trust
- Service Manager – SMBC Integrated Children's Service
- Head of Safeguarding & Learning - SMCB Safeguarding Children Unit
- Performance & Development Manager-Stockport Safeguarding Children Board (SCR Chair)
- Named Nurse - Safeguarding Mental Health Tameside and Stockport - NHS Pennine Care Foundation Trust
- Director / Author - Verita
- Senior Consultant - Verita
- Head of Neighbourhoods - Stockport Homes
- Senior Probation Officer - Community Rehabilitation Company
- Senior Probation Officer - National Probation Service
- Independent Investigation Lead - NHS England (North)

This Panel will agree meeting frequency in order to:

- Monitor the progress of the review and identify key themes or issues to emerge.
- Consider the learning that has been gained throughout the review.

The minutes of these meetings will be kept by the serious case review business support officer and shared with all members within 10 working days.

The independent reviewer will share findings for a 2nd SCR panel meeting. There will be a further meeting to agree a draft report and the outcome of the meeting will aim to be agreement over the final content and approval of the findings.

Where there is disagreement there will be as many meetings held as required to reach an agreed final draft of overview report.

Practitioner Interviews

The independent reviewer will conduct individual conversations with practitioners who held a key role Child D's care. Members from the SCR panel will be encouraged to complete the conversations with the independent reviewer in order to ensure that panel members are helping to facilitate the review and contribute to analysis and identifying themes.

The purpose of the practitioner conversations is to support a narrative of events which can be identified through the chronologies and to allow the practitioners to tell their story, identify significant events, interactions or issues, and help to identify the contributory factors that are enhancing professional practice and identify any barriers or shortfalls that may be an impediment or require improvement. The conversations are intended to highlight practice that worked well, in addition to challenges, or barriers to good practice.

Staff will be asked for permission to record these interviews. We intend to record these conversations with a digital recorder and saved if required for disclosure purposes. The performance & development manager of Stockport Safeguarding Children Board (SCR chair) will save the recordings as files on Stockport ICT system and delete them as soon as the review is complete. The SCR Panel can have access to these recordings if required.

Where staff members do not wish to be recorded a co-interviewer will write notes from the meeting to make a record of what was discussed.

Practitioners identified to be interviewed for this SCR are:

- 3 x Social workers, children social care;
- 3 x midwives;
- GP;
- Health visitor Stockport NHS Foundation Trust ;
- Independent Reviewing Officer - Safeguarding Children Unit;
- Police officers x 3 - Greater Manchester Police;
- Probation officer -National Probation Service;
- Team manager - SMBC Children's Social Care;
- Assistant midwife - Stockport NHS Foundation Trust
- Adult mental health worker - Pennine Care NHS Foundation Trust

Every effort will be made to meet with family members of Child D and other key family members.

	<p>Practitioner Group Meetings</p> <p>It is hoped that at the conclusion of the criminal proceedings, that the practitioner group can meet to discuss the key findings, although it is recognised that an interim report may have already been prepared by that date, with the practitioner views and SCR panel views having been given. This will most certainly be a step in the dissemination of learning from the review.</p> <p><u>The Independent Reviewer</u></p> <ul style="list-style-type: none"> • Will review all documentary evidence in relation to the Case – i.e. particular records or reports that are requested in consultation with the panel. • Will produce an overview report for the panel. • Will present this overview report to Stockport Children Safeguarding Board • Will contribute to a learning and development event for practitioners and managers if required to do so. <p><u>Stockport Safeguarding Children Board</u></p> <ul style="list-style-type: none"> • The performance and development manager for Stockport Safeguarding Children Board will act as the SCR review manager and chair the SCR panel meetings and practitioner panels. • The performance and development manager for Stockport Safeguarding Children Board will request agency chronologies • The business support officer will compile combined chronology using specific software. • The performance and development manager for Stockport Safeguarding Children Board and independent reviewer will liaise with HM Coroner, legal representatives and any other person identified. • This overview report will be published on completion of the review. • The performance and development manager for Stockport Safeguarding Children Board will support contributing agencies in the development of a multi-agency action plan to address the key findings. • Both multi-agency and single agency action plans will be reported and monitored by Quality Assurance and Performance Management Sub and Stockport Safeguarding Children Board
5.	<p>Good Practice</p> <p>This review will seek to identify good practice which is identified through the process of conversations, documentation reviews and group work as applicable.</p> <p>Good practice that has taken place will be acknowledged and highlighted in the SCR and practitioners and managers will be given the opportunity to identify systems and practices which work well.</p>
6.	<p>Reference to disclosure , criminal proceedings or any other matters causing delay</p> <p>If there are any delays to the progress of the review for whatever reason, the review panel should be notified as soon as possible. This information will also be conveyed to Stockport Safeguarding Children Board.</p>

7.	<p>Confidentiality and anonymity arrangements</p> <p>No papers or details of this review will be shared with any person who does not need to have the information. If required advice on this matter should be sought from the independent reviewer or the review managers if for any reason this review needs to be discussed. Where there is a conflict of interest in relation to confidentiality the individual organisations will seek to resolve this as early as possible.</p> <p>Outside the confines of this review, all efforts will be made to maintain the anonymity of the witnesses and their families and workers involved in the case at all times.</p>
8.	<p>Ethos of the Review including commitment to family and wider social group involvement and adherence to the Equality Act 2010</p> <p>Stockport Safeguarding Children Board seeks to promote an open culture of learning. The priority is to ensure that organisations are engaged in a way that will ensure that important factors in a case can be identified and appropriate action taken to make improvements. All professionals from agencies contributing to this review will participate without fear of blame for actions they took in good faith at the time (p66) in order to maximise this opportunity to improve our services. The review will be coordinated in such a way that all involved will have a voice in the review and where challenge, exploration and discussion are encouraged.</p> <p>The review:</p> <ul style="list-style-type: none"> • will recognise the complex circumstances in which professionals work together, • will seek to understand who did what and why, • view practice from the viewpoint of individuals and organisations taking account of hindsight, • be transparent about the way information is collected and analysed, and • use research to evidence and inform findings. <p>Other considerations:</p> <p>Legal and coronial proceedings will run in parallel to this SCR and information will be provided as required. Criminal proceedings mean that information will be provided to the coroner as requested.</p> <p>Coroner court is scheduled.</p> <p>Single agency processes may take place in this SCR as is the case for any other review. It is expected that single agency learning as a result of single agency review will be fed into the multi-agency case review process.</p> <p>The review will seek to have the voice of the family and wider social groups if possible. At all times they will be offered the utmost respect and sensitivity. They will be free to bring any supporters to meetings as they choose. Meetings will be arranged to suit them and their needs. A second interviewer will accompany the Independent Reviewer to take written notes.</p>

9.	<p>Arrangements for feedback on progress to the commissioners</p> <p>The Head of Service for Safeguarding and Learning will keep Stockport Safeguarding Children Board informed about the progress of the review and any issues that arise.</p>
10.	<p>Statement that report will be written with recommendations made if appropriate</p> <ul style="list-style-type: none"> • The independent reviewer will prepare a report of her findings and those will be shared with the SCR Panel in the first instance. The report will be written with the expectation that it will be published in full and without redaction. • The SCR panel may work with the independent reviewer to formulate recommendations, reflections or challenges based on evidence that she has found in order to improve local services.
11.	<p>Publication and Dissemination</p> <ul style="list-style-type: none"> • When the SCR panel is satisfied that the review has been completed and agreed the draft report, it will be presented to Stockport Safeguarding Children Board. Consideration will need to be given to sharing information with Liverpool Safeguarding Children Board. The independent reviewer will attend Stockport Safeguarding Children Board to share the review findings. This will be the final opportunity to make comment before the review is finally 'signed off'. • Stockport Safeguarding Children Board has the responsibility to decide on the way the report is to be anonymised and if any parts of the report are to be redacted. A date for publication will be agreed. • Consideration will be given to media notification and publication date with reference • Stockport Safeguarding Children Board will seek a legal view in regard to publication in terms of the European Convention of Human Rights • On conclusion of the review and before publication, the final report will be shared with the families involved as appropriate. • The final report will be published on Stockport Safeguarding Children Board Website, and the learning disseminated through learning events. • The final report will be lodged in NSPCC repository for SCR's as a national resource.
12.	<p>On completion of the review, Stockport Safeguarding Children Board will include the findings in the safeguarding learning events in order to disseminate the learning to front-line practitioners.</p> <p>Stockport Safeguarding Children Board will seek to maintain a programme of improvement around the issues identified and ensure that that improvement is sustained and embedded.</p>

Framework 2 Terms of Reference – Independent Investigation of a Serious Incident

<p style="text-align: center;">Core Terms of Reference for Independent Investigations under HSG (94) 27/ Serious Incident Framework 2015</p> <p>Preliminary terms of reference set by NHS England discussed at the SCR Panel set-up meeting on 29.9.2016 are :</p> <p>The Individual Terms of Reference for Independent Investigation 2015/25893 have been set by NHS England North and agreed by Stockport Safeguarding Children’s Board.</p> <p>These terms of reference will be developed further in collaboration with the author, the Independent Panel Chair and affected family members where appropriate. However in order to meet the combined requirements of a Serious Case Review (Child) and a Mental Health Homicide Independent Investigation, the following terms of reference will apply;</p> <ul style="list-style-type: none">• Assist the Independent Panel Chair to determine a chronology of all agency involvement and request where appropriate relevant Agency responses.• In the absence of an internal report, assist the mental health provider to produce a comprehensive IMR.• Review the appropriateness of the treatment of the service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.• Review the adequacy of risk assessments and risk management, including specifically the risk posed to others including children.• Examine the effectiveness of the service user’s care plan including the involvement of the service user and the family.• Consider the quality of both health and social care assessments on which decisions were based and actions were taken.• Involve the affected families and the perpetrator as fully as is considered appropriate, in liaison with the police and other support organisations.• Review and assess compliance with local policies, national guidance and relevant statutory obligations.• Consider and comment on the extent that mental health issues may have impacted on parenting capacity.• Consider the level and extent of agency engagement and intervention and whether this was appropriate to the assessment of the parents’ ability to provide adequate care and supervision of the child.• Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.• Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

	<ul style="list-style-type: none"> • Consider any evidence of a child having suffered, or been likely to suffer significant harm that was not recognised by organisations or individuals in contact with the child or perpetrator; or not shared with others; or not acted upon appropriately. • Determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement • Co-produce a written overview report to Stockport Safeguarding Children’s Board and NHS England that includes measurable and sustainable recommendations. • Assist NHS England North in undertaking a brief post investigation evaluation. <p>Supplemental to Core Terms of Reference :</p> <ul style="list-style-type: none"> • Assist/support the Provider in developing a robust, measurable outcome based implementation plan. • Support the Commissioners in developing a structured plan for review of implementation of recommendations. This should be a proposal for measurable change and be comprehensible to service users, carers, and others with a legitimate interest.
--	---

Biographies

Jane Booth

Jane Booth is an independent social care consultant with more than 40 years' experience as a practitioner and manager. She holds a Certificate of Qualification in Social Work, a Diploma in Applied Social Studies and an MA in Child Care Law and Practice. She has worked with both children and adults as a practitioner, manager and inspector. She currently is the Independent Chair of two Adult and Children Safeguarding Boards in the North West. She has not worked for any of the agencies whose work is considered as part of this review.

Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-profile investigations and reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations and individual management reviews. As head of training Chris has developed and delivered courses on different aspects of systematic incident investigation. In the course of her career she has held senior positions at regional and local level within the NHS, including director of mental health services for older people.

Gemma Caprio

Gemma is a senior consultant at Verita and is based in the Leeds office. Gemma has gained extensive investigative and governance experience within the NHS having worked in primary care, at an acute trust and at North West Strategic Health Authority, supporting the transition from North West Strategic Health Authority to NHS England and the commissioning and publication of mental health homicide investigations.

Dr Mostafa Mohanna

After graduating from medical school with an MB, BCh, Mostafa went on to get his basic training in psychiatry at Leicester and subsequently, after gaining membership of the Royal College of Psychiatrists (MRCPsych), became a lecturer with the Leicester Medical School. From there he went on to become a senior registrar in the Cambridge rotation. Mostafa then took up a consultant post in Lincoln in 1990 and has been in that position since. Mostafa, during his consultant tenure, became the clinical tutor organising the junior doctor rotation and from there went on to become the clinical director for the mental health services. He then became the medical director for the newly formed Lincolnshire Partnership Trust in 2001 and has been in that post since. The post involves, amongst other things, investigating untoward incidents and complaints and liaising with external bodies coming into Pennine Care NHS Foundation Trust to investigate incidents. As medical director, Mostafa is joint lead, with the director of nursing, on clinical governance and quality, and has the lead on research and clinical effectiveness. Mostafa was recently made a Fellow of the Royal College of Psychiatrists (FRCPsych).

Glossary

ADHD	ADHD is a chronic condition marked by persistent inattention, hyperactivity, and sometimes impulsivity. ADHD usually begins in childhood and often lasts into adulthood. As many as 2 out of every 3 children with ADHD continue to have symptoms as adults.
Care Leaver	A young person entitled to ongoing support having been in the care of a local authority.
Child Protection Conference and Plan	<p>Following section 47 enquiries, an initial child protection conference brings together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child's future safety, health and development. If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth.</p> <p>The purpose of a conference is to bring together and analyse, in an inter-agency setting, all relevant information and plan how best to safeguard and promote the welfare of the child. It is the responsibility of the conference to make recommendations on how agencies work together to safeguard the child in future. One of its functions is to agree whether a Child Protection Plan is required to safeguard the child/ren and if so develop an outline child protection plan, with clear actions and timescales, including a clear sense of how much improvement is needed, by when, so that success can be judged clearly.</p>
Independent Reviewing Officer	An officer of the Local Authority who has had no role in line management of a case who ensures the plan for the child is in line with the child's needs and progressing on a timely basis.
Looked after	This refers to a child who is accommodated by the Local Authority either as a result of a care order or by agreement with the child's parents.
Bi-polar Disorder	<p>Bi-polar disorder, also known as manic depression, is a mental illness that brings severe high and low moods and changes in sleep, energy, thinking, and behaviour.</p> <p>People who have bipolar disorder can have periods in which they feel overly happy and energized and other periods of feeling very sad, hopeless, and sluggish. In between those periods, they usually feel normal. You can think of the highs and the lows as two "poles" of mood, which is why it's called "bipolar" disorder.</p>

Pre-birth Assessment	If concerns relate to an unborn child, consideration should be given as to whether to hold a child protection conference prior to the child's birth. In such cases an assessment of risk and need should be completed including the child/children's additional needs and deciding how these should be met. It promotes more effective, earlier identification of additional needs, particularly in universal services and aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development.
Team Around the Child	This term describes a formal process for managing and coordinating multi-agency support to a family where there is a Child in Need. In all cases a Common Assessment Framework will have been completed in Stockport to provide a framework for the support required. The agency with the primary involvement will usually initiate this process and provide a lead professional. The process involves regular meetings between professionals and the family and requires the family to consent.