Bury Integrated Safeguarding Partnership

Serious Case Review Joshua

Final version 29 June 2021

Commissioned in accordance with Regulation 5(1) (e) and (2) of the

Local Safeguarding Children Board Regulations 2006

Overview Report (June 2021)

Lead Reviewer and Independent Chair: Paul Sharkey (MPA)

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1. Introduction

1.1. This Serious Case Review (SCR) concerns the child Joshua[1], who on the 11.09.19 died at the age of nearly eleven months through the actions of his father (John), in whose care he was at the time of the incident. John was subsequently arrested by the Greater Manchester Police who commenced a criminal investigation.

1.2. Joshua was born in Manchester in October 2018 and was the first child to his mother (Jennie) and father (John). Jennie later gave birth to a daughter in October 2019 (Mary). Joshua was of dual heritage, namely White British by his mother and dual heritage Black British Caribbean through his father.

Joshua-Who He Was.

1.3. Joshua was described by those professionals who saw him (in July 2019) as a happy child, ' all smiles and babbling……lots of crawling about and full of smiles as he explored his red fire engine'. He loved it when nursery rhymes were sung to him giving out lots of giggles and trying to clap his hands. His parents were proud of him thinking him amazing and so clever. He had attached well to them and was loved not just by them but also his wider family of grandparents, aunts and others. He was, 'a ping pong ball with legs' finding everything funny. He interacted well with his mother (and father) who would sit on the floor with him with crayons and paper, which he loved.

1.4. The Chair of the Bury Integrated Safeguarding Partnership (BISP) decided on the 30.09.19 to commission a Serious Case Review (SCR). An Independent Chair/Lead Reviewer was appointed in October and work started on the review that month.

1.5. The lead reviewer presented an interim report to the BISP Executive on the 20 May 2020. It was an interim report because at the time of writing in May/June 2020, the lead reviewer and panel were awaiting a Root Cause Analysis report, from the Greater Manchester Mental Health NHS Foundation Trust. This report was received by the lead reviewer on the 29.06.20 and provided useful insight into the circumstances around the way that John's mental health needs, in the two weeks leading up to Joshua's death (August 31 to 11 September 2019), were responded to by the mental health liaison service based at the North Manchester General Hospital Accident and Emergency department. It has informed the analysis of this document which is now the final report.

Methodology and Review Processes

1.6. Essentially the review is underpinned by the, 'Welsh model', of extended reviews (Welsh Government; 2012) and draws on the, 'Pathways to Harm' (Sidebotham P et al; May 2016, pages 22-26: Brandon. M et al: March 2020, pages 12-14; 23-25) systems model to understand the agency/organisational context

[1] The names of the child and his parents have been changed for reasons of anonymity and family confidentiality

in which children sustain harm. This seeks to move beyond focusing exclusively on the level of the practitioner- 'active failures'- and offers an analysis that locates the actions/decisions of the practitioner within a wider organisational context of 'latent failures' characterised by 'barriers and defences' embedded within the agency. It is the presence of these barriers and defences both within and between (at the interfaces) the organisational systems that gives rise to the latent failures and results in a more or less safer operating environment for practitioners to make decisions and take actions to safeguard children and young people.

1.7. The SCR was independently chaired and led by Mr. Paul Sharkey who had had no previous connections with any of the Bury or Manchester agencies involved with the family. He is an experienced reviewer from a social care/safeguarding/public protection background in both the statutory and third sector.

1.8. The reviewer worked with a panel made up of senior managers from the involved agencies from Bury and Manchester. It met four times between November 2019 and July 2020. It was assisted by Dr. Mark Potter, a consultant psychiatrist appointed by NHS England, who advised on mental health matters regarding John's involvement with the adult mental health agencies in Manchester and Bury. On the review's completion he will provide NHS England with a brief report on any relevant mental health lessons emerging from the review.

1.9. The SCR drew its evidence from,

- Short information reports from all of the Bury and Manchester agencies involved with the family.
- Relevant documentation such as agency assessment reports.
- The Root Cause Analysis report undertaken by the Greater Manchester Mental Health NHS Foundation Trust (June 2020)
- An integrated chronology.
- A Practitioner's event held in January 2020.
- Individual focused discussions with several practitioners who had significant involvement with family members.
- A meeting with Family members.

Aims of the SCR

1.10. The aim of this SCR is, 'to identify improvements which are needed and to consolidate good practice. The BISP and the Manchester Safeguarding Partnership and their respective partner agencies should translate the findings of the review into programmes of action which lead to sustainable improvements and the prevention of death, serious injury and harm to children' (Working Together:2015: Chapter 4, paragraph 7).

1.11. The SCR seeks to, 'understand both why mistakes were made and critically, comprehend whether mistakes made on one case frequently happen elsewhere and understand why. The overall purpose is to explore how practice can be improved more generally through changes to the system as a whole'. (Child Safeguarding Practice Review Panel: practice guidance, p7: April 2019)

1.12. The SCR has considered the following overarching questions, namely, why were agencies in Bury and Manchester unable to safeguard Joshua? How can practice be improved through systemic changes with the Bury and Manchester Safeguarding Partnerships respectively to prevent/minimise the re-occurrence of what happened to Joshua?

1.13. The following key lines of enquiry (KLOE) have been considered for analysis.

1. Risk

How effective, both pre and post birth, were agency assessments of risks and needs regarding Joshua, his parents, and the unborn child?

2. Vulnerability of Babies

How well did agencies recognise and respond to the vulnerability of Joshua, particularly in regard to the trilogy of risk around, parental mental health, substance abuse and domestic abuse?

3. Thresholds

Should Joshua's welfare have been located within a Child in Need or Child Protection (level 4/5) band (as per the BISP Threshold Framework), rather than at the Team around the Family (TAF/level 3) band?

4. Joshua's voice and lived experience

How well was Joshua's voice heard and his lived experience recognised by agencies?

5. Inter-Agency Communication

How effective was inter-agency communication and information sharing in relation to safeguarding and promoting the well-being of Joshua? Was consent a barrier?

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6. The Bury multi-agency safeguarding hub (MASH)

How effectively did the Bury MASH gather and analyse information from partner agencies and how effectively did this inform decision making in the case?

7. Parental mental health and learning disability

How effectively did adult mental health and learning disability agencies use historic information in relation to the parents' mental health and John's learning disability? Was this information shared and used for analysis of risk and need regarding Joshua? How effectively did the relevant agencies respond to the parents' mental health and learning disability needs, including any transitions between agencies?

8. Good Practice

What examples were there of good practice?

Scope

1.14. The review's focus of interest covered the period from 01.01.18 (initial pregnancy of Jennie) to the date of Joshua's death on the 11.09.19. Parental social history prior to this time is included in brief to provide context.

1.15. This review explicitly acknowledges the many difficult challenges for professionals in safeguarding children and vulnerable adults in a complex, rapidly changing, multi-agency operating environment of uncertainty, incomplete information, resource pressures and service fragmentation. In keeping with current official guidance, (Child Safeguarding Practice Review Panel: April 2019) this review, whilst analysing the rationale for professionals' actions and decision making, expressly does not seek to blame or find fault with individual practitioners for actual or potential practice shortcomings. Reviews are not designed for this purpose; rather, it is the role of regulatory bodies[2] to hold organisations, their leaders, and individual professionals to account for not meeting professional standards.

1.16. The key objective of this review is to identify learning within a systems perspective of organisational barriers and enablers that either hinder or aid individual practice, decision making, and actions taken within the context of inter and intra agency/organisational working.

Parallel Processes

1.17. A criminal enquiry was undertaken by the Greater Manchester Police following Joshua's death. John was subsequently charged with the murder of his son. His trial was originally set for 23.03.20 but was rescheduled for late November 2020 due to the Covid19 emergency. He was found guilty of manslaughter by reason of diminished responsibility and sentenced to a hospital order under section 37 of the mental health act.

1.18. It is understood that an inquest into Joshua's death will take place on conclusion of the criminal process.

[2] A further source of accountability will be the inquest into Joshua's death.

Family Involvement

1.19. Jennie gave her views to the lead reviewer in late February 2020 which are included in this report. The lead reviewer has not been able to speak to John following advice from the Greater Manchester Police.

2. Synopsis of Events and Case Overview

Pre-2018

2.1. John originates from Manchester and experienced a difficult childhood characterised by several significant adverse childhood experiences (Early Intervention Foundation; February 2020) which included exposure to domestic abuse, parental mental health issues and parental substance misuse. Arising out of this abusive environment, he developed a set of complex mental health, behavioural, learning disability and educational needs that were met by a range of social care, educational and health agencies in Manchester. At sixteen years old he was compulsory detained, at a local adolescent in-patient mental health facility, under section 3 of the Mental Health Act;1983 (MHA, 1983) between 2014-2016.

2.2. He was discharged under a community treatment order (CTO) in February 2016 which lapsed in July 2016. This was because there was agreement by John's multi-disciplinary team (MDT) that his community treatment order should be allowed to end after six months (in July 2016), as he had remained stable and well; and had adhered to the conditions around engaging with treatment, abstaining from cannabis, and living at the agreed accommodation.

2.3. On discharge of the CTO John received support from the Manchester Early Intervention Team (EIT) until January 2018. Responsibility for John's care was then transferred to the Manchester (Adult Social Care) Transition Planning Team, (MTPT) which was charged with reviewing his care annually. Outpatient medical oversight under section 117 (MHA, 1983) was provided by the Manchester Learning Disabilities service psychiatrist (the responsible clinician, RC2)[3]. Shared Lives[4], a Manchester Council housing agency with a remit to support vulnerable adults provided John with supportive accommodation as part of the multi-agency support plan on transferal from the EIT. (See appendix 1 for further explanation of the roles and remits of the Manchester social care and health teams that provided CTO support and S.117 after care).

[3] A Manchester University NHS Foundation Trust. The LD service is co-located with social care practitioners.

[4] A regulated Care Quality Council service.

2018

2.4. Jennie became pregnant with Joshua in February 2018 by John and registered with maternity services (Pennine Acute Hospital Trust) in late March. John's support agencies were notified by Manchester EIT of the pregnancy, they having recently discharged him. The couple stayed at Joshua's maternal grandmother's house until June but were unable to remain there and became homeless. They were allocated temporary accommodation (a private rental) in Bury on the 26.06.18 by Manchester City Council housing solutions and allocated a floating support service caseworker (FSS1) in early August 2018.

2.5. Meanwhile, John had by June come to the attention of the Greater Manchester Police (GMP) of having links with a local[5] organised crime group (OCG). This continued in 2018/19 with several intelligence reports to that effect.

2.6. The couple registered with a Bury GP (general practitioner) practice in August 2018. John was discharged from the care of the Manchester Learning Disability (health) service on the 07.08.18 because of a lack of attendance and remained without a similar support service up to Joshua's tragic death in September 2019, albeit that a later referral was made to Bury Learning Disability Team by Manchester Transitional Planning Team in April 2019.

2.7. Joshua was born on the 16.10.18 at North Manchester General Hospital (NMGH) and discharged with his mother on the 18.10.18. They transferred to the care of the Bolton community midwifery service who transferred care to the Bury health visiting service shortly after. A health visitor (HV1) started home visiting under a Universal Partnership Plus plan (UPP)[6] on the 29.10.18, visiting four times up to January 2019. Responsibility transferred to HV2 who remained involved until the 17.05.19, having visited on four occasions. The family was then transferred to the Bury (a different area) health visiting team under the care of HV3 and HV4 (on the 23.05.19).

2.8. HV1, recognising the relative vulnerability of the parents, made a referral in November 2018 to a local Children's Centre for outreach family support, albeit no concerns were noted regarding the physical day to day care of Joshua. Following liaison with MSW2 (a Manchester Adult Care social worker from the Transition Planning Team, involved with John) and information sharing about John 's mental health history (with his consent), HV1 made a referral to the Bury MASH (multi-agency safeguarding hub) on the 03.12.18. An initial response team (IRT) social worker (BSW1) started a Child and Family (C and F) assessment on the 07.12.18 which was completed in early February 2019. The Children's Centre ceased its involvement with the family because of the on-going C and F assessment.

[5] Believed to be an OCG in Manchester.

[6] The UPP offer is the level 4 (highest level) health visiting service intervention of the Healthy Child Programme for families with complex health needs. Level 3 is known as Universal Plus (UP) for vulnerable families and Level 2 is the Universal service offer of basic intervention where there are no additional needs identified.

2019

1. The C and F assessment decided on no further action and case closure, on the grounds that there were no identified concerns for Joshua's care, no evidence from MSW2 of John's mental health deterioration and the family having declined help. This was communicated to HV2 via Jennie, and not from BSW1 directly.

2. Both parents and Joshua were seen for a patient assessment by the GP on the 07.02.19 with positive outcomes. John received a thorough new patient mental health check and was advised to make a consultant appointment. However, unknown to the GP, John had been discharged from RC2's clinical oversight in early August 2018 and understood that RC2 (from the Manchester Learning Disability (clinic) service) remained John's consultant psychiatrist in lieu of not having received any notification that he had previously been discharged from the service in August 2018. The practice did not receive a letter prior to the February 2019 consultation, at any time in August 2018 or thereabouts informing the practice that father had been discharged from psychiatric services for non-attendance at appointments.

3. In early April the Bury Learning Disability (BLD) team received a referral from the Manchester Transitional Planning Team requesting a support assessment for John; this started on the 25.04.19. By now Jennie was again pregnant and duly registered with the Pennine Acute Hospital Trust (PAHT) midwifery service on the 02.04.19.

4. MSW2 (from the Manchester Transitional Planning Team), having closed the case on 01.04.19, made a referral to the Bury MASH on the 25.04.19 with concerns about John 's behaviour; not having taken his medication[7] for three months, and housing issues. This followed a call the previous day from a Shared Lives worker to Bury Children's Social Care reporting similar concerns to MSW2 regarding John being in a distressed state, following an incident at the Abraham Moss office. In the event, the concerns were followed up by Greater Manchester Police who sent a police officer to the family home in Bury. Both parents denied any domestic abuse and Joshua was deemed to be, 'safe and well'. As noted above, the Shared Lives referral was followed up with the Bury MASH the next day by MSW2.

5. Bury MASH sent the referral to the Initial Referral Team (IRT) on the 25.04.19. On the same day, a (second) C and F assessment was started by social worker (BSW2), who completed it on the 15.05.19. BSW2 recommended a level 3 intervention, Team around the Family (TAF/single agency) approach and a referral to the Bury Outreach Service based in a local Children's Centre. At this point there were several agencies involved with the family, including the health visiting, midwifery and GP services for Joshua/Jennie, Manchester Transitional Planning and Shares Lives services for John and a Manchester floating housing support worker (FSS1) for the family.

[7] At the time of John's discharge from the Early Intervention Service in February 2018, he was prescribed; Aripiprazole 10mg (once daily) and Atomoxetine, 80mg (once daily), by the Learning Disability (LD) Team. This team was responsible for both prescribing and monitoring of John's medication. However, he was discharged from the LD team in August 2018. It is unclear as to what arrangements were made regarding continuing medication.

6. Meanwhile, John's mental health started to decline when he attended the Accident and Emergency (A/E) department of the Northern Manchester General Hospital (NMGH) on the 09.05.19 with a support worker from Shared Lives. He had been violent earlier at the social work office (Abraham Moss), said he wanted to kill himself and others and had stopped taking his medication. He was seen by the mental health liaison team by which time his agitation (thought to have been due to social stressors) had settled with no signs of psychotic symptoms. He was subject to a structured assessment and referred to his GP with a request to consider restarting his previous medication, Atomoxetine. There was no reported discussion about Joshua or safeguarding concerns.

7. The proposed joint Bury Learning Disability/Adult Social Care assessment did not materialise as John had apparently moved to Manchester in May, having reportedly separated from Jennie and Joshua. He was discharged from the Bury Learning Disability (BLD) service (having not been seen by them), on the 04.06.19 with a suggestion that he be referred to the appropriate Manchester agency.

8. HV4 from the Bury health visiting service took over on the 23.05.19 and eventually (after one no access visit on the 17.06.19) made a joint visit with the recently allocated (Bury) outreach worker (OW1-) on the 05.07.19, when mother and Joshua but not John (who had since returned to the family) were seen. OW1 completed her work with the family in late July, them saying that further support was not necessary. The case was closed on the 01.08.19.

9. Jennie had missed three midwifery appointments during June-August as well as not attending appointments with HV4. A third referral was made to Bury MASH by the Royal Bolton Pennine Acute Trust midwifery service on the 02.09.19[8] which followed an earlier self-referral (29.08.19) by Jennie to 'Bury Healthy Minds'[9] for help. Bury MASH decided on sending a letter to Jennie on the 05.09.19 asking her to contact them within seven days.

10. Meanwhile, John had attended North Manchester General Hospital (NMGH) Accident and Emergency (A/E) department three times between the 31.08.19 and the 08.09.19, appearing in an agitated state saying that he had not taken his medication for several months and wanting to be sectioned. He was seen by the mental health liaison team (MHLT) on two occasions (31.08.19, 03.09.19) and subject to a full mental health risk assessment on the 03.09.19 by a mental health practitioner (MHP1) with a discharge plan involving a referral to the Bury Access and Crisis Team who received it on the same day.

11. The Bury Access and Crisis Team screened the referral on the 03.09.19. Because of the thorough assessment previously completed by MHP1, it was deemed that a further assessment was not needed. A decision was made to request an out-patient appointment for John with a consultant psychiatrist and a referral to the community mental health team. A screening by the consultant psychiatrist should have taken place on the 05.09.19 but for reasons unknown to the agency (and to this review), this did not happen. The referral stayed in consultant screening for the following week and was due to be screened on the 12.09.19, the day after the tragic death of Joshua.

[8] Did not attend the ante natal clinic. A special circumstances form (SCF) was completed by the midwife in ante natal clinic as a s47 referral due to non-attendance, saving babies lives scans required, with a note to contact Bolton community midwives again.

[9] Operated by Pennine Care NHS Foundation Trust

12. John presented again to NMGH A/E on the 08.09.19. The on-shift practitioner (MHP2), in light of the recent assessment of the 03.09.19, stated to A/E triage that further information was required before an assessment was indicated. MHP2 neither received nor sought any further information and John was not assessed by the mental health liaison service.

13. John had also attended his GP on the 02.09.19 when he was given a two-week supply of medication (Aripiprazole, 10mg/tablet/daily).

14. Tragically, Joshua died on the 11.09.19 through the actions of his father.

3. Analysis against the Key Lines of Enquiry

3.1. Risk and Needs Assessments-Threshold Intervention Levels

3.1.1 There were three occasions for agencies to have undertaken risk and need assessments. Firstly, in the ante-natal period of Joshua's birth, secondly, in December 2018 to February 2019 (the first Bury CSC Child and Family Assessment) and thirdly, the second Bury CSC Child and Family Assessment of May 2019.

Pre-birth assessment of Joshua

3.1.2 Using the 'Pathways to Harm' systems approach (Sidebotham; 2016) the two key universal services that had initial contact with the parents prior to the birth of Joshua were the North Manchester General Hospital midwifery service[10] (26.03.18) and the GP practice in Bury. The key defensive barrier for identifying and mitigating any potential serious harm to Joshua at this early stage was by way of recourse to the Greater Manchester Safeguarding Partnership, 'pre-birth assessment' protocol'. Were there grounds at that time for its use in safeguarding and promoting the future welfare of Joshua?

3.1.3 The evidence presented to the review would suggest not. It indicated that there were no clear and current risks manifest at this stage that would have warranted a request for service to either the Manchester MASH (up to the June 2018 move to Bury) and from June, the Bury MASH, for a pre-birth assessment. Both parents were open about their background. Indeed, John had told the midwife at the booking in appointment on the 31.03.18 that he was on medication for Attention Deficit Hyperactivity Disorder (ADHD). Albeit he offered no additional information about his mental health history.

3.1.4 In this regard, the review was informed[11] that if a male partner had presented with ADHD as stable and on medication, the risk would have been deemed low, as a diagnosis of ADHD alone would not raise

[10] Jennie was seen by the Salford midwives from late March to June 2018 and then, following the move to Bury, by the Bolton midwives from June to Joshua's birth

[11] By the panel member from the NHS Bury CCG

safeguarding (or other) concerns. No further questioning would have taken place, given what was shared with the midwifery service at the time. Access to partner's records was not available to the midwifery service. An ADHD diagnoses on its own would not have met the threshold for a referral into Children's Social Care. Therefore, none was made.

3.1.5 Jennie self-reported with a previous history of anxiety, depression, and self-harm some seven years before, aged fifteen; having received counselling from the Child and Adolescent Mental Health service (CAMHS). She reported as being emotionally well to the midwifery service and did not disclose any recent mental health episodes.

3.1.6 Jennie had frequent ante-natal contact with the maternity and midwifery services, often accompanied by John. Both parents said that they were, 'stable' and looking for work, with no other disclosures of any problems, including domestic abuse or substance/alcohol misuse. The maternity notes documented that there were no other agencies involved with the family. As previously noted, John's ADHD, according to the midwifery report provided for this review, by itself would not have warranted consideration of a pre-birth assessment.

3.1.7 In essence, none of the factors listed in the Greater Manchester Safeguarding pre-birth assessment guidance were present or known to the midwifery service, thus precluding it from making a pre-birth assessment referral. In any event, it was decided to continue to assess Jennie's emotional well-being throughout the pregnancy. A special circumstance form (SCF) was generated as a result of John's ADHD and mother's history which was updated following Joshua's birth, stating that there were no concerns identified by midwifery and hospital staff.

3.1.8 Regarding the Primary Care (GP) service, there is minimal evidence of any involvement with Manchester/Salford primary services by the parents prior to moving to Bury in June 2018. Following the move, John joined the GP practice on the 13.08.18 with Jennie joining on the 30.11.18, after Joshua's birth. John, despite several letters of invitation to attend for a new patient appointment did not do so until the 07.02.19, along with Jennie and the new baby. The Practice had received a letter on the 20.12.18 regarding John's mental health from the Greater Manchester Mental Health Trust. This was ten-month-old information (06.02.18) relating to an appointment set for him on the 09.05.18. Thus, the evidence would suggest that the GP practice had no information on the parents of any significance during the ante-natal period, thereby, negating the need for any information sharing with the maternity/midwifery service.

Finding 1: There were no grounds for the Northern Care Alliance midwifery/maternity services to have made a referral to the respective Manchester/Bury MASHs for a pre-birth assessment of Jennie.

First Bury Child and Family Assessment: December 2018-February 2019

3.1.9 At this point the family had been residing at the Bury address since late June 2018 and had been allocated a health visitor (HV1) shortly after Joshua's birth on the 16.10.18 at the North Manchester General

Hospital. HV1 assessed that the family was vulnerable and required a raised level of intervention, namely the Universal Partnership Plus[12] service offer.

3.1.10 The first Child and Family Assessment (CFA1) by Bury Initial Response Team (IRT) was prompted by HV1 who had spoken to John's social worker from Manchester Adult Social Care, Transitional Planning Team, (MSW2). They had shared information, including a comprehensive, citizen's full care act assessment, on the 21.11.18, about John's mental health. This had considered his previous history of being a patient at the psychiatric unit under section 3 of the Mental Health Act: 1983 between 2014-2016, aged sixteen to eighteen. HV1, with John's consent, made a referral to the Bury Multi Agency Safeguarding Hub (MASH) on the 03.12.18 regarding concerns about his mental health and the state of the property.

3.1.11 The referral was processed by the MASH and subsequently allocated to a social worker in the IRT (BSW1) on the 07.12.18 who started the C and F assessment. A home visit was made on the 12.12.18 when the parents were spoken with separately and neither disclosed any issues regarding domestic abuse. John spoke openly about his mental health and indicated that he felt it was currently stable. He told BSW1 that he had not used cannabis for the previous four years. There were no concerns noted regarding the parents' care of Joshua.

3.1.12 BSW1 consulted with HV1 and the father's social worker (MSW2) who had been involved with him for two years. HV1 said that the parents did not think that they needed any additional support (complimentary to HV1's involvement) at that time. MSW2 corroborated John's report regarding the stability of his mental health and was not aware of any recent evidence of ongoing substance abuse or domestic abuse. Given the positive reports received the assessment was completed in early February (subsequent to a discussion with BSW1's manager) with a recommendation of no further action. The case was closed to Bury Children's Social Care on the 04.02.19.

3.1.13 On the evidence of no identified concerns, no indication that John's mental health was deteriorating, that the family was subject to a Universal Partnership Plus service from HV1 and were not wanting any additional support from Bury Children's Services, the decision by BSW1 and the manager for no further action and closure would seem to have been reasonable and proportionate in all of the known circumstances.

3.1.14 That said and despite several phone calls to the IRT by HV1 for an update on the C and F assessment, none was forthcoming. HV1's successor, HV2 only heard about the outcome from Jennie on the 14.02.19. Clearly, BSW1 should have directly reported back to HV1/2 the assessment outcome, given that the original referral had come from the health visiting service.

Finding 2. The Bury IRT decision for no further action and case closure arising from the first Child and Family Assessment was reasonable and proportionate in all of the known circumstances of the time.

[12] See note 4, page 6 for explanation of UPP.

Lesson 1. Social workers undertaking Child and Family Assessments must liaise with referrers on progress and inform them of outcomes, in compliance with national and local safeguarding guidance.

The Second Child and Family Assessment: April-May 2019

3.1.15 By this time, Jennie was pregnant with the unborn sibling of Joshua and was registered with her Bury GP practice and the Bolton Foundation Trust midwifery/maternity services. MSW2 had completed a citizen's care assessment on John in November 2018 (reviewed on the 07.03.19), who was also subject to section 117 support under the Mental Health Act 1983; which had recommended,

- ➢ Regular contact with John.
- ➢ Support to search for a house that is a permanent arrangement in the Manchester local authority.
- ➢ A transfer (early April) to Bury Learning Disability Team for support assessment.

3.1.16 Of significance, the care assessment had noted that John's,

> '*behaviour has reportedly and evidentially become much more stable in the last two years, which has been attributed by professionals to successful medication. He has also been observed to be very happy with the new baby (Joshua) and has demonstrated he can meet his son's needs and knows how to access support from Jennie or from a professional……John has demonstrated that he is not wholly vulnerable in the community lately. He has natural support to assist with managing this risk that John has* ***a long-standing history of smoking cannabis which has been identified as significant(ly) contributing to his mental health needs.'***

3.1.17 The assessment also identified two key risks, both graded, 'High'. Firstly, that in the event he were to smoke cannabis again,' *there is a significant risk that this could trigger psychosis again and make him aggressive and lead him to be re-sectioned. John currently has natural support*[13] *to assist him with this'.* A second 'high' risk was John missing his medication which up to that time had been deemed, 'very *successful in managing his mental health conditions.'* The assessment noted that in the event of this happening it would pose, a significant risk to his psychotic symptoms (including hallucinations) returning, in addition to the risk of him becoming aggressive.

3.1.18 Additionally, the care assessment had noted that John had been assessed as having a significant learning disability, in which he had,' *significant cognitive deficits prior to the reported onset of any significant mental health disorder, or any drug use'*.

3.1.19 These risks (smoking cannabis, not taking his medication, his learning disability and also an over-reliance on self-reporting without triangulating), were therefore well documented by MSW2 at the point of referral to the MASH on the 25.04.19. The referral itself had identified concerns around John 's mental health decline, his wanting to harm others, his self-reporting of cannabis use and not taking medication (two key risk factors identified by MSW2, see above), domestic abuse and poor housing conditions.

[13] Taken to mean from Jennie.

3.1.20 MSW2 and the Manchester Transition Planning Team had recently closed the case on John because of his residency in Bury and had made a referral to the Bury Learning Difficulties Team on the 25.04.19.

3.1.21 The Bury MASH decided appropriately to send the referral onto the Bury IRT for a Children and Family assessment. This was allocated on the 25.04.19 to BSW2. The assessment noted from the referral that John had disclosed (amongst other things) to having not taken his anti-psychotic medication for over three months and wanting to hurt someone. BSW2 noted the historical information on John's mental health from MSW2's care assessment included in the reference back to the first C and F assessment of February 2019.

3.1.22 However, enquiries with Bury Children's Social Care have indicated that MSW2 was not spoken with by BSW2, nor was this very informative and detailed care assessment viewed and considered as part of the C and F assessment.[14] BSW1 had made attempts to contact MSW2 on the 01.05.19 who was reportedly unavailable and seemingly did not return the call. BSW2 (in the communication with the lead reviewer) stated that John's mental health was considered, and his medication non-compliance addressed at a home visit on the 01.05.19; albeit how effectively these two tasks were done is a moot point.

3.1.23 John told BSW2 on the home visit (01.05.19) that he had not taken his medication for four days rather than three months. There was no evidence of enquiry about his potential cannabis use. It appeared that BSW2 had taken John's self-reported account on good faith rather than triangulate and speak directly to MSW2. Had this happened it would have become evident that there had been no psychiatric or medication oversight of John since August 2018, save monthly prescribing between January to April 2019 from his GP practice.[15]

3.1.24 Moreover, critical information (from the Care Act assessment) regarding the two previously identified key risk factors, namely, the dangers of John 's not taking his medication and smoking cannabis, would have become evident and included in the C and F assessment. Liaison between BSW2 and MSW2 would also have elicited the information that a referral had recently been made to the Bury Learning Difficulties Team in respect of John, making possible a linkup between the borough's children and adult services and the potential for a co-ordinated response in meeting this vulnerable family's needs.

3.1.25 There was no evidence of exploring with John his previous reference to wanting to hurt someone. This should have been followed up as part of the C and F assessment.

3.1.26 A further risk factor, highlighted in the care act assessment, was John's significant learning disabilities suggesting that (amongst other things) he would be unlikely to keep to prescribing arrangements without external support from an agency. Therefore, the evidence would suggest that his claim to have been without medication for four days was less likely than his original report of three months.

3.1.27 According to BSW2 (in written communication with the lead reviewer), John had left the family home during the time of the assessment. A conversation with his Shared Lives worker on the 14.05.19 led BSW2 to

[14] BSW2 had spoken on the 14.05.19 to John's key worker (I.e. the person he was staying with) from Shared Lives who was not responsible for oversight of his mental health and medication needs.

[15] Albeit this did not necessarily mean that he collected it or took it.

understand that he had moved into accommodation in Manchester, provided by the agency. This was the ongoing plan. He would be transferring his GP from Bury to Manchester to ensure he could access his medications. BSW2 visited Jennie on the same day who said that John had moved out because of his declining mental health, that the relationship had broken down and she no longer wanted to continue with it. She intended to contact the landlord to change the tenancy in her name and claim benefits as the sole carer for Joshua. She denied that there had been any domestic abuse between the couple and that a stain on the wall had been caused by John throwing a pot noodle at the wall.

3.1.28 To their credit, BSW1 did record in the C and F assessment that, '*the couple minimise the verbal and physical abuse incidents that take place' and* suggested that they would benefit from a planned piece of work in this regard, not least to better understand the potential impact of domestic abuse on Joshua. The assessment also recognised that despite the couple's relationship having broken down during the assessment process, '*it would appear that Jennie and John will often experience periods of time when their relationship is off and on'*, thus suggesting that the separation was likely to be temporary, as indeed, proved to be the case.[16]

3.1.29 However, despite recent evidence of the dynamic nature of the couple's relationship the C and F assessment, somewhat contrary, deemed that that the risks to Joshua (and Jennie) from domestic abuse and his father's mental health were reduced because John was no longer in the household. Yet, it is well recognised that the risk of domestic abuse can increase at times of couple separation and that such developments should be a key consideration in a Child and Family assessment. The logic of this insight should have suggested the need for a contingency plan covering the possibility of a return to the household by John. This was not evident in the C and F documentation or in the subsequent single agency outreach plan of OW1. Such considerations underscored the imperative for a high degree of quality assurance and management scrutiny prior to sign-off by the team manager.

3.1.30 BSW2 and their manager assessed that Jennie (who was pregnant with the unborn child) and her son would need some support. They discussed a referral to a local Children's Centre and Team around the Family (TAF) support, to which Jennie (reportedly) agreed. On this basis a, 'step down notification', was completed with the following actions;

- Parents to engage with support around domestic abuse.
- Mother to attend the children's centre to widen her support network.
- Mother to take Joshua to play sessions at the children's centre.
- Mother to receive pre-natal support.
- Mother to be offered support and advice around housing and finance.

[16] This was not the first time that the couple had temporarily separated, having done so on the 26.11.18, as noted in the first C and F assessment and also recorded in the second assessment by BSW1. In any event, John had returned to the household by the time of the first home visit by OW1 on the 18.06.19.

3.1.31 This might have been a reasonable decision and appropriate course of action for Joshua and his mother, in the event that there was a degree of certainty that John was not returning to the household. However, within a short period of time (and certainly by the 18.06.19 when the family was visited by the outreach worker, OW1), John had returned to the family, thus raising the potential level of dynamic risk and need requiring re-assessment and consideration of a higher level of intervention around Child in Need (Level 4) or possibly even, Child Protection (Level 5).

3.1.32 There is some ambiguity in the documentation provided for this review in relation to the recording of the parents' intention concerning the breakup in May 2019. As set out above, it would seem that BSW2 believed John's move to Manchester to be long term. On the other hand, there are two references, one in the Child and Family assessment[17] and one in the integrated chronology (14.05.19), to John saying that he and Jennie had made up and that he would be returning home. Indeed, the second reference records that BSW2 spoke with John on the telephone on the 14.05.19 noting that,' *since his request to be sectioned he has received support and is hoping to move back in with Jennie'. He also gave consent for information to be gathered from his mental health worker (MSW2).*

3.1.33. Thus, it would seem that there was evidence at the time of the decision to move to 'step-down' (15.05.19); at least to consider John's stated wish to return to the family and either ascertain its validity with the couple at the time, or build in a contingency plan, involving the children's centre/outreach staff or the keyworkers from Shared Lives informing BSW2 of this eventuality. However, this did not happen.

3.1.34 For these reasons, the Review found that the C and F assessment was flawed[18]. Whilst understanding the logic of a level 3 TAF for Jennie and her son, on the assumption that John's departure was long term, the assumption needed to be tested, especially in regard to evidence of heightened risk at couple separation; and in the event proved to be false. In addition, direct enquiries (triangulation) with the Manchester Transitional Planning Team via MSW2 were needed in order to gain a more detailed and comprehensive understanding of John's mental health, learning disabilities and substance abusing risks, rather than an over-reliance on his self-reporting.

3.1.35 Rather than prematurely concluding that the family should be offered a Team around the Family (TAF/level 3) approach,[19] there were very strong reasons-and not in hindsight-for the assessment to have met the statutory threshold for (at least) a level 4 (Child in Need) intervention, and arguably, a level 5 (Child Protection) response.[20]

3.1.36 Assuming the parents were in agreement, a Child in Need plan could have provided a multi-agency framework of support for (and monitoring of) Joshua and his parents in the time leading up to the birth of Joshua's sibling in October 2019. Arguably and of significance, the plan could have included arrangements for meeting John's mental health needs through liaison and co-ordination of the necessary adult services.

[17] At page 3, last sentence in the 'Current referral' section.
[18] Also the unanimous view at the practitioner's event.
[19] The outcome was actually a referral to a Children's Centre for (single agency) family support outreach service.
[20] See the Bury Integrated Safeguarding Partnership Threshold document.

3.1.37 Moreover, given Jennie's pregnancy, there were strong grounds, in the opinion of the lead reviewer, for a pre-birth assessment to have been undertaken regarding Jennie's unborn child. The family circumstances met several of the risk factors set out in the Bury (Greater Manchester Safeguarding) pre-birth assessment guidance.

3.1.38 Mindful of not wanting to over-focus on individual practitioners' actions and decisions,[21] there were several systemic barriers ('latent failures', as per Sidebotham et al; May 2016) that might have hindered a more accurate Child and Family assessment that could have taken the full range of risk and need factors into consideration. The practitioners' learning event identified the following systemic factors that may have been in place;

- Staff shortages and insufficient experienced social workers.[22]
- High caseloads[23] and resultant insufficient IRT capacity to reasonably cope with demand.
- The potential (at the time) for practitioners to use 'loopholes' enabling override of the 'fail safe' aspects of the assessment system in order to cope with demand and stretched resources.
- Insufficient front line management scrutiny of assessments before signing off due to demand.

3.1.39 However, the above factors do not correspond with the written accounts of BSW2 and their manager (TM1). [24]. TM1 reported that the team had a stable workforce with no agency workers. Morale was good with regular supervision given to the social workers. BSW2 said that they had a protected case load (fifteen to twenty) and was supported by a mentor in addition to regular supervision by TM1[25]. BSW2 echoed their manager's views about good team morale and supportive office camaraderie.

3.1.40 An additional possible factor (suggested at the Partnership meeting of the 20.05.20) was the potential for a lack of case ownership of the family by Bury IRT, given that they were in temporary accommodation in the borough and due to be rehoused in Manchester. Uncertainty around the timing of a return to Manchester compounded by the inherent difficulties of cross border working (information sharing and the co-ordination of services) may have exacerbated the 'ownership' of the family by Bury children's services.

3.1.41 In any event, the TAF recommendation resulted in (single agency) family support involvement from a local Children's Centre outreach team between June to early August 2019. The outreach team did receive a

[21] NB, see paragraph 1.15.

[22] There were 18 social work posts across the 3 IRT teams in April/May 2019 and of these 4 were empty-2 were vacant and 2 long term sick, making a vacancy rate of 22%. 5 were level 3 (one an agency worker covering for a social worker who was acting up into a team manager post and one on long term sick), 7 were level 2, 3 were ASYE (including BSW1) and 1 long term sick who did not return.

[23] Evidenced in the notes from the practitioner's event.

[24] But see BSW2 and her team manager's account of this.

[25] There was one supervision session with this case on the 29.04.19.

copy of the C and F assessment (with no clear directive to notify the Bury MASH and Children's Social Care in the event of John's return to the family) from BSW2 but for reasons unknown, a 'step-down', notification was not sent. Compounding this was the lack of access by outreach services to the local authority (Bury) electronic case recording (CSC and Early Help) systems. The absence of the notification was of some significance because it precluded a TAF meeting and would have set out the specific identified actions to have been met with the family by the assessment.

3.1.42 Given that the C and F assessment was aware of the range of other agencies involved with the family it is not known why a single agency TAF was recommended. The logic of the assessment would have suggested a multi-agency TAF approach.

3.1.43 Arguably, co-ordination of the range of multi-agency services, namely, health visiting, GP, midwifery, Manchester housing agency, adult mental health and the Bury outreach service/Children's Centre, could in principle, have been achieved by means of a TAF plan. The Review is unclear as to why a multi-agency (as opposed to a single agency) TAF plan was not offered to the family. In the event, even the single agency TAF was not offered, as recommended by the C and F assessment.

3.1.44 Despite giving their apparent consent to the proposed TAF, the parent's declined it. The episode raised questions about how well the parents understood the purpose of the C and F assessment and what they were giving consent to. A further issue was the need for a process to pro-actively engage families where risks emerge later on; namely a contingency plan as referred to above in paragraphs 3.1.29/33. The outreach worker (OW1) carried out a fresh needs assessment directly with the parents who agreed to work on issues around play, learning and safety in the home (I.e., the provision of a fire guard and safety gate). This marked a more limited range of issues from those identified in the original IRT C and F assessment, notably those around domestic abuse and John 's mental health. The work was completed in mid-July following four pre-arranged visits over five weeks.

3.1.45 OW1's observations at the time noted no concerning matters or evidence of substance abuse, domestic abuse or parental mental health deterioration. Indeed, Joshua appeared to be a happy and contented baby who was developing well within his expected milestones. Interaction with his parents was appropriate and positive. Moreover, John was open with OW1 about his mental health background and his involvement with mental health support services. There were no risks observed by OW1 regarding the circumstances of Joshua's care by his parents who reportedly decided to finish their involvement with OW1 in mid-July 2019. That said, Jennie's recollection was that it was OW1 and their manager who decided to end contact because, in their view, all of the identified tasks had been completed.

3.1.46 However, this practice episode raised questions about.

- Whether current levels of staffing capacity and experience within the IRT service are sufficient to safely meet demand and produce C and F assessments to the required standard and quality?
- Whether there are effective arrangements in place so that newly qualified social workers in IRT teams are effectively supported in undertaking complex C and F assessments?
- The thoroughness of management oversight of Children and Family Assessments?

- The extent to which the parents understood the purpose of the Child and Family assessment and consented to the recommended outcome, in this case a Team around the Family (TAF) plan?

- The need to consider contingency planning in C and F assessments where there is the potential for significant, 'downstream', risk emerging later on.

- Why the recommendations for a multi-agency TAF were not implemented by the Family Support/Outreach service?

- The inability at the time for outreach services to have access to the electronic CSC (LCS) and Early Help electronic recording systems.

Current Developments

3.1.47 The Review learnt from the outreach service that changes have been made since the tragic death of Joshua. These include,

- TAF, 'step down', cases now include a TAF meeting chaired by the assessing IRT social worker. There is a clear handover with the outreach service worker where the plan is explained to the family who are required to give their written consent.

- A contingency plan should be available at the point of stepping down, if identified actions are not met or families disengage from the process.

- The outreach service now has access to the Bury Children's Services electronic recording systems. Information is therefore readily available.

Finding 3: The May 2019 Children and Family assessment was flawed because it did not include sufficient consideration of,

- Three, known, key risk factors; namely John not taking his medication, smoking cannabis and his significant learning disabilities.

- Did not directly speak to MSW2 and consider sufficiently his care assessment.

- An over-reliance on John's self-reporting and a lack of triangulation with other agencies.

- Did not test the assumptions that the parent's relationship had finished, and that John had moved to long term accommodation in Manchester.

- Did not include a clear contingency action in the C and F plan for report back to the IRT in the event that John returned to the household.

Finding 4: There were reasonable grounds for Joshua being made the subject of a Child in Need plan at level 4 of the Bury Integrated Safeguarding Threshold Framework; rather than at a level 3 Team around the Family (TAF) offer. A Child in Need plan could have provided a robust multi-agency framework of support for (and monitoring of) Joshua and his parents, work around domestic abuse and the provision of adult mental health support to John, in the time prior to Joshua's death in September 2019.

Finding 5: It follows that there were grounds for a pre-birth assessment to have been undertaken on Joshua's (unborn) sibling in 2019.

Lesson 2. Child and Family assessments must not solely rely on parental self-reporting, should involve information gathering from all agencies involved with the children and family, test assumptions around the permanency of couple separation, consider the need for a contingency plan in the event of the potential for emerging risks and be subject to effective management scrutiny and oversight.

Lesson 3: Where there is multiple agency family involvement, TAF plans should be multi-agency and not single agency.

Lesson 4: Bury Children's Social Care should assure the BISP that the IRT is operating a safe and effective service that accurately assesses the needs of infants under one and any risks to them from parents/care givers, results in

3.2 Vulnerability of Babies

1. Infancy is an inherently dangerous time for children. *'The importance of conducting pre-birth assessments has been highlighted by numerous research studies and Serious Case Reviews which have shown that children are most at risk of fatal and severe assaults in the first year of life, usually inflicted by their carers.'* (Greater Manchester Safeguarding Procedures, section 4.10; Pre-Birth Assessments, paragraph 12)

2. Brandon et al (2016) found that, 'infancy remains the period of highest risk for serious and fatal child maltreatment, there is a particular risk of fatality for both boys and girls during infancy' (p.40). 74% of the fifty cases on non-fatal physical abuse included in the Brandon study were aged under one year (p.62).

3. There was little evidence that any of the agencies involved with Joshua and his family were conscious of his inherent vulnerability. In fairness, the evidence, up to around July 2019, suggested that Joshua was being adequately cared for by his parents, especially his mother. The health visiting and children's outreach services noted a happy baby who seemed well attached to his parents, with no observable or discernible contemporaneous significant risks to him.

4. In regard to the trilogy of risks[26], MSW2's Care Act assessment of the 30.11.18 had documented the issues of John's mental health and substance abuse history. In particular, highlighting the significant risks of John not complying with his medication, him requiring support to attend medical appointments and recourse to cannabis use. To her credit, the first health visitor (HV1) recognised these as potential risks to Joshua and, in conjunction with MSW2, made a safeguarding referral to Bury MASH.

[26] Parental mental health, substance abuse and domestic abuse. Also known as the 'toxic trio' (see Brandon et al: 2008)

5. However, as mentioned above, these factors were insufficiently considered in the Child and Family Assessment of May 2019, there being a seeming lack of triangulation and lateral checks with adult support agencies for John. There was little overt evidence of domestic abuse between the parents, notwithstanding the references to John's anger on occasions[27]. This issue should have been followed up more directly with Jennie, especially in the light of her later disclosures to the lead reviewer (February 2020)[28] of three incidents of physical abuse over a three-year period, plus episodes of verbal conflict and behaviour suggestive of coercion and control by John.

6. In this regard the concept of, 'cumulative risk of harm', (Brandon et al: 2016:75) present when domestic abuse co-exists with substance misuse and parental mental health (known as the 'trilogy of risk') could have been a very helpful analytical tool in this case. However, as Brandon et al point out, the trilogy are not the only parental risk factors that might contribute to cumulative risk of harm. A narrow focus on the trilogy by professionals can mask the potential adverse risks of other stress factors impacting in a cumulative way on the family, such as;

- Adverse experiences in the parents' own childhoods (relevant for both parents)
- A history of criminality, particularly violent crime (relevant for John)
- Social isolation (relevant for the family rehoused in Bury away from their families and social/agency support networks in Manchester).
- Poor education (relevant for John)
- Poverty (relevant for the family)
- Acrimonious separation(s) (relevant for the parents)

often co-exist alongside the trilogy of risk and can interact with them to create a very potentially harmful environment for the child(ren). In this case, it is also possible to add, John's learning difficulties, the family's transient housing status, the resultant challenges of cross border working for agencies and professionals; and the vulnerabilities associated with being placed in temporary accommodation in an area (Bury) unfamiliar to them without the support networks (family and professional) available in their area of origin in Manchester.

Finding 6: With the exception of HV1; agencies' recognition and response to Joshua's inherent vulnerabilities as a baby, including the 'toxic trio', were poor.

Lesson 5. The Bury Integrated Safeguarding Partnership (BISP) and Manchester Safeguarding Partnership need to ensure that the concept of the inherent vulnerability of babies is disseminated widely and embedded in practice amongst all agency partners, especially adult services.

[27] Jennie had denied to BSW2 that there had been any domestic abuse between the couple and had said that a stain on the wall was as a result of John throwing a pot noodle at the wall.

[28] Disclosed by Jennie in her conversation with the lead reviewer in February 2020.

3. **Joshua's Voice and Lived Experience**

3.1. Lived experienced is defined as, 'Personal *knowledge about the world gained through direct, firsthand involvement in everyday events rather than through representations constructed through other people. It may also refer to knowledge of people gained from direct face to face interaction rather than through a technological medium'.* (Oxford English Dictionary).

3.2. Clearly, Joshua was not old enough to have spoken to the various professionals that he came into contact with. His, 'voice', and lived experience would have been mediated through his parents and the direct observations of the professionals who saw him. Given Joshua's lack of a voice it was necessary for professionals to have paid particular attention to the nature and quality of interactions with his parents, extended family, and themselves, his wider context of transitory housing, family social isolation and poverty, and the impact on his physical and emotional development.

3.3. The evidence suggested that, in regard to those agencies involved with Joshua and his family, the professionals' understandings and perceptions of his lived experience were mixed. His 'voice' was largely absent (according to the agency report) from the health visiting records. That said, HV1, had some insight into the child's lived experience by dint of supporting the family via a Universal Partnership Plus (UPP) level of service. This accurately recognised the parents' and Joshua's vulnerability, especially in the context of their being placed in out of area, temporary accommodation in Bury, where their support network (family and agencies) was very limited. HV1's observations were evidenced by her referrals to the Children's Centre in November 2018 (when he was only one month old) and in December to Bury MASH. HV1 continued with an enhanced level of support up to May 2019, at which point the transfer to the more local team occurred. This team was aligned to the local GP practice and the family was allocated to HV4.

3.4. In part, because of the no further action outcome from the second Bury C and F assessment of May 2019 and the Children's Centre intervention in June/July, HV4 assessed the family's level of support at the less intensive Universal Plus. The initial home visit (following a no access home visit on the 17.06.19) was made jointly with OW1 on the 05.07.19, when no concerns regarding Joshua's care were noted. John was not present but was reported by Jennie to have returned to the household, following tension between them regarding him having stopped taking his medication. Jennie said that he was taking his medication again. An opportunity was missed to assess Joshua's progress and lived experience when he was not brought by his parents to a routine 9–12-month developmental examination arranged for the 21.08.19 by HV4.

3.5. OW1 saw Joshua four times during their involvement in June/July of 2019. OW1 observations of Joshua and his interaction with both parents were detailed and comprehensive. He was noted to be happy, content and developing well ('a ping pong ball on legs') within his expected milestones, with positive interaction with both parents. Joshua and his parents appeared to be a happy family to OW1. OW1 last visit was on the 19.07.19 when parents reportedly stated that they no longer needed the service, albeit Jennie's recollection was that this was a decision made by OW1 and their manager. Outreach involvement was closed on the 01.08.19. The evidence would therefore suggest that OW1 gained a good appreciation of Joshua's lived experience during period of involvement.

3.6. Regarding Bury CSC's involvement, Joshua's voice and lived experience, 'was *not as well detailed as it could have been both within the assessments and the general case notes'* (Bury CSC agency report). The interventions were insufficiently child focussed, were too centred on Jennie's parenting abilities and the father's mental health history. Joshua was noted as being, 'too young to offer his views'. There were only two visits made to the family for the second C and F assessment which was not sufficient to have gained a reasonable level of understanding of Joshua's progress and, 'lived experience'. As indicated by the agency report, 'further *assessments should have taken place to analyse the presentation of Joshua whilst in the care of his parents'.*

3.7. Joshua was seen on two occasions for his immunisations by the local (Bury) GP practice, the last time being on the 29.01.19. No concerns were noted. He was also seen at the practice on the 07.02.19 with his parents; the GP had a strong and positive memory of a smiley, happy baby who captured everyone in his smile. The floating support worker (FSS1) from Manchester City Council Homeless Service had frequent contact with the family. FSS1 noted Joshua to have been a happy little boy who was always clean and tidy with plenty of toys. The house was warm and welcoming. There were no concerns noted for Joshua who was observed to be laughing and giggling by FFS1 on the last occasion they saw him.

3.8. Joshua's presence in the family was noted by MHP1 (mental health liaison team) as part of John's mental health risk assessment on the 03.09.19. Joshua was not felt to be at risk from his father at that time; in fact, no professional or member of the community ever identified that he was at risk of harm within the family. However, it would appear that the child's lived experience was not considered and that there was a lack of, 'Thinking Family'.

Finding 7: In common with many SCRs there was a tendency for professionals to develop an over-optimistic ('rule of optimism') mindset regarding Joshua's positive interaction with his parents and not locate his lived experience within a wider holistic context. While he appeared to be developing well his lived experience took place within a context of,

- Poor housing.
- Poverty and low income
- Young first-time parents with vulnerabilities and minimal social and family support networks in Bury

Lesson 6. Professionals need to look beyond the, 'here and now', of a child's lived experience and locate it within a wider holistic context of family stresses and strengths.

4. Inter-Agency Communication

4.1. There was at best a mixed record of effective inter-agency communication. An example of good communication being the sharing (with his consent) of John's mental health history between MSW2 and HV1 and Bury MASH/IRT, regarding the first C and F assessment. However, despite several requests from HV1 to Bury IRT for feedback on progress with the first C and F, none was forthcoming, which fell short of accepted

practice. Moreover, there was sub-standard information sharing of John's mental health issues with the second C and F assessment as mentioned previously.

4.2. There was poor information sharing between the family GP and the mental health services involved with John in 2018/19. Indeed, the Bury GP practice did not receive any written notification that John had been discharged from the Manchester Learning Disability (clinic) service in early 2018. RC2 was assumed by the GP practice to have been involved when this was not the case. Timely information sharing between the three Manchester agencies and their Bury counterparts in August 2018 was absent. There were communication problems with the Children's Centre outreach service access to Bury CSC social care and early help electronic records. This has since been rectified with the outreach service now having full access to these records. The second C and F assessment and its recommendation for a TAF was ineffectively communicated to the family support outreach service who implemented a limited single agency support plan with the family. There were several key deficiencies in inter-agency information sharing within the Bury MASH and partner agencies, especially the Police which are set out in the next section.

Finding 8: There were several instances of very poor information sharing between agencies as detailed in the above paragraphs.

5. Bury Multi-Agency Safeguarding Hub (MASH)

5.1. By way of context, Bury MASH[29] is run by Bury Council and operates by co-locating a range of professional and administrative staff from agencies with responsibility for safeguarding children in one location, namely, Bury Police Station. However, the review understands from the Greater Manchester Police (GMP) that the 'MASH' is not an integrated unit with the same line management but rather a term for co-location within one floor of the Bury Police Station. Staff continue to be employed by their employing agency, but co-location is considered the most effective way of building relationships, trust and understanding between the agencies (including Bury Children's Social Care and Greater Manchester Police) so that staff are confident about sharing information. Upon receipt of an external referral any agency can approach any other agency - as appropriate to the nature of the risk- for information to help inform their response to it, albeit there is a reliance on agencies being pro-active in that regard. The GMP does not have responsibility for Bury (local authority) MASH; this being a term used by the local authority.

5.2. The Bury MASH's objectives are,

- To improve the safeguarding decision making at the point of requesting a Children's Social Care Service.
- The early identification of need, harm and risk.
- Improved identification of children and families who may benefit from early help.
- Provision of guidance and advice through consultation

5.3. One of its key tasks is, *'to facilitate the free flow of information and intelligence between statutory agencies in order to enhance the opportunities to safeguard vulnerable children and adults within its remit and the MASH working parameters as agreed'.* (section 1.3 of the Bury MASH document; April 2019)

[29] Taken from the Bury MASH document,' Team Bury, Working Together for a better Bury, Multi-agency safeguarding hub, Principles', April 2019.

5.4. The evidence suggested that the first contact with the Bury MASH (the December 2018 referral from HV1) fell short of acceptable standards. A contact record[30] was created by Bury MASH on the 06.12.18. MSW2 was spoken to (by a Bury MASH social worker) regarding John's mental health and lateral enquiries were made with other relevant agencies, as per standard operating procedures. However, for reasons unknown and of some significance, the screening did not include an information request to the Police[31]; therefore, none was sent. This appeared to be a missing link on the contact record and should have been undertaken, albeit the contact appropriately proceeded to a C and F assessment with the IRT.

5.5. The second contact regarding the referral to the MASH by MSW2 on the 25.04.19 proceeded to a second C and F assessment. Police information was recorded on the contact record regarding the recent incident involving John and his son at the Shared Lives office (Abraham Moss) on the 24.04.19 and the subsequent Police welfare visit. However, because there was no request to the Police to provide relevant information for the C and F assessment John's past involvement with the police regarding his previous arrest on suspicion of conspiracy to murder and suspected involvement with local Organised Crime Groups in Salford was not included. This was possibly very salient information in regard to Joshua and his mother's safety and wellbeing and should have been forthcoming and included in the C and F assessment. Requested information from Probation, the Youth Offending Service and One Recovery by the MASH was not referred to in the C and F assessment. There was no indication whether or not information from these agencies was received.

5.6. Contact three was received on the 02.09.19 from Jennie's midwife who was concerned at her having missed several recent ante-natal appointments. The evidence suggests that lateral information from other agencies was not gathered and analysed effectively. The lead reviewer and panel were unable to establish why this was the case. Documentation from the recent involvement of the Children's Centre was not accessed. The outreach worker (OW1), who was on leave, was eventually contacted and advised that she had closed the case in early August 2019.

5.7. Moreover, the MASH screening process failed to locate (in so far as it was not asked for) information from health, the police, John 's mental health worker, GP and housing, despite there having been two C and F assessments completed by IRT, which should have been accessible on file[32]. This was a concern. Jennie was sent a text message and a letter asking her to make contact with Bury Children's Services. The referral was eventually processed for a Child and Family assessment but seemed not to have been progressed. Again, the panel was unsure as to why this was the case.

5.8. Given that a central function of a multi-agency safeguarding hub is effective information sharing this case has raised questions about the degree to which salient information is effectively gathered and shared by the Bury MASH and partner agencies. This review would suggest that the BISP is assured by those agencies responsible for the Bury MASH that it is maximising its information sharing function in the interests of children, young people and vulnerable adults and in compliance with current operation principles and procedures.

[30] Information provided by the MASH team manager on the 28.04.20

[31] There was information held by the GMP (June 2018) of John coming under suspicion of having links with a local organised crime group.

[32] The panel and lead reviewer did not receive a satisfactory explanation as to why this was the case.

Finding 9: On none of the three occasions was a request made to the MASH (Police) by MASH (CSC) for police information. If a request had been made the relevant information (including intelligence on John's alleged connections with local organised crime groups) would have been shared. The first two MASH referrals were passed on appropriately for Child and Family assessments. However, there were significant gaps in gathering and receiving salient information from the police in regard to referrals one and two (no request by Bury to the Police on both occasions; in referral 2 there was no information asked for on John 's possible criminal involvement with a local Organised Crime Group) and other relevant agencies. In referral three there appeared to be very little evidence of timely information gathering from partner agencies. These findings suggest that information sharing within the Bury MASH may have been problematic during the time period under scrutiny.

Lesson 7. Bury MASH and its partner agencies should review, as a priority, the operation of its multi-agency information sharing function, particularly to ensuring that the full range of lateral enquiries is made with all relevant agencies in a timely way. The review should assure the BISP that this is working effectively in the interests of maximising the safety and wellbeing of children, young people and vulnerable adults and is compliant with MASH operating principles, and objectives.

6. Parental Mental Health and Learning Disability: John

6.1. Following his discharge from the psychiatric unit in February 2016 and in line with the Care Programme Approach (CPA)[33], John (then aged eighteen) became subject to a community treatment order (CTO)[34]. Whilst in the unit he became involved with the Manchester Early Intervention Team (EIT)[35] who took responsibility, through a care coordinator, for his post discharge after care service arrangements under section 117 of the Mental Health Act 1983[36]. The plan consisted of John living in supported accommodation provided by 'Shared Lives' (A Manchester Council housing agency with a remit to support vulnerable adults) service for people with learning difficulties, with additional support from the Manchester Learning Disability Team and the consultant psychiatrist, RC1 (responsible for overseeing and prescribing his medication); and a social worker (MSW1) from the Manchester (Council) Transitional Planning Team (MTPT).[37]

3.6.2 His CTO was reviewed in July 2016 by the responsible clinician (RC1) and the EIT care coordinator who determined that he was keeping to the terms of his order (amongst other things, taking his medication[38] and avoiding drugs) and making good progress in his placement and the community. John said that he no longer wanted to be subject to the CTO. In view of his progress and wishes, RC1 felt that the CTO could not be extended and was therefore rescinded.

3.6.3 Arguably, John had been out of the support of the psychiatric unit for a relatively short time and consideration could have been given to extending the CTO for a further six months to ensure (as far as possible) that the external pressures would not overwhelm him. Indeed, the GMMH root cause analysis

[33] The Care Programme Approach (CPA) is an overarching system for coordinating the care of people with mental disorders. The CPA requires identification of a named care coordinator. (see 'Mental Health Act; 1983, Code of Practice; Department of Health; 2015).

[34] A CTO lasts for six months and can only be extended following a review by a responsible clinician (consultant psychiatrist).

[35] Part of Greater Manchester Mental Health Foundation Trust (GMMH).

[36] Section 117 of the MHA; 1983 requires clinical commissioning groups and local authorities, in cooperation with voluntary agencies, to provide or arrange for the provision of aftercare to particular patients detained in hospital for treatment (including section 3 of the act) who then cease to be detained.

[37] An adult social care team for Manchester people.

[38] Aripiprazole (an anti-psychotic medication), 15mg OD (once daily) and Atomoxetine (an ADHD medication) 90mg OD.

report noted that,' *despite having been assessed as no longer requiring the safety net of the CTO and reportedly engaging with the Manchester Early Intervention Services (EIT), the investigation found John's stability was likely to have been due to the support he was receiving from his multi-disciplinary specialist team and there was a misconception of how equipped the proposed services were to maintain his stability'.* [39]

3.6.4 John continued with the support provided by EIT, Shared Lives and the MTPT during the remainder of 2016 and all of 2017. In June 2016, his mother died which proved to be a significant emotional episode for him[40]. He was supported through this by the workers from Shared Lives and MTPT. He also met and started a relationship with Jennie in this period. His mental health deteriorated in the summer of 2017 due to the stress of coping with the first anniversary of his mother's death, which was reportedly managed well by him and the services involved.

3.6.5 There were occasions when he decided to go and live with his father and other relatives in seeking to test out independent living from the support provided by Shared Lives. There were also occasions when he was difficult to engage because of his moving around and seeming to forget about or miss several appointments. However, these were consistently chased up by phone calls to himself or his support worker at Shared Lives and MSW1.

> Finding 10: Overall, John's needs were reasonably well met by the S.117, multi-agency support package during the post discharge period (2016-17) from the psychiatric unit, particularly in regard to developing his independence skills and maintaining a reasonable level of mental health. That said the GMMH root cause analysis concluded that, currently; John would have been referred to a community mental health team due to his complex needs.

3.6.6 In considering a transfer to community-based agencies, the EIT had discussed approaching the Manchester Community Mental Health Team but felt that on balance, John's psychotic illness was stable and that his primary needs were in regard to his learning disability, hence the most appropriate service would be the Manchester learning disability team, operated by the Manchester University NHS Foundation Trust.[41] [42]A referral was made to the team on the 22.09.17.[43]

3.6.7 In line with the Care Programme Approach (CPA),[44] John was discharged on the 18.01.18 from the co-coordinating oversight and care of the EIT into the joint care of the Manchester Transitional Planning Team (the local authority; responsible for his social care and housing needs, in conjunction with Shared Lives) and the Manchester Learning Disability Community Team (MLDCT), who had responsibility for his mental health and medication needs. A consultant psychiatrist (RC2) from the outpatient learning disabilities service (provided by the Manchester Foundation Trust)[45] took over as the responsible clinician with the role of monitoring John's medication. The lead reviewer understood[46] that MSW1 from the MTPT

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39 NB, See also note 42 below regarding a referral to community mental health service in current circumstances.

40 He had found her dead.

41 But see paragraph 3.6.3 above.

42 Whilst outside of this SCR's time scale it is suggested that the GMMH could usefully review this practice episode to identify any potential learning in its response to people with dual mental health/learning disability diagnosis and the most appropriate service intervention, namely a community mental health or learning disability approach.

43 The GMMH root cause analysis (RCA) noted that, in hindsight, the learning disability and MTPT were not best placed to meet John's complex needs and under current circumstances he would not be accepted into these services. His referral now would be redirected to the appropriate community mental health service.

44 And S.117 of the MHA 1983.

45 NB RC2 was at the time employed by the Calderstones Partnership NHS Foundation Trust but was hosted by the Central Manchester Foundation Trust, now the Manchester Foundation Trust.

46 From discussion with GMMH personnel.

was identified as having responsibility for ongoing care and annual review of the after-care plan. However, the extant documentation does not make it explicitly clear as to which agency (and therefore, which professional) had statutory responsibility for co-ordination and single point of contact (SPOC) oversight of John's S.117 after care within the CPA.

S.117: Legal and care responsibility

3.6.8 and S.117 after care is a vital component (MHA; 1983, Code of Practice; 2015) in a patient's overall treatment care on discharge from detention in a hospital. Its purpose is to provide any support, care and/or treatment that an eligible person may require to remain well and reduce any risk of deterioration to their mental health, with the intention of preventing a further readmission to hospital. The duty to provide after care continues for as long as the patient is in need of such services and does not necessarily stop when a CTO ends. As previously mentioned, the MHA; 1983 requires Clinical Commissioning Groups (CCGs) and local authorities (where the individual was ordinarily resident before entering hospital) to commission and/or arrange for S.117 after care through the provision of appropriate services by suitable agencies. In John's case this was jointly with Manchester CCG and Manchester City Council as the local authority.

3.6.9 Moreover, the responsibility remains with the original CCG and local authority[47] even if the patient locates to another area (in John's case, Bury), until such time as the CCG and local authority decide that the services provided are no longer needed, when it can be rescinded. In this event, it is good practice (see Manchester City Council; ASC Procedures) for discharge to be done in a formal meeting that includes the subject individual and any representative, such as a relative, friend or advocate. Rescinding a S.117 has to demonstrate that the need for services and support is no longer required, such as to do so would not compromise the individual's mental health and result in a deterioration.

3.6.10 Because S.117 after care comes under the framework of the Care Plan Approach (CPA) a care coordinator should be allocated[48]. This is an individual worker who is responsible for the ongoing assessment, planning and review of a person's care and/or treatment. The aim is to adopt a multi-disciplinary approach that seeks to provide effective and co-ordinated support. In John's case this appeared not to be explicit in the records around his hospital discharge, albeit that MSW1 (and MTPT) had the task of annual review of the plan. It would therefore seem that there was a lack of clarity and robustness in regard to explicitly recording and agreeing on which agency and professional was to take the care coordinator role. This shortcoming was to have implications for the later management of John's S.117 after care regarding effective co-ordination, planning, premature ending of psychiatric oversight and medication and closure, as set out below.

3.6.11 In any event, this SCR was informed by Greater Manchester Mental Health Foundation Trust (GMMH) that all risk information on John was transferred appropriately from EIT to the three receiving agencies at the point of his discharge. Indeed, EIT had spent time with the Learning Disability Team and the psychiatric consultant (RC2) discussing John and both had access to his records via the Patient Recording Information System (PaRIS).

3.6.12 John attended an out-patients' appointment with RC2 on the 06.02.18 when his medication was discussed. A follow up letter was sent to him detailing the next appointment. However, by March 2018 he had left his Shared Lives placement and moved in with Jennie[49] who was living with her mother in Manchester and in the early stages (first trimester) of pregnancy with the future Joshua. It may have been the case that he had moved address[50] by then so that the letter might not have reached him. Also, there was an assumption that he could read.

[47] See, Local Government Association, (August 2018),' Ordinary Residence Guide-Determining Local Authority Responsibilities under the Care Act and the Mental Health Act'.

[48] See Manchester City Council, ASC procedures;6.4 Section 117 after care, p4)

[49] He slept on the sofa.

[50] He was living in Manchester between November 2017 and February 2018 to which the letter may have been sent.

3.6.13 On the 05.03.18 John called 111 (NWAS) reporting that he had run out of medication and was requesting a repeat prescription, despite being prescribed twice in January and once in March, albeit not necessarily collecting them.

3.6.14 On the 11.04.18 RC2 received a letter from the previous care coordinator at EIT notifying that John's case was closed to them and that she was no longer his care-coordinator. It was noted that John was open to Manchester Transition Planning Team who was, ostensibly, now the agency responsible for his care co-ordination, albeit that this had not been explicitly recorded. He was re-referred in June 2018 to Shared Lives and found a placement where he stayed for two nights before returning to Jennie.

3.6.15 In passing but worthy of note, John and Jennie attended at Manchester Housing Solutions (MHS) on the 07.06.18. They had been staying at the latter's mother home in Manchester but there was insufficient room (John had been sleeping on the sofa) and they needed their own home, given the impending arrival of Joshua in October. They were found temporary accommodation by MHS and moved to Bury on the 26.06.18.

3.6.16 Of some significance, the review was informed by MHS that had the couple presented to the housing service after June 2018 they would have been found temporary accommodation (pending being offered permanent housing at a later date) in Manchester. MHS had implemented this policy in July 2018 in respect of vulnerable families (and single people) who had a social worker or mental health worker (as in the case of John) so as to ensure continuation of care. [51]Had this happened one month earlier the couple would have been able to maintain their very important links with their existing family and agency support networks. The temporary move to Bury, in the lead reviewer's opinion was a major factor in adding to the vulnerability of an already vulnerable family by severing these links to their support networks, compounded by the difficulties of cross border agency working. [52]

> Finding 11. The relocation to Bury disrupted and weakened the couple's crucial links with their family and agency support networks. It was a major factor in adding to the family's social isolation and increased vulnerability that was compounded by difficulties in cross border agency working.

3.6.17 In any event, John failed to attend his out-patient appointment with RC2 on the 07.08.18, possibly, because his new address was not known to the Learning Disability team. His Shared Lives worker reported that he had left the project without any notice and may have gone to live with his girlfriend (Jennie) whose address was not known. There had also been a change of social worker from MSW1 to MSW2 in the MTPT. In actuality he was now residing in Bury with Jennie, having been placed there by the MHS. There was no documentary record of any attempt to locate or contact John; via the MHS worker for example, when he was discharged from the learning disability team, including medical oversight from RC2 on the same date (07.08.18), due to non-attendance.

3.6.18 Given his relative vulnerability, particularly in regard to not taking his medication, his documented learning disabilities and likelihood of reverting back to substance misuse (cannabis) , with associated risks of experiencing further psychotic episodes; questions arise[53] as to why efforts were not made in August 2018 to locate him and hold a S.117 review in line with local protocol and good practice (see section 6.4 Section 117 After care of Manchester City Council; ASC procedures, section 8). Moreover, it was known by the agencies that he was in a relationship with Jennie who was pregnant, thus presenting potential risks to them as well; an instance of needing to, 'Think Family'.

3.6.19 He should not have been discharged without ensuring that he either, no longer needed the service, or that an alternative service was provided, in line with the existing S.117 responsibilities. There were no

[51] N.B. See appendix 2; Manchester Housing Policy and Practice

[52] See paragraphs 3.7.2 and 3.7.3 below

[53] From the practitioners 'event and other sources.

attempts by any of the three agencies [54] to investigate his whereabouts (through MHS) or make arrangements for him to be supported by the Bury Learning Disability Team, albeit that he remained subject to S.117 support and after care, which were known about by the MTPT (this fact was referenced in the care act assessment completed by MSW2 in March 2019). As previously noted, John's GP practice did not receive a letter prior to the February 2019 consultation, at any time in August 2018 or thereabouts, informing the practice that John had been discharged from psychiatric services for non-attendance at appointments.

3.6.20 The SCR was informed that there was very little information available regarding John 's discharge in August 2018 from the learning disability service, save for the consultant-GP letter which did not show any provision for transfer of care, risk or any arrangements for continuing his medication. The review was not clear as to which; if any, agency and clinician, therefore had oversight responsibility for John's medication after August 2018. His S.117 plan was not mentioned at all in the LDS discharge letter of August 2018, despite it continuing to be a statutory requirement. There was no evidence of any further follow up or arrangements made regarding John's care or risk considerations.

3.6.21 The evidence from this practice episode suggests that, firstly, there was no clear plan for John. Secondly, there was a lack of liaison and co-ordination between the three agencies caused by the absence of an effective multi-disciplinary team (MDT) work approach to John's S.117 after care under the CPA schedule. Indeed, there was no minuted evidence of any regular MDT meetings. Thirdly, no liaison with the MHS floating support worker (FSS1) who knew of John's whereabouts and could have apprised the learning disability and transition teams of this information. The lack of a joined up MDT approach and the absence of any planning or review, led to minimal information sharing, including, most significantly, MTPT, seemingly being unaware of John's S.117 after care plan (despite a later reference in the care assessment to John being subject to a S.117) and hence not asking the mental health agencies for it, or the pathway in the event of any mental health deterioration.[55] There was no challenge from MTPT to RC2 regarding John's discharge in August 2018 from the latter's medical oversight and the resulting lack of medicinal support, deemed so important in preventing a relapse in his mental health. It would seem that a key reason for the above deficits was the absence of a clear set of local (Manchester) guidance (a latent failure) around multi-disciplinary teamwork in respect of S.117 after care of vulnerable individuals recovering from mental health issues, including those who were transient in and out of Manchester, as was John.

3.6.22 In short, had there been an effectively functioning MDT, with named a care coordinator, full knowledge of the S.117 plan with timely reviews as per local guidance and the involvement of other agencies such as the MHS, John could have been located in Bury and suitable arrangements made to continue with his S.117 plan, including appropriate social care and health support from Bury agencies. This was a missed opportunity by the MTPT and the Manchester learning disability service to have done so in compliance with local protocol. The SCR could find no evidence that this course of action was considered and the recorded reasons as to why not. The result was that John became 'lost' and his needs neglected by the care system in Manchester, including the key element of a responsible clinician to oversee his medication.

3.6.23 Notwithstanding that this review is not about individual blame, the above episode is an example of 'active failures' at the practitioner level. However, it is important to understand what the 'latent failures' were at the organisational and inter-agency levels. These include but are not confined to, systemic barriers to information sharing/inter-agency communication, failure to understand that the MTPT and the learning disability service continued to hold joint S. 117 responsibility, the seeming lack of written, clear inter agency guidance regarding agency roles and responsibilities of S.117 after care, the lack of a voice from John in decision making through a convened review meeting, the lack of an integrated 'whole systems' service to meet John's complex health and social care needs; a concomitant fragmentation of adult health and social services and the dangers of , ' silo' working. Arguably, these latent factors contributed to the active failures of the practitioners and John's resulting neglect. It is at this level that, 'second order', systemic changes

[54] Manchester Transition Planning Team, Shared Lives and the Learning Disability (clinic) Team.

[55] See the Shared Lives and Transition Planning Team agency report provided for this SCR.

need to be made by agencies (Sidebotham et al, 2016, pages 23-26) in order to achieve a safe operating environment for practitioners to make safe decisions regarding vulnerable people.

Finding 12. John should not have been discharged by the Manchester learning disability service on the 07.08.19 without ensuring that he either, no longer needed the service, or that an alternative service was to provide. This contravened his S.117 after care rights, marked the beginning of the neglect of his care and wellbeing and was not in his best interests. He began to become, 'lost 'to the Manchester social care/ learning disability/ health support system from this date, albeit FSS1 from the MHS remained involved.

Finding 13. Underlying John's marginalisation was a lack of a co-ordinated multi-agency/disciplinary team approach to the planning, implementation and review of his S.117 plan. The lack of an allocated care coordinator from the MTPT resulted in minimum information sharing; MTPT seemingly being unaware of the S.117 plan and no challenge to RC2 regarding John's discharge. A key contributing factor to this was the lack of local guidance around agency roles and responsibilities in regard to S.117 working within a multi-agency context.

Finding 14: Had there been an effectively functioning MDT approach, with a care coordinator, full knowledge of the S.117 plan, an understanding of professionals' roles and responsibilities, the involvement of other agencies such as the MHS and John himself, he could have been located in Bury and suitable arrangements made to continue with his S.117 plan, including appropriate social care and health support from Bury agencies. This was a missed opportunity by the MTPT and the Manchester learning disability service to have done so.

Lesson 8: The three Manchester agencies (MTPT, the Learning Disability Service and Shared Lives) responsible for John's Section 117 after-care support and the Manchester CCG, should undertake a learning review (possibly a Safeguarding Adult Review by the Manchester Adult Safeguarding Board) into why there was no re-assessment of his needs and a referral to their Bury counterpart agencies in August 2018. The learning review should include analysis at the structural level of organisational barriers, defences and interfaces (latent failures) that seeks to understand the underlying systemic causative factors (as referenced in paragraphs 3.6.21-23) accounting for the active failures at practitioner level.

3.6.24 MSW2 eventually located John, Jennie and the newborn Joshua at their Bury address and visited them on the 30.11.18. He was told of HV1's involvement and contacted HV1 on the same day to enquire whether a referral to Bury Children's Social Care had been undertaken regarding John's parenting capacity. MSW2 shared John's mental health background with HV1. As previously mentioned, HV1 then duly made a referral to the Bury MASH in early December 2018.

3.6.25 Having located John, MSW2 (who was ostensibly, still the responsible care coordinator) undertook a citizens' care act assessment in late November 2018. It noted that John had become much more stable in the previous two years due, in part, to successful medication and him wanting to become well, rejoin society, attend college and start learning how to live independently. It was further noted that he remained potentially vulnerable in the community to the risk of a long-standing history of cannabis smoking which had been identified as significantly contributing to his mental health needs. Moreover, it remained the case that were he to be offered cannabis again, there was a significant risk that this could re-trigger his psychosis, make him aggressive and result in him being re-sectioned. He was deemed to have had, 'natural support' from Jennie and her family to assist him with the cannabis issue, although it was not clear what the rationale and evidence was for this claim.

3.6.26 The report noted that the risk of missing his medication was assessed as 'High'. In this event there was a significant risk of his psychotic symptoms (e.g., hallucinations) returning and him becoming aggressive. It was noted that he, *'currently has no natural support (from Jennie) to assist him with this (and) requires support to attend medical appointments (and) reminders/prompting to ensure he collects his medication'*.

3.6.27 The assessment summarised that because of his mild[56] learning difficulties, lack of natural support in his life, his mental health issues (albeit previously successfully managed with medication) and a new baby, 'it *is prudent to remain proportionally and ergo peripherally involved'.* It added that he was able to meet most of his social care needs and that Jennie was an important source of support. The two were managing satisfactorily and there were no concerns about their ability to meet their baby's needs. Indeed, John was noted to be very happy with his new son. There was no evidence of any domestic abuse.

3.6.28 The assessment recommended; regular contact with John, support to find permanent housing in the Manchester local authority and case transfer to Bury where he was currently living. There was to be a review on the 07.03.19.

3.6.29 John had previously registered with a Bury GP practice in August 2018 and had been sent several invitations (to the Bury address) for a new patient check, none of which he attended.[57] His first attendance was on the 07.02.19 along with Joshua and Jennie. He was given a mental health new patient check. He said that he had had no drugs or alcohol and no mental health assessment for twelve months. His mood was noted as stable, he was well kempt with a good level of care and appearance, no agitation, reactive and spontaneous. He was able to develop a rapport with the GP quickly and easily, was noted to have capacity to be involved in his care plan and review of medication. He was not socially isolated and was aware of how and when to seek help. He was advised to contact the consultant to arrange an appointment; the GP not having been notified by RC2 of John's discharge in the previous August.

3.6.30 MSW2 closed the case on John on the 01.04.19. [58] The lead reviewer did not understand the rationale for this decision given the production of the recent care assessment (see paragraphs 3.6.25/28 above) by MSW2. Moreover, there was no evidence of a care act review having taken place as scheduled for March 2019. The SCR understands (Local Government Association; August 2018) that the legal responsibility 'for ownership', of the care act assessment duty lay with Manchester City Council, given that he and his family were due (at some point) to be re-housed by the authority and would thus be deemed as being ' ordinarily resident' in Manchester.[59] Therefore, Manchester City Council (via the MTPT) should on these grounds, have kept responsibility for John's care act support (in compliance with guidance and protocol) rather than have closed the case when it did.

3.6.31 Some three weeks after case closure the (local authority) Bury Learning Disability Team (BLDT) received a referral on the 25.04.19 from Manchester Council Transition Planning Team (the same day as BSW2's allocation at the Bury Initial Response Team to the second Child and Family assessment) requesting an assessment with a view to BLDT taking on support for John [60]. His full mental health history was provided, albeit no mention was made that he was subject to S.117 of the Mental Health Act 1983. [61]It was noted that John had moved to Bury with his girlfriend and that he had attended the Manchester Shared Lives offices at the Abraham Moss building on the 24.04.19 in a distressed state stating that he had not taken his medication and may be a risk to others. These concerns were passed onto Bury MASH/IRT.

[56] Although at page 9 of the report he is noted as having, 'a significant level of learning disability'.
[57] It was assumed that he could read.
[58] From information received at the practitioner event.
[59] Albeit that issues of case responsibility for an individual's support needs and costs between originating and receiving local authorities when a person moves is complex and open to legal interpretation. (See Local Government Association; August 2018)
[60] If this had happened, Manchester would have retained case responsibility and funding commitments.
[61] Had this been known BLDT would have supported Manchester to commission services rather than introduce him to a new team (see e mail from Bury Head of Adult Safeguarding to the lead reviewer (20.05.20)

3.6.32 BLDT arranged with the community learning disability team (Pennine Care NHS Foundation Trust) to undertake a joint screening assessment of John's needs and agreed to do a home visit on the 21.5.19 by a social worker and community nurse. John was telephoned on several occasions but did not respond and a letter was sent (assuming he could read) informing him of the impending visit.

3.6.33 On the 08.05.19 John telephoned 111 (NWAS) asking for a repeat prescription as he had run out of his medication. On the 09.05.19 he presented at the North Manchester General Hospital accident and emergency department with a Shared Lives support worker (SLSW1) in a distressed state. He said that his relationship with Jennie had broken down (she had reportedly returned with Joshua to her mother's house) and that he was homeless, that he wanted to kill himself and others, had been violent at the social service office (Abraham Moss) and had stopped taking his medication.

3.6.34 He was seen by a worker from the mental health liaison team who assessed that he did not appear to be experiencing psychosis but did report feeling paranoid. This was interpreted as being more linked with anxiety about his social situation rather than psychosis. The assessing practitioner advised John to see his GP to discuss restarting his ADHD medication and accessing help in a crisis and was discharged.[62]Despite mention of his family and social situation there was no discussion of his current living circumstances with Jennie and his seven-month-old son. There was no consideration of any risk to Jennie or the child as it was assumed that he was not living with her and inferred that no contact was happening. This Review would agree with the comment of the Root Cause Analysis (RCA) that, 'during *this assessment a referral should have been discussed with the patient and the social worker who attended with him. The notes record, 'No safeguarding issues reported', whereas it was the responsibility of the worker to have assessed this for themselves'*. Moreover, there was no consideration given to a referral for secondary and/or learning disability services.

3.6.35 The RCA suggested that in the light of John's self-reports of struggling with his relationship with Jennie, his learning disability/mental health history and a range of social stressors, he should have been seen,' *as requiring comprehensive assessments as a complex case with increased risk'.*

3.6.36 On the 13.05.19 John and a Shared Lives support worker (SLSW2) attended the GP practice in Bury. John informed the GP that he would be moving out of the area (presumably back to the Manchester area) and was advised to register with a new practice. The Bury learning disability team was subsequently advised that John had moved to Salford but then re-advised that he had moved back to Bury. The two Bury professionals[63] visited the address as planned but found the property to be (apparently) empty. They duly advised the MTPT (MSW2) of this and were told that he was back in Manchester. Given he was no longer believed to be in Bury (at the Bury address) they closed the case to adult services.

3.6.37 It would seem that John had got lost between the Manchester Transitional Planning Team (MSW2) and Bury LD services, due in part, to his comings and goings between the two areas in April and May. It would also seem that he was leading a somewhat chaotic existence, homeless, not taking his medication, estranged from Jennie, his son, and the support he had previously gained from this relationship. In the event he eventually returned to live with the family, probably sometime later in May/early June.

3.6.38 Nevertheless, he remained the responsibility the local authority regarding his S.117 and care act support. His case should not have been closed by the MTPT. This practice episode was a missed opportunity to have provided him with an appropriate and proportional level of support, oversight and risk assessment regarding 'Think Family' considerations.

3.6.39 Several letters were sent by the Bury GP practice to John between May and the end of August inviting his attendance but with no response. During this time, he was moving around between his father in Salford and other relatives and friends in Manchester, as well as staying for short periods with Jennie and Joshua. It was

[62] See Root Cause Analysis (GMMH Foundation Trust; June 2020)

[63] From BLDT and the Pennine Care NHS Foundation Trust community learning disability team respectively.

a fluid time for him and marked the onset of a deterioration in his mental health which by the end of August/ early September had become acute and possibly psychotic.

Finding 14: The Manchester Transition Planning Team should not have closed John's case on the 01.04.19 as it retained legal responsibility for supporting him via his S.117 and Care Act eligibilities. John thereafter became lost to the system leading to an increase in his vulnerability through having no effective social and health support (save for his Bury GP) up to the death of his son in September 2019. This episode was a missed opportunity to have provided him with an appropriate and proportional level of support, oversight and risk assessment regarding 'Think Family' considerations.

Lesson 9: Manchester Adult Safeguarding Board should undertake a learning lessons review (to include the issues in lesson 7) that seeks to understand the systemic reasons why John's case was closed in early April 2019, why he did not receive S.117 and Care Act support and why there was a missed opportunity to do so.

The Mental Health Liaison Team

Organisational Context

3.6.40 the (North Manchester) mental health liaison team (MHLT) is operated by the Greater Manchester Mental Health Foundation Trust (GMMH)[64] and is based at the North Manchester General Hospital. It takes staff referrals from the Accident and Emergency department, the general wards, Children's A and E and children's wards[65]; and assesses a patient's mental state by taking a holistic psycho-social history. The assessment includes a comprehensive analysis of the patient's needs and risks to themselves and others. It concludes with signposting the individual onto the most relevant service that will meet their needs and risks. Since April 2020 the service has been underpinned by a set of national minimum standards known as, 'Core 24' (see NICE/NHS England: November 2016: Achieving Better Access to 24/7 Urgent and Emergency Mental Health Care) which, amongst other things sets out recommended staffing levels (including skills mix) and proscribed response times to seeing patients who are experiencing a mental health crisis.[66] The Greater Manchester Mental Health NHS Foundation Trust (GMMH) had taken a decision to stagger the roll out of the Core 24 programme which was only partially implemented when John was seen in September 2019. The mental health liaison team at NMGH was thus not staffed to Core 24 levels at this time (which provided for three members of staff per shift, rather than two) and did not achieve this increased staffing level until April 2020. The service reportedly struggled to meet demand in September 2019.

3.6.41 The service was in transition in September 2019, having recently been restructured to take on the assessment of children and adolescents (Ageless Mental Health Liaison) from Children's A and E and the children's wards, on top of the adult work. The change had led to some anxiety within the team as there was little experience in working with children, albeit there had been some training provided by the local Children and Adolescent (CAMHS) service. To this end MHP2, a Band 7 CAMHS senior practitioner, had recently joined the team to facilitate the development. However, the change to an all-age response had increased the workload of the team as that time.

3.6.42 The team was nurse led, with an eight-hour shift being staffed by two nurses. There were some staffing issues at the time with the team being five or six staff down (from a complement of 12-15 nurses, including 2-3 agency staff which fluctuated) for various reasons. There was access to a consultant psychiatrist for advice whose expertise was

[64] The service is commissioned by Manchester CCGs.

[65] Covering Children was a recent addition to the service with no increase in staffing numbers to cover this.

[66] The standard is for a person experiencing a mental health crisis they should receive a response from the mental health liaison service within a maximum of one hour of the service receiving the referral. A mental health crisis is a situation that the person or anyone else believes requires immediate support, assistance and care from an urgent mental health service (NICE/NHS: Core 24: 2016)

in later life issues rather than children. [67]A junior doctor was on call to support the team (when demand increased) but this was sporadic and not structured. Reportedly, there was a perception that asking for a doctor created tension as they were so busy and so staff stopped asking.

3.6.43 A and E referrals came directly from the triage nurse and took priority over ward referrals. They were subject to time related targets, whereby all patients were to be seen within one hour. A typical adult assessment would take around two hours in total; one with the patient and one to write up the assessment. Child assessments took much longer; up to three or four hours, which could lead to a, 'stacking up', of A and E adult patients. This led to a degree of stress and anxiety amongst the team, where reportedly, morale was less than optimal. A triage process was in operation which consisted of the team mental health practitioner asking the A and E nurse some questions, determining whether more information was needed and then making a decision about seeing the patient or not. The team was very busy with 12-15 referrals each day. An eight-hour shift would average 5-6 referrals.

3.6.44 Of some significance, there was a degree of ambiguity and a lack of clarity amongst staff, regarding the necessity (or otherwise) of seeing all referred patients at that time. The GMMH Trust standard operating procedure was not clear regarding guidance for staff on criteria and thresholds for responding to referrals and completing crisis assessments. In the lead reviewer's opinion, this was a key contributory factor and an example of a latent failure in the service process, that increased the likelihood of unsafe outcomes for patients, as was the case with John. However, following the Joshua incident an e mail was sent to staff instructing that all patients would now be seen, albeit the review understands that there is no document or patient pathway formalising this change. The SCR is encouraged to learn that the Root Cause Analysis action plan includes recommendations[68] to address this key flaw and would suggest that they (and the entire action plan) are implemented as soon as possible.

3.6.45 Regarding awareness of risk to the children of assessed patients, the notion of, 'Think Family' and safeguarding were not (reportedly), at the time, well embedded in the team. The subject could come up sporadically within an assessment but was not a consistent focus.

John

3.6.46 John's mental health was in state of decline in September 2019 when he was seen by MHP1 (the first mental health practitioner) on the 03.09.19, in the company of Jennie and Joshua. He told MHP1 that he felt anxious, paranoid and was worried that he was getting worse. He was also using cannabis daily and had told the triage nurse that he had not taken his medication since May. He appeared to have insight into his situation as he knew he was getting worse and understood the negative impact of cannabis. He was given a comprehensive and thorough mental health assessment by MHP1 (which included consideration of his previous history of adolescent violence and aggression and admission to the Gardner Unit) who opined that he was experiencing mild paranoid thoughts that were very vague and not acute. He did not seem low or depressed and there was no evidence of any recent violence or aggression.

3.6.47 MHP1 concluded that John's mental health had probably deteriorated due to not having taken his medication, but primarily because of his use of cannabis. MHP1 made a referral to the Bury Access and Crisis team for a further assessment so that John could be supported to re-start his anti-psychotic medication which could be monitored. He was advised to desist from his cannabis use and to contact a local drug and alcohol team for support.

3.6.48 MHP1 did not think that there was a need for immediate support from a home treatment team as he was not presenting with an acute need. Bury Access and Crisis team received MHP1's assessment and rationale for the referral and John's details on the same day. MHP1 received confirmation by e-mail advising receipt of the referral.

3.6.49 MHP1 discussed the assessment and referral with John and Jennie (Joshua was also present) who were both agreeable to the suggested course of action. John wanted to get better, showed good insight and was happy for Jennie to know about the plan and support him. The couple were smiling and seemed like a 'happy family'. MHP1

[67] The consultant left in September 2019, but the post was re-filled a few months later.

[68] Recommendations 2 and 3 of the Root Cause Analysis report.

assessed that there were no grounds to have made a safeguarding referral on Joshua as the father had a supportive family and had not reported any suicidal thoughts or suggestions of harming others.

Finding 15: MHP1 conducted a competent and timely assessment which effectively ascertained John's contemporaneous mental health needs and risks of violence to himself, Joshua and Jennie. This included appropriate and relevant consideration of his historical mental health issues. The referral plan to the Bury Access and Crisis team was effected in a timely manner and was reasonable and proportionate in all of the given circumstances at the time.

Finding 16: Based on the known contemporaneous evidence there were no grounds for MHP1 to have made a safeguarding referral to Bury MASH. However, adopting a, 'Think Family 'approach could have led to considering (subject to the parents 'consent) making a referral for family support.

3.6.50 John presented again at the A and E department of NMGH on the 08.09.19 (Sunday) at around 6pm, requesting to be sectioned and admitted to hospital. The (senior) practitioner on duty (MHP2) in the mental health liaison team was telephoned by the triage nurse who reported that John was acting in a bizarre manner and was unable to engage in conversation properly. In what was a busy shift, MHP2 identified (via PaRIS: patient records system[69]) that John had been seen and assessed by MHP1 some five days earlier and should by now have been involved with the Bury Access and Crisis Team.[70] He had also been prescribed two weeks medication by his GP on the 02.09.19 and was expected to return in two weeks to re-evaluate his medication. MHP2 was relatively new to the team and had not undergone an in-depth induction into navigating the PaRIS system and was not able to access John's historical records.

3.6.51 The proposed referral was discussed and not accepted by the mental health liaison team citing that John had been seen several days before; nothing appeared to have changed and that there was no evidence of mental illness warranting assessment. The senior practitioner had consulted the PaRIS case notes and noted that John had been seen on the 03.08.19 and been advised to contact the Bury Access and Crisis team. MHP2 felt that from the information in the referral that another assessment from the mental health liaison service was not indicated at that time but would look again if the referrer (I.e. A/E triage) could provide more detail. There was no further contact between A and E and MHP2 who did not get back to A and E to close the communication loop. This resulted in John not being seen by MHP2.

3.6.52 John should have been seen and his mental health needs assessed and updated by MHP2. The review panel, lead reviewer and GMMH Root Cause Analysis were of this view, as was, in hindsight (and to his credit), MHP2. The service response, as cited by the Root Cause Analysis, did not, *'appear to have recognised John's previous and more recent risk history or the recent concerns from the previous assessment when a referral was made to the Bury Access and Crisis team. Furthermore, his behaviour at triage was different to the behaviour when assessed days previously. All these factors would indicate a further mental health liaison service assessment would have been appropriate'.* Moreover, not seeing John also precluded clarifying whether he had been seen by the Bury Access and Crisis team (he had not); in addition to any consideration of potential harm to Joshua and his mother; thus, suggesting there was no wider thought given to, safeguarding issues and 'Thinking Family'. [71]

3.6.53 However, it should be noted that even if John had been seen there was no certainty that immediate action would have been taken, or that he would have been sectioned and detained under the Mental Health Act:1983, as

[69] PaRIS (patient record system) is a new standardised Trust recording system with the aim of improving access to clinical records for service users across a wider GMMH footprint.

[70] NB In the event, he was not engaged with the Bury Access and Crisis Team at this time (see paragraph 3.6.34 below) and would not be prior to the death of Joshua on the 11.09.19.

[71] The Root Cause Analysis pointed out that an approach or plan for John could have been adopted such as would have been developed for a frequent attender.

he wished. On the assumption that he had been referred for a Mental Health Act assessment this would have been undertaken externally by an Approved Mental Health Practitioner, who may or may not have decided to section him.

3.6.54 In any event, John not being seen was an example of an, 'active failure' by the practitioner but this must be seen within the wider organisational context of several, 'latent failures', that, in the opinion of the lead reviewer, did not make for a safe and effective operating environment. These include but are not confined to,

- An organisational context of the mental health liaison team being in a transitional state, both in regard to working towards Core 24 standards and an all-age response.
- Staffing under capacity to meet demand, being exacerbated by increased workloads arising because of the introduction of Children and Adolescent assessments, with no increase in staffing.
- Anxieties around achieving the one-hour target for seeing A and E patients.
- A resulting increase in practitioner stress and low team morale.
- No written patient pathway that provided clarity to practitioners around the mandated requirement to see referred patients within the set times.
- A perception of minimal support from medical staff and a reluctance to call on doctors due to prevailing tensions.
- Cutting corners: the emergence of an informal (discretionary and inconsistent) internal team triage process to manage increased demand pressures because of the lack of a clear, written and well embedded operating service protocol.
- Think Family and safeguarding children principles not being embedded into the core practice of staff.
- Inconsistent staff familiarity with the correct use of PaRIS.
- Poor communication between A and E and the MHLT.

Finding 17: John should have been seen and given a mental health assessment on the 08.09.19, albeit that the practitioner operated within a framework of unclear guidance on appropriately accepting referrals and completing crisis assessments.

Finding 18: There was an unsafe operating environment (as set out above) within the mental health liaison team, at the time of John's presentation, which hindered consistently safe practice and positive patient outcomes.

Lesson 10: Manchester CCG and the GMMH should undertake a review of the mental health liaison service mindful of the previous findings. The review should ensure that the proposed GMMH action plan arising from the Root Cause Analysis is fully implemented, that the service is fully compliant with Core 24, is staffed appropriately to meet demand and has the necessary policies and procedures, including safeguarding and Think Family that results in safe and effective patient outcomes.

3.6.55 The SCR understands that improvements are in train, including an intention to have three staff per shift and a clear directive to the team that all patients referred by A and E will be seen as standard. Moreover, the recently completed GMMH Root Cause Analysis report (June 2020) has identified the issues in the paragraph above and incorporated them in the report's learning and recommendations. The SCR looks forward to seeing an action plan from the GMMH (and all of the other relevant agencies involved in this SCR) in due course.

The Bury Access and Crisis Team

3.6.56 The referral made by MHP1 on the 03.09.19 for John to have longer term mental health support had since that date been with the Bury Access and Crisis Team. Having been initially screened on the 03.09.19 by two practitioners the referral was awaiting further screening on the 05.09.19 by a psychiatrist. This was for John to have an out-patient appointment and support from the community mental health team. Unfortunately, the screening did not happen, apparently because of various staff changes within the team. The referral remained in the consultant screening workflow for the following week and was due to be screened on the 12.09.19, the day after Joshua's death. The SCR learnt from Bury Access and Crisis Team that even assuming John had been screened on the 12.09.19 the earliest appointment offered would, it is estimated, have been some 6 weeks later and the latest appointment some 12 weeks.

3.6.57 It is unclear as to the precise reasons why Joshua's screening did not happen on the 05.09.19. It suggests that there may have been some systems issues in regard to the timely completion of the screening. The agency has recently (July 2020) informed the lead reviewer that following the incident it conducted a review of the consultant screening process. This has now been revised to mitigate any future delays in the screening process so as to ensure that the service is operating safely and effectively.

3.7 **Other Issues**

3.7.1 Housing; see paragraph 3.6.15/16 above and Appendix 2 below.

Finding 19: Self-evidently, keeping vulnerable homeless families with children in their own localities where they have a greater chance of continuity of support services is preferable to, 'exporting' them to locations where they have minimal links to family and support networks. It is encouraging to learn that this has been the policy of Manchester Housing Service since July 2018. Unfortunately, it came one month late for Joshua and his family.

3.7.2 Consequent to this SCR, Manchester City Council Homeless Service has identified and implemented the following lessons and associated actions. Namely,

- To triage all cases to ensure that they are kept in Manchester if they are being supported by agencies such as Social Services and Mental Health Services, to ensure there is a continuation of care. The expected outcome is that customers will not lose or have a break in the vital support they need.

- Support workers will ensure that they speak to children's and adult services if customers cease to engage with support being offered. This may be in Manchester or within other local authorities where the customer is placed. The expected outcome is that singles and families will receive a more co-ordinated multi-agency approach.

3.7.3 This SCR has identified an additional lesson, namely that,

Lesson 11 The Manchester Housing Floating Support Service should ensure that it links up and liaises with other professionals and agencies (e.g., social and mental health workers, health visitors and family support workers) who have involvement with vulnerable Manchester families placed in Greater Manchester local authorities. The expected outcome would be to ensure early involvement by the Floating Support Service with the aim of families and singles receiving a co-ordinated and multi-agency service as soon as possible after moving into their temporary accommodation in the new location.

3.7.4 Cross border issues: As evidenced by the above analysis, Joshua and his parents experienced significant difficulties in continuation of services (especially mental health support for John) on being moved by Manchester Homeless Service to Bury. Moreover, some of the practitioners in Bury (health visiting) remarked on the challenges of working with so called, 'transient families' and the problems involved in liaising with, 'home' agencies in seeking to provide a degree of service continuity. This was especially problematic in the case of families placed, either in temporary accommodation, or moving about rapidly between local authorities, where they were difficulties in referring to local services.

Lesson 12. There is a need for the Greater Manchester Children and Adult Safeguarding Partnerships to develop cross boundary working protocols that promote effective co-ordination and continuity of services for vulnerable families and individuals who move across local authorities within Greater Manchester.

3.8 Examples of Good Practice

3.8.1 The first health visitor (HV1) and MSW2 evidenced persistence in their communications which led to a referral to the Bury MASH in December 2018.

4. Family Views of Jennie, her mother and grandmother

4.1 At the meeting with the lead reviewer held at the end of February 2020, the following views were expressed.

- **Midwifery and Health Visiting**: The midwives had done their jobs as had the health visitors, the first one (health visitor) had been helpful. She had tried to get them moved to better accommodation.

- **Bury Children Social Care social worker/ Family support from Children's Centre**: The social worker had completed an assessment in May 2019 which had resulted in Jennie and family having involvement with a family support worker from a Children's Centre. This was quite helpful, particularly in offering Jennie the possibility of joining various support groups at the Children's Centre. She decided not to take this up.

- **Adult Social Care: Manchester and Bury:** The social worker from Manchester was helpful to John but because of the move to Bury he never got a social worker from Bury which he needed because he couldn't look after himself.

- **Mental Health Services for John:** Jennie didn't know that John had not been taking his medications for some time. He was told to go away when he went to the hospital in the days before the incident. He wanted to be sectioned but was ignored. He didn't get the help he needed. The move from Manchester to Bury made things difficult because he had to start with new services who didn't know him.

- **Housing:** Jennie felt that they weren't much help as they were not moved from the Bury accommodation. They wanted to be in Manchester and close to her mother. This was where their support came from, both the family and the local community.

- Jennie and her mother/grandmother felt very strongly that she, John and the baby had been 'taken out of their comfort zone' by being moved to temporary accommodation in Bury, rather than finding somewhere close to her family. This was not an area familiar to them and they didn't know anybody there. She wanted to stay in the area she and John came from, nearby to her mother and local community in Manchester.

- John experienced some racial abuse from neighbours in the Bury accommodation. Jennie (and mother/grandmother) said that Bury was not a multi-racial area[72], unlike where she is now in Cheetham Hill. Jennie felt that if they had been found a home locally, 'it wouldn't have happened'.

- The lead reviewer asked Jennie and mother/grandmother knowing what they know now, what changes would they like to see/ things being done differently? They replied that a social worker should have been sent out to John to support him and that 'people should have looked into John's background, about his mental health'.

4.2 The lead reviewer would like to meet with John if at all possible and after the conclusion of the criminal trial to hear and record his views on the services he received.

5. **Summary and Conclusions**

5.1 Joshua was the first-born child to his parents, Jennie and John. Tragically he died at 11 months of age through being thrown into a local river by his father on the 11.09.19. John is due to stand trial in November 2020 for the death of his son.

5.2 John, in addition to having a learning disability also had a background of significant mental health issues and adverse childhood experiences which led in 2014 to his two-year detention in a local psychiatric facility. On discharge in February 2016, he was cared for (initially under a Community Treatment Order and from July 2016, S.117 support) in the community through a Manchester multi-agency health, social service and housing support plan which effectively met and managed his needs and risks, including, in particular, maintaining his medication uptake and helping him desist from cannabis use.

5.3 The parents started a relationship in 2016 and lived for a while at Jennie's mother's house in Manchester. They became homeless in June 2018 and were moved that month by Manchester Council Housing to temporary accommodation in the neighbouring local authority of Bury. By this time Jennie was pregnant with Joshua. She was well supported by the maternity and midwifery services and gave birth to him on the 16.10.18.

5.4 Due, in part to being re-located in Bury; John, from June 2018 lost contact with the Manchester health and support agencies. Because of a lack of attendance, he was discharged from psychiatric oversight, which included his medication arrangements in early August 2018. This was of significance because, despite being subject to S.117 after-care to the MTPT and the Manchester Learning Disability service, it marked the beginning of his difficulties in receiving and taking his medication, which hitherto had served to stabilise his behaviour and well-being.

5.5 John should not have been discharged from the medical oversight of the Learning Disability service as he was still subject to his S.117 entitlements. There was minimal multi-agency working and co-ordination between the two agencies caused in part by the lack of local guidance around respective agency roles and responsibilities in relation to S.117 working. Had there been an effectively functioning MDT, with a care co-coordinator, full knowledge of the S.117 plan and the involvement of other agencies such as the MHS, John could have been located in Bury and suitable arrangements made to continue with his S.117 plan, including appropriate social care and health support from Bury agencies. This was a missed opportunity by the MTPT and the Manchester learning disability service to have done so in compliance with local protocol.

5.6 The SCR has suggested that the three Manchester agencies (and the Manchester CCG) undertake a rigorous learning review of how and why this happened with a view to developing systems and processes that seek to ensure that vulnerable individuals receive a continuity of care when they move into a new area.

[72] Bury is a multi-cultural and diverse borough. The area where the family lived was mainly White British.

A key lesson would suggest, at the very least, that there needs to be clear practice guidance in relation to multi-agency/disciplinary work around S.117 planning, implementation and review, in addition to agency/practitioner roles and responsibilities.

5.7 The family remained in Bury during 2018/19 in a relatively isolated position, away from their support networks in Manchester. A Bury Children's Social Care Children and Family assessment completed in February 2019 decided (on reasonable grounds) that there was no role for them and closed the case. John was still involved on a reduced level with the two Manchester agencies, Shared Lives and the Transition and Planning Team.

5.8 The latter agency ceased its involvement in early April 2019 and towards the end of that month made a referral to Bury Learning Disability Service and Children's Social Care respectively. The Transition and Planning Team should not have closed John's case as it was responsible for his support by virtue of the recently completed care act assessment. Partly because of John's coming and going between Bury and Manchester where he was staying short term with various family members, he was not seen by Bury Disability Service in May. They understood that he was living in Manchester and closed the referral. Thus, by May, he had no mental health/learning disability secondary agency support and was left in a vulnerable position.

5.9 From this time John's mental health started to deteriorate, he had not taken his medication for several months, was taking cannabis, had split up from Jennie (who was pregnant) and was homeless in Manchester. A second Children and Family assessment in May 2019, recommended a Team around the Family (Level 3) plan to support Jennie, it having been assumed that John's split was permanent and that the risk from him was therefore minimal.

5.10 The flawed assessment did not sufficiently include important information from the Manchester care assessment about the inherent risks of John not taking his medication and reverting to cannabis use, in addition to his learning disability. This SCR was of the view that the family's situation in May 2019 warranted (at least) a multi-agency Child in Need plan at level 4 intervention given their level of need and the known risks. This could have provided support around childcare, housing and mental health for John, in addition to monitoring Joshua and the unborn child's progress and well-being and escalation to level 5, child protection if needed.

5.11 Notwithstanding the apparent, active failures in practice, the SCR has identified some possible organisational, 'latent failures' within the prevailing Initial Response Team service arrangements which, where appropriate, should be addressed by Bury Children's Services.

5.12 John returned to the family in late May/early June. The TAF plan somehow became translated into a single agency intervention (despite there being several agencies involved at this time), by Bury Outreach Service that was of limited scope (four sessions over June and July) and fairly practical in nature. At the parents' request the service ceased in mid-July leaving just the health visiting service at the minimum level of Universal Partnership.

5.13 Thereafter, John's mental health seemed to have rapidly deteriorated in August, probably because of his cannabis use and non-medication.[73] In September 2019 he attended the GMMH Accident and Emergency department at the North Manchester General Hospital three times. He was seen on the 03.09.19 by MHP1 from the mental health liaison team who conducted a competent assessment resulting in a support plan and a referral on the same day to the Bury Access and Crisis Team. Despite being initially screened on the 03.09.19 there were process delays in progressing the referral by which time the tragic incident with Joshua had occurred on the 11.09.19, which meant that John was not seen by the Access and Crisis service.

5.14 Three days before the incident on the 08.09.19, John presented at the NMGH Accident and Emergency Department, seemingly in a poor state and wanting to be sectioned. The mental health practitioner (MHP2)

[73] To be established, or otherwise, by the criminal trial and eventual inquest.

decided not to see John because he had recently had a thorough mental health assessment with MHP1 some five days before and was due to be seen by the Bury Access and Crisis Team. The SCR found that John should have been seen and assessed by MHP2. However, despite this active failure, the SCR identified a number of possible organisational latent failures that militated against safe practice.

5.15 However, it should be noted that even if John had been seen and assessed by MHP2 there was no certainty that he would have received an immediate response to his wish for sectioning and admission to hospital.

5.16 Finally, this SCR has identified a number of factors which combined to produce a 'Pathway to Harm' in respect of Joshua. These were;

- Vulnerable first-time parents living within a context of low income, lack of appropriate housing and away from their social and family support networks.
- A father with learning disabilities and mental health needs which were not met in the crucial months leading up to Joshua death.
- A father who had become lost to the Manchester adult social and health support agencies on the family's move to Bury in June 2018, prompted by Manchester housing agency.
- The lack of continuity of S.117 after-care and care act support to John by Manchester Learning Disability Service and the City Council Transition Planning Team from August 2018.
- The absence of a multi-agency/disciplinary approach by the Manchester agencies to John's S.117 after care plan.
- A fragmented and very complex adult health and social care system that militated against effective inter-agency communication, timely case transfer and continuity of care for John.
- The lack of a robust system for ensuring effective and rigorous Children and Family assessments that achieve the right threshold of intervention.
- The lack of a multi-agency understanding and appreciation of the inherent vulnerability of infants under one year old.
- Little multi-agency appreciation of the child's lived experience in challenging socio-economic and familial circumstances and a tendency to consider the' here and now', through an overly optimistic lens, rather than from a more holistic perspective of strengths and stresses.
- Difficulties of cross border working between agencies.
- Problems with the Bury MASH in inter-agency information sharing.
- The lack of a safe operating environment within the GMMH mental health liaison team that struggled to cope with patient demand, lacked clear written principles and processes regarding case acceptance; and where principles of 'Think Family' and safeguarding were not well embedded into practice.
- Operational problems within the Bury Access and Crisis Service regarding the effective and timely screening of John's referral from MHP1.

6.Recommendations

For BISP and Partner Agencies

6.1. Bury Children's Social Care should assure the BISP that it's IRT is operating a safe and effective service that accurately assesses the needs of infants under one and any risks to them from parents/care givers, results in the most appropriate level of intervention and is subject to robust managerial scrutiny and quality assurance. This could take the form of an independent audit of cases of babies under one that were referred to the IRT over a defined time period.

6.2. Bury MASH and its partner agencies should review, as a priority, the operation of its multi-agency information sharing function, particularly in regard to ensuring that the full range of lateral enquiries are made with all relevant agencies in a timely way. The review should assure the BISP that this is working effectively in the interests of maximising the safety and wellbeing of children, young people and vulnerable adults and is compliant with MASH operating principles, and objectives.

6.3. The Bury Access and Crisis Service should assure its commissioning body and the BISP that it is operating a safe, timely and effective service by undertaking a review of why John's referral from the mental health liaison team of the 03.09.19 was not screened and processed in a timely way.

6.4. The BISP should share the learning from this SCR with the Greater Manchester Safeguarding Fora (children and adults) with a view to developing cross boundary working protocols for children and adult services that promotes effective co-ordination and continuity of services for vulnerable families and individuals who move across local authorities within Greater Manchester. Such protocols should be based upon best practice in other regions.[74]

For Manchester Safeguarding Partnership and Partner Agencies

6.5. The three Manchester agencies[75] responsible for John 's Section 117 after-care support (in addition to Manchester CCG and Manchester City Council as the commissioning agencies) should undertake an internal learning review (possibly a Safeguarding Adult Review by the Manchester Adult Safeguarding Board) into, (1) why there was poor multi-agency/disciplinary working between the MTPT, Manchester Learning Disability Service and Shared Lives around John's S.117 after care planning, implementation and review, leading to his discharge from the Disability Service in August 2018, (2) that seeks to understand the systemic reasons why John's case was closed in early April 2019, why he did not receive S.117 and Care Act support and why there was a missed opportunity to do so. The learning review should include analysis at the structural level of organisational barriers, defences and interfaces (latent failures) that seeks to understand the underlying systemic causative factors (as referenced in paragraphs 3.6.21-23) accounting for the active failures at practitioner level.

6.6. Manchester and the GMMH Trust should undertake a review of the mental health liaison service mindful of findings 17 and 18. The review should seek to ensure that the service is now fully compliant with Core 24, is staffed appropriately to meet demand and has the necessary policies and procedures, including safeguarding and Think Family, which results in safe and effective patient outcomes.

6.7 The Manchester Housing Floating Support Service should ensure that it links up and liaises with other professionals and agencies (e.g., social and mental health workers, health visitors and family support workers) who have involvement with vulnerable Manchester families placed in Greater Manchester local authorities. The expected outcome would be to ensure early involvement by the Floating Support Service with the aim of families and singles

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[74] E.G see https://proceduresonline.com/trixcms1/media/4050/transfer-protocol-birmingham-ct-and-solihull-childrens-services-v2-fms_260919131219.pdf

[75] Manchester Transition Planning Team, Shared Lives and the Learning Disabilities Team.

receiving a co-ordinated and multi-agency service as soon as possible after moving into their temporary accommodation in the new location.

For both the BISP and Manchester Safeguarding Partnership

6.8 The BISP and Manchester Safeguarding Partnership (MSP) should seek to ensure that (1) the concept of the inherent vulnerability of babies is disseminated and embedded in practice amongst all agency partners, especially adult services, (2), should take suitable action that seeks to ensure that professionals look beyond the, 'here and now', of a child's lived experience and locate it within a wider holistic context of family stresses and strengths.

6.9 The Manchester agencies should be invited by the BISP to comment on this report prior to its approval and take ownership for implementing any single agency improvement actions. A suitable accountable body such as the Manchester Safeguarding Partnership should take responsibility for overseeing action implementation and report back to the BISP to confirm implementation.

6.10 The findings and learning from this SCR should be widely disseminated across the two partnerships.

7.References

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8.Glossary

Family members

Joshua: born October 2018: First born and subject of this SCR: died 11.09.19

Mary: born October 2019: Second born and sister to Joshua

Jennie: Mother to Joshua and Mary

John: Father to Joshua and Mary

Key Professionals

HV1, 2, 3, 4: Bury Health visitors

BSW1 and BSW2: Bury social workers

MSW1 and MSW2: Manchester social workers (Manchester Transitional Planning Team)

SLSW1 and 2: Shared Lives support workers

FSS1: Floating support service support worker (Manchester Housing Support Service)

OW1: Outreach worker 1 (Bury)

RC1 and RC2: Responsible Clinicians (psychiatrists attached to the Manchester Learning Disability Service)

MHP1 and MHP2: Mental Health Practitioners (Mental Health Liaison Team)

Terms

A/E: Accident and Emergency department

BISP: Bury Integrated Safeguarding Partnership

BLDT: Bury Learning Disability Team

BCSC: Bury Children's Social Care

BACT: Bury Access and Crisis Team (mental health)

CAMHS: Child and Adolescent Mental Health Service

CFA: Child and Family Assessment

CCG: Clinical Commissioning Groups (Bury and Manchester)

CTO: Community Treatment Order

EIT: Early Intervention Team

GMP: Greater Manchester Police

GP: General Practitioner

IRT: Initial Response Team (Bury)

KLOE: Key Line of Enquiry

MASH: Multi-Agency Safeguarding Hub (Bury)

MHLT: Mental Health Liaison Team (Greater Manchester Mental Health NHS Foundation Trust)

MHA 1983: Mental Health Act; 1983

MTPT: Manchester Transitional Planning Team (local authority)

MLDS: Manchester Learning Disability Service

NHSE: National Health Service (England)

NMGH: North Manchester General Hospital

OCG: Organised Crime Group

OW: Outreach worker (Bury)

RCA: Root Cause Analysis

PaRIS: Patient access record information system

SCR: Serious Case Review

SCF: Special Circumstances Form

S.117: Section 117 of the Mental Health Act: 1983

TAF: Team around the Family (Level3)

UPP: Universal Partnership Plus (plan)

Appendix 1

Teams involved with John's community treatment order and S 117 after care.

1.Manchester Early Intervention in Psychosis Team, Greater Manchester Mental Health NHS Foundation Trust

The Early Intervention in Psychosis Team (EIT) works with people who have experienced a first episode of psychosis. It is a multidisciplinary team supporting mainly younger people experiencing a first episode of psychosis. The team consists of staff from a variety of disciplines, including medical, nursing, social work, occupational therapy, and psychology.

2.Mental Health Liaison Team, North Manchester General Hospital, Greater Manchester Mental Health NHS Foundation Trust

Based within the acute hospital, mental health liaison services enable 24/7 access to specialist mental health care. This is delivered by a clinically led multidisciplinary team who operate 24/7, to provide specialist psychiatric assessment, advice and treatment for anyone with a known or suspected mental health need in the acute hospital.

Manchester Mental Health Liaison Services operate in order to deliver CORE 24 mental health liaison services in North Manchester General Hospital and other hospital sites in Manchester.

3.Transition Team, Manchester City Council

This service is a small team of approx. 10 social care staff to assist with the transition most commonly from child and adolescent services to adult services and support up to the age of 25 years in some cases to ensure smooth transition into adult hood. Some of these cases may also be known or open to other services, at the time of the incident there was no standard operating procedure that outlines how they would joint work.

4.Shared Lives, Manchester City Council

This service offers accommodation and related practical tenancy support to those referred. This can be in shared facilities or placed with adult placement carers in their homes as appropriate. It provides keyworkers who remain involved with service users while they are supported by the service.

5.Learning Disability Psychiatric Outpatient Service, Manchester City Council/Manchester NHS Foundation Trust

This service provided outpatient appointments from a Consultant Psychiatrist specialist in Learning Disability to monitor those referred with respect to their Mental Health and Learning Disability. It offered specialised mental health assessments and where necessary informed the work of any other services and professionals involved.

Appendix 2

Manchester City Council Housing

1.The SCR was informed by the Manchester City Council Housing Directorate that it is current policy and practice to house single people and families outside of Manchester, into Greater Manchester while they await an offer of permanent accommodation. Offers of permanent accommodation are made in Manchester unless the client is happy and settled in the new area and the Directorate through the Homeless Floating Support Service would

support them to remain in that area if possible. Singles and families can remain in temporary accommodation for an average of three years, but this can be longer for larger families, albeit there are some exceptions.

2. If a family or single have a social worker in Manchester or identified partners (e.g., mental health) who are working with them, the Directorate will try and place them in temporary accommodation in Manchester. If it is a single female who identifies as being pregnant, she will be placed in temporary accommodation in Manchester.

3. If a single or family has been placed outside Manchester and the Directorate feels that they should be in Manchester they will be transferred back, albeit this can be quite disruptive.

4. The Directorate uses properties across Greater Manchester because of the shortage of affordable accommodation in Manchester.