SALFORD SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

Child H

20th October 2010

1. INTRODUCTION

1.1 Decision to hold a Serious Case Review (SCR)

1.1.1 In 2010 Adult G, telephoned the Police to say that he had just killed Child H at his home. The Police attended the scene and Child H was found dead in the bedroom.

1.1.2 Child H had been stabbed and strangled. Adult G claimed that he had experienced a psychotic episode.

1.1.3 Although the death occurred in the administrative area of Manchester, Child H's normal residence was in Salford and she was known to many of the agencies working with children and families

1.1.4 Child H had also been previously the subject of a Child Protection Plan in a number of authorities, most recently Salford.

1.1.5 Ofsted and Government Office North West (GONW) were notified of the death, as was the Chair of Salford Safeguarding Children Board SSCB). In view of the circumstances, a Serious Case Review Meeting was held by SSCB (Serious Case Review Sub- Committee).

1.1.6 The recommendation of the Serious Case Review Sub- Committee was that in accordance with the guidance contained in paragraphs 8.9 to 8.12 of "Working Together to Safeguard Children", the criteria for undertaking a Serious Case Review in respect of Child H had been met.

1.1.7 In making this recommendation the Serious Case Review Sub-Group considered the guidance contained in Chapter 8 of "Working Together". "When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should **always** conduct a SCR into the involvement of organisations and professionals into the lives of the child and family….These SCR's should include situations where a child has been killed by a parent, carer or close relative with a mental illness".

1.1.8 The recommendation for undertaking a Serious Case Review was conveyed to and considered by the Chair of Salford Safeguarding Children Board (SSCB). The Chair of SSCB made the decision to hold a Serious Case Review on the 4th May 2010.

1.1.9 Ofsted and GONW were informed of this decision on the 4th May 2010.

1.2 Agencies Contributing

1.2.1 In order to establish the facts of the case in relation to each individual agency, Individual Management Reviews (IMR's) were conducted covering the following agencies:

Greater Manchester West NHS Foundation Trust
Greater Manchester Police

Greater Manchester Probation
Salford Community Health
Manchester Community Health
Salford Royal Hospital Foundation Trust
GP Services
Sustainable Regeneration (Housing)
Salford Children's Services (Education)
Salford Children's Services (Children's Social Care)
SureStart and Extended Schools
Manchester Children's Social Care
Great Places Housing Group
Spurgeons- (a voluntary sector childcare organisation)
Overview Health Report

Salford Community Safety Unit contributed a brief Report of their contact with Adult A Manchester Mental Health and Social Care Trust contributed a brief Report of the referral to them of Adult G.

1.2.2 Information included all contacts with Child H and IMR Report writers were also asked to include any information about family members in as far as the information related to the terms of reference for the SCR.

1.3 Key Lines of Enquiry

1.3.1 Each agency Individual Management Review Report was asked to examine the quality and effectiveness of their organisations intervention and support and consider: -

1. whether historical information was given appropriate emphasis within agency assessments and interventions.
2. whether the information sharing and communication systems within and between agencies and across boundaries were effective, including forming a holistic picture to provide joint understanding and action.
3. whether the children and their experiences were at the centre of all agency assessments and interventions and they were listened to as part of the decision making process (this includes adult focused services).
4. identify the role of the children's fathers and the extended family that was known and understood.
5. whether agency responses were appropriate and timely and was the cumulative picture of the risk to the children built up to inform interventions with emphasis on the missing male figures in the children's lives.
6. how mother's disengagement with services was managed and how this informed ongoing agency assessment of risk to children and herself: and how was this communicated to other agencies involved with the family.
7. the impact of mother's mental health and substance misuse on both the ability to parent and the consequences this had for the children.
8. whether the significance of violence within the family was recognised and dealt with appropriately.

9. whether all agencies and professionals gave due and proper consideration to all diversity issues, including ethnicity, religion, language, disability and cultural issues in the delivery of services.
10. whether the organisations have the necessary resources and capacity: whether the professionals working with the family were suitably skilled, adequately supervised and can management decision-making be evidenced.

1.4 Time Frame for the Serious Case Review

1.4.1 The Review will cover the time period from January 2003 when there were first agency concerns about the family to April 2010 when Child H died. Additional historical information is referred to, as appropriate, in order to set the family's actions and agency interventions in context.

1.4.2 The key subjects of the SCR are Child H, the mother of Child H (Adult A), the most recent stepfather of Child H (Adult B), the three youngest half siblings of Child H (Child A Child B and Child C) and another half sibling of Child H (Adult C).

1.4.3 In addition relevant information was included on extended family members where that information impacted on Child H.

1.4.4 Key information was also sought on Adult G, the alleged perpetrator of the violence against Child H resulting in the death of Child H.

1.4.5 The completed SCR was presented to Salford Safeguarding Children Board for scrutiny and approval on the 11th October 2010 and agreed by the Chair of SSCB on the same day.

1.5 Membership of the Serious Case Review Panel

1.5.1 Composition of the Serious Case Review Panel was as follows:

Judith Longhill	Independent Chair
	Head of Safeguarding. Salford Children's Services
	Detective Inspector. Chilld Death Review Team. Greater Manchester Police
	Head of Sure Start and Extended Schools
	Assistant Chief Executive, Greater Manchester Probation Trust
	Designated Nurse, Mental Health Services
	Named Nurse, Safeguarding. Salford Royal Foundation Trust
	Designated Doctor, Salford
	Head of Strategy and Enabling, Sustainable Regeneration
	Principal Manager, Safeguarding Manchester Children's Services

	Professional Advisor, Safeguarding and Quality. Spurgeons
	Independent Consultant Nurse – for Health Overview Report

The Independent Chair of Salford Safeguarding Children Board is Ms. Gill Rigg.
The Independent author of the Overview Report was Mr. Dennis Charlton, an Independent Consultant in Child Protection.

1.6 Involvement of Family Members

1.6.1 The Chair of the SCR Panel wrote to key family members outlining the process of the Serious Case Review and informed them that the Overview author would be inviting them individually to meet him to discuss any contribution they may have
The Overview Author offered flexible appointments to each significant extended family member and to Child H's mother. Two family members made contact and met the Overview Report author. Their views made a significant contribution to the Overview Report were incorporated into the SCR Overview Report.

1.6.2 Salford Safeguarding Children Board recognises that the tragic death of Child H has had a devastating impact on family members and offers both condolences to them and appreciation for their willingness to contribute to this process.

1.10 Parallel Proceedings

1.10.1 Adult G was arrested on the day of Child H's death and charged with murder. He pleaded guilty to murder at his trial and was given a mandatory life sentence.

1.10.2 Appropriate action was taken to protect Child H's half siblings. (Child A, Child B and Child C). Discussion took place, as appropriate between the Crown Prosecution Service and the Serious Case Review Panel to ensure that the parallel processes were harmonised.

2. Summary of Events

2.1 Although the timeframe for this SCR commences from 2003 when there started to be significant agency involvement with the family in Salford, there was a significant family history. Adult A had seven children in all to four different fathers. Her oldest son, Adult C, lives with maternal grandmother and Child H's older half sister lives with her paternal great aunt. The three oldest children of Adult A were placed with extended family members from a young age as their mother was unable to provide them with sufficient stability and failed to offer them adequate protection.

2.2 Adult A has a long history of offending behaviour, including physical assault, robbery and drug misuse. There were additional offences related to her drug addiction. She had served two custodial sentences. As a child Adult A was in local authority care and possibly as a result has found it difficult to be compliant with agencies working with her. Adult A received treatment from May 1999 for drug misuse problems, primarily heroin and crack cocaine. An ongoing feature of this case has been the illicit use of drugs and the impact of that on parenting and family functioning.

2.3 There is a long history of child protection interventions with Adult A's children. Child H was placed on the Child Protection Register in another geographical area (a pre-birth Conference) in December 1997. There were concerns relating to both her parents drug use and also criminal activity and a lack of stability within the family. When Adult A moved with Child H to Greater Manchester in February 1998, Child H was placed on the Child Protection Register in the local authority area where she resided, under the category of likelihood of emotional abuse.

2.4 When Child H and her mother moved to another local authority in Greater Manchester in May 1998 she was placed on the Child Protection Register under the category of "likely to suffer neglect". At that time there were concerns noted about Adult A's drug use and her lifestyle choices. The category of registration was changed in May 1999 to that of "likely to suffer physical abuse". This was because there had been a number of domestic violence incidents in relation to Adult A and a previous partner. In January 2001 Child H was deregistered from the Child Protection Register in the local authority area where she lived. There were no reported health concerns and Adult A had made positive progress in developing relationships with staff at the nursery.

2.5 The first contact with the family for Salford agencies was in August 2000 when a Salford Health Visitor made an visit to the family following information from health colleagues in another health area that mother (Adult A and her child (Child H) had moved to Salford. Child H was seen and appeared healthy. Home conditions were reported as poor, with no cooking facilities and no heating. The first contact with Salford Children's Services was in January 2002 when Child H's mother sought support because of financial difficulties. At that time Child H was living with her mother and stepfather (Adult B). There was no additional significant agency contact in Salford until 2003.

2.6 Child A had been born in February 2002 and Child B was born in April 2003. The father of both of these children was Adult B. Both Child A and Child B were of dual heritage, their father was recorded as living between Pakistan and Salford. Child H was seen in school on the 26th June 2003 for routine height and weight monitoring. Both height and weight were satisfactory.

2.7 During 2003 there were a number of concerns about the stability of Adult A's relationship with her partner (Adult B), with some concerns about domestic violence and also the poor condition of the family accommodation. A package of support was identified by Children's Social Care in late 2003. As a result of information accessed about Adult A from other local authority areas (when Child H had been on the child protection register) an Initial Child Protection Conference was held in relation to Child H, Child A and Child B, in 2004. The children, including Child H, were not placed on the Child Protection Register at that time. During this period Adult A continued to attend clinic for a methadone prescription.

2.8 There was ongoing contact between a number of agencies including health, Drugs services and Children's Social Care during 2005 and 2006 with concerns focused on the impact of Adult A's often illicit drug use, the standard of accommodation and

Adult A's aggressive behaviour in the community. There were no indications at this stage that there were further significant identified child protection issues.

2.9 During 2006 and 2007 there were a number of concerns including domestic violence incidents between Adult A and her partner, Adult B. There were also incidents of severe confrontation and aggression between Adult A and neighbours in the community, resulting in Adult A being subject to Probation orders. The concerns about Adult A using street drugs were still evident.

2.10 Child C was born in early 2008.

2.11 During mid 2008 there were a series of serious domestic violence incidents between Adult A and Adult B that the children witnessed and Adult A attempted suicide on three occasions. The suicide attempts being witnessed by the children. One of these attempts required specialist hospital treatment.

2.12 Because of the nature of the suicide attempts Adult A was made the subject of an Order under the Mental Health Act. The children were looked after by their maternal aunts and a Child Protection Conference was convened. At this time Adult A was using street drugs.

2.13 All four children were made the subjects of child protection plans in the autumn of 2008.

2.14 Adult A was at this stage threatening to take her children back into her care and she was informed that such actions would lead to child protection interventions.

2.15 In October 2008 Child H, as an emergency measure was returned to her mothers care. There had been a conflict between Child H and her carers (maternal aunt's family) that meant that the placement was no longer viable. Although the return of Child H to mother was intended to be an emergency measure an absence of appropriate planning meant that this move became permanent.

2.16 Plans were put in place for Adult A to undertake a parenting assessment. Because of Adult A's lack of cooperation this parenting assessment never took place.

2.17 In May 2009 a Child Protection Review Conference made the decision that the child protection plans in respect of all four children would be discontinued. This was a flawed decision and based on inaccurate information given to the Review Conference about the progress that Adult A was making. The three youngest children had been returned to their mother's care in March 2009, although that decision had been made outside of the child protection multi disciplinary review forum.

2.18 There were ongoing problems reported throughout 2009 including.

- Incidents of violence between family members
- Continued problems with Adult A's illicit drug use
- Incidents of the children being left "home alone"
- Child H being given too much responsibility for looking after the younger children
- Accommodation problems
- Adult A's lack of cooperation with agencies

2.19 There were also growing concerns about Child H's disturbed and often aggressive behaviour within the school setting. Child H had refused to attend therapeutic sessions with Child and Adolescent Mental Health Services.

2.20 The same concerns continued throughout 2009 and early 2010. There were also some serious incidents of violence between Adult A and extended family members. Increased behavioural problems were manifested by Child H at school and there was evidence of a lack of adequate supervision of the younger children by Adult A.

2.21 There was also an incident in March 2010 when Child B was found at home without any adult present.

2.22 In early April Adult G, contacted the Police by telephone to say that he had killed Child H. She had apparently been asked to childmind Adult G's daughter. Adult G was not known to any of the agencies dealing with Child H and her family.

3. Key Issues

3.1 The Serious Case Review identified a number of serious failings in the management of this case.

3.2 Although there was a significant amount of historical information known about Adult A, that information was never adequately analysed and used appropriately to help gain an accurate understanding of the level of risk to the children. The Serious Case Review stresses the importance of the use of historical information in assessments of family functioning. In this case there was an over optimistic and unrealistic perception of Adult A's capacity to care for the children.

3.3 The Serious Case Review is critical of the information sharing and communication systems within and between agencies. There were numerous examples where information should have been routinely shared between agencies but was not. This effectively meant that there was only a partial understanding by many agencies about the full extent of problems within the family. The SCR is particularly critical of the failure to share information between Manchester and Salford Children's Services about the contact between Adult A and one of her older children Child E.

3.4 There were also worrying gaps in communication between the various health teams engaged with the family. The Serious Case Review identifies some significant cross boundary issues, including information sharing between GP's that need to be addressed. There was also patchy information sharing between schools and no written record of transfer when Child H moved to a neighbouring school.

3.5 A common finding of SCR's is the recurring problem of information transmission when a family moves from one administrative or geographical area to another. This Serious Case Review echoes those findings.

3.6 The Serious Case Review is also critical about the quality of assessments that were undertaken. There was a lack of in depth analysis employed throughout the assessment process suggesting that there were serious skills deficits in this case.

3.7 Overall the children were not at the centre of all agency assessments and interventions. There was substantial evidence that the child protection plans that were in place in 2008-2009 were ineffective and never fully implemented. Consideration should have been made at this time to safeguarding the children through legal proceedings.

3.8 There was also a failure to properly consider Child H's role in the family. She was effectively taking on, because of her mother's drug use, the care of her younger siblings. This role was inappropriate and potentially damaging to her development.

3.9 During 2008 there were a number of disturbing suicide attempts by Adult A that were witnessed by the children. Although therapeutic services, through Child and Adolescent Mental Health Services, were offered to Child H, she was reluctant to engage with these services. There was a need for a much more creative approach to helping Child H to take up these services.

3.10 In common with research findings from other Serious Case Reviews the role of the children's fathers was not fully explored. Nor were extended family members engaged in a planned systematic manner in order to consider the most effective interventions with the family. The Serious Case Review recommends that family members should be involved in a much more systematic manner in future, particularly when they have a central role in safeguarding the children. In this specific case, when the children were living with extended family members, they received an inadequate level of support. This in turn may have impacted on future arrangements for the children's care.

3.11 The Serious Case Review is also critical of the way in which a cumulative picture of the risk to the children was not built up. During 2008 and 2009 there were numerous concerns about the children and a series of incidents relating to the children being left at home alone, increased levels of violence in the community, out of control drug use and increased examples of disturbed behaviour at school by Child H. These incidents were dealt with largely as single incidents and not as an accumulating picture of the growing chaos within the family.

3.12 Between October 2009 and March 2010 there were 7 separate incidents when Section 47 Enquiries under the Children Act 1989 should have been undertaken whereby the local authority should have responded to incidents regarding the children by making enquiries to enable them to decide whether to take action to safeguard or promote the child's welfare. The failure to take such action and to hold strategy meetings between the Police, Children's Social Care and other key agencies was a significant feature in this case.

3.13 There were indications throughout this SCR that thresholds for robust child protection interventions were too high and that decision-making about levels of risk was poor. In particular the decision to allow Child H and her siblings to return to their mother's care in 2008 and 2009 was not based on any firm evidence that there had been a substantial change in Adult A's capacity to care for the children. Similarly the decision to discontinue the Child Protection plans in May 2009 was based on the false

premise that Adult A's parenting had improved and that she was cooperating with plans. There was also a failure by agencies to challenge these overoptimistic plans.

3.14 Adult A had a long history of drug abuse and there is evidence from this Serious Case Review that the full impact of this on the children was not fully appreciated by professionals working with the family. There were also some concerns that staff within the Drug Service were not always familiar with the links between child protection and illicit drugs misuse. The combination of drugs misuse, domestic violence and parental mental health alongside historical factors should have led to a much higher level of concern than was seen in this case.

3.15 There were also some key issues about ethnicity identified in this Serious Case Review. Although the family had a complex ethnic make up many of the agencies involved with the family were either unaware of this dimension or had failed to record ethnicity accurately in their documentation. This contributed at least in part to issues of "identity" never being satisfactorily addressed with Child H.

3.16 There were a number of resource issues identified by individual agencies. Drug Services for example had resource issues with regard to supervision of workers. There was also a lack of capacity within the school for drop-in sessions with the school nurse. There were in addition resource issues with Community Health Services trying to manage increasing demand. There were also some deficits in skills identified in Children's Social Care. Many of these resource issues have been addressed or are in the process of being addressed; the issues related to skills deficits will require careful consideration by Salford Safeguarding Children Board and its partner agencies.

3.17 The Serious Case Review focuses on the problems inherent in working with families who are difficult to engage with. In these situations there is a need for professionals to call upon a range of skills and to have very close control over events and interventions in the family life. In this case there was a marked deficit of these skills and as a consequence plans for safeguarding the children were inadequate.

3.18 None of the agencies contributing towards this Serious Case Review, except the General Practitioner, held any information about Adult G. It is understood that Child H regularly visited him and would take Adult G's dog for a walk. There was no reason for any family members to have anticipated that Child H would have been subjected to such a horrific assault

3.19 In these circumstances the death of Child H was not predictable or preventable although the ongoing harm to Child H because of the poor quality of care offered by her mother was both predictable and preventable, if Child H (and her siblings) had been removed from their mother's care in 2008-2009 through legal proceedings. The Serious Case Review takes the view that this action should have been very seriously considered and given the lack of progress in improving the standards of care for the children, it would have been legitimate for proceedings to have commenced at that time.

4. Priorities for Learning and Change

4.1 The decisions made in the early Child Protection Review Conference in 2003 and May 2009 were fundamentally flawed and not based on an accurate understanding of the level of risk, the capacity for Adult A to change or the true impact on the children. It was particularly worrying that there was a lack of challenge to the recommendations and decisions being put forward by Children's Social Care. It is a priority that there is a cultural change whereby legitimate professional challenge ensures that there is a true multi-agency dimension to complex decision making in safeguarding children

4.2 There should be a priority considering the use of existing models of assessment. It is clear from both this Serious Case Review and national evaluations of Serious Case Reviews that assessments are generally of poor quality, fail to sufficiently analyse historical information and are static instead of taking an ecological perspective. This is a significant point of learning for the LSCB.

4.3 In order to ensure that all agencies are contributing properly to child protection it is essential that there is attendance at forums where key decisions are made about child protection plans. It is a priority for the LSCB to ensure that there is compliance with the requirement to attend Child Protection Initial conferences and Reviews

4.4 This SCR confirms the findings from previous research that domestic violence, parental mental health and drug/alcohol misuse are key factors in child protection. This means that the working arrangements and shared understanding between Adults Services that focuses on adult behaviours, and Children's Services must be more integrated with a common theme of the child at the centre of agency involvement and intervention. This will require a significant cultural change of direction in how services are focused and delivered and will be an LSCB and Children's Trust priority.

4.5 In this particular case Child H did not access therapeutic services although there was a very clear need for that input. It is clearly wrong if children who are often the most damaged are unable to access appropriate services and a priority for the LSCB and the Children's Trust should be to ensure that there is a flexibility of service delivery of specialist therapeutic services.

4.6 This case has clearly demonstrated that there are threshold for intervention issues (and in all likelihood there will have been such issues for several years). The lesson from this Serious Case Review is that it is a fundamental building block for child protection work that there are jointly agreed and shared thresholds for both children in need and child protection work. This is a priority for the LSCB and the Children's Trust.

4.7 An area where there has been significant learning is that of the skills required in dealing with highly resistant families. There are a number of initiatives that could be considered including, co-working, reflective supervision, peer case discussion. At present there is evidence of a skills deficit and this will be addressed as a priority. In particular the LSCB will consider the use of Family Group Conferences as an important tool in working with families.

4.8 The Serious Case Review demonstrated that issues of ethnicity are not being considered as seriously as they should be. Nor are they recorded accurately or systematically. The key lesson is that without systematic recording of accurate information, there is a greater likelihood that important information will be lost or misinterpreted and this in turn may have a significant impact on the outcome of the case. There are similar lessons to be learnt about recording in general and the LSCB and Children's Trust will prioritise this

4.9 The LSCB recognises that through a number of tragic cases both on a local and national level that public confidence in child protection work is at present low. A lesson from this Serious Case Review process is that agencies need to reaffirm their commitment to child protection and safeguarding through a reconsidered compact between agencies. This should serve as a base for a positive re-branding of committed child protection work in Salford.

5 Recommendations

5.1 Overview Report Recommendations

Salford Safeguarding Children Board will monitor the action plans produced in response to the recommendations from the overview report.

1. The LSCB must ensure that there is evidence that the process whereby agencies are able to challenge recommendations and decisions made in Child Protection Conferences and Child Protection Reviews is being fully utilised. This should be audited on an annual basis and a Report of the findings submitted to the LSCB for scrutiny. This recommendation will require a significant cultural change lead by the LSCB and individual agency senior managers.

2. The LSCB should review the use of existing models for assessment, including Initial assessments, Core Assessments and the Common Assessment Framework. The Review should consider both the quality of assessments, and the skills required by practitioners to undertake assessments. This has wider national implications in that the poor quality of assessments, particularly the lack of analysis of historical information, is a common theme of Serious Case Reviews.

3. The LSCB should ensure that all statutory agencies, including commissioning services are committed to attending all relevant Initial Child Protection Conferences and Child Protection Reviews. Attendance should be monitored and an Annual Report made available to the LSCB. (Discussions within the SCR Panel suggest that this recommendation should also be considered by Manchester SCB).

4. The LSCB should ensure that there are clear protocols for joint work between Adults and Children's Services. These protocols should be supported by joint training of adults and children's practitioners and managers. Areas of priority for this are in the fields of domestic violence, drug/alcohol misuse and mental health. An auditing process should be introduced to ensure that the protocols are complied with.

5. The LSCB should lead discussions, in collaboration with the Children's Trust, to develop a strategy whereby specialist therapeutic services (CAMHS) are able to be flexible in providing services to children in need who are difficult to reach.

6. The LSCB should review thresholds adopted by agencies for child protection interventions. This review should include children in need/child protection thresholds and also the thresholds used for Strategy Meetings, joint investigations by Police and Social Workers. An audit of threshold activity should be reported to the LSCB and any remedial action required prioritised in the LSCB Annual Report.

7. The LSCB should ensure that practitioners working directly with "highly resistant" families have adequate skills to offer effective interventions. This will require the LSCB to lead and coordinate individual agency safeguarding plans to improve the skill level of their staff.

8. The LSCB should ensure that all children's records and assessment documentation, including the Common Assessment Framework documentation has a record of ethnicity and that there is evidence within the assessment processes and delivery of services that issues of ethnicity and diversity are considered appropriately.

9. As an initial step the LSCB should commission an audit, on a multi-agency basis, on recording standards in child protection cases. As a follow up individual agencies should report their arrangements, including audit arrangements, to the LSCB for maintaining a high standard of recording in child protection cases.

10. The LSCB should consider the benefits of introducing a model of Family Group Conferences as an additional means of supporting extended families in developing plans for children in need.

11. The LSCB in collaboration with the Children's Trust should introduce a multi agency "compact" setting out the standards that all agencies are committed to in child protection and child safeguarding work. This "compact" should include auditing arrangements across all agencies and be prioritised in the LSCB business planning processes.

12. The LSCB should ensure that there is effective monitoring and auditing of the agreed Regional protocol for cooperative cross boundary work. This recommendation applies to both Salford and Manchester LSCB.

Individual Agency Recommendations

Central Manchester University Hospitals NHS Foundation Trust

Rec No		ToR
1.	There is a need for review of the CMFT Missed appointments policy to ensure that there is guidance to senior staff as to the action to be taken	

when children and young people are not brought to appointments

2. There needs to be a review of the CMFT single agency Level 3 safeguarding training content to include missed appointments, non engagement of families and the need for Staff to escalate safeguarding concerns. The training also needs to include ensuring that safeguarding needs are assessed at the child's admission to hospital with the same importance as clinical need. The impact of ethnicity and culture also needs to be included.

3. Children's acute health services where care is provided to children and young people who have complex health needs should ensure that the child's care is reviewed on a 6 monthly basis.

4. Child abuse needs to be considered as a differential diagnosis when children present to hospital.

5. There is a need to review the CMFT Discharge planning policy to ensure that the need for discharge planning meetings are considered for children and young people.

Salford Children's Social Care

Rec No		ToR
6.	The Case Transfer Protocol to be reviewed in the light of the issues from this case and to incorporate the requirement for a comprehensive Chronology to be provided along side the Transfer Summary for the recipient Team. This to be supported by a clear directive from the Assistant Director setting out the expectation for proactive adherence between teams and across Local Authority boundaries.	1
7.	The Draft Regional Procedure for the "Transfer of Child Protection Plans From/To Other Local Authority Area" be ratified and incorporated into the Salford Child Protection to ensure proactive sharing and gathering of information across Local Authority boundaries. This to also make it an explicit requirement that the allocated Social Worker/Team Manager notify the Safeguarding Unit Administrator no later than one working day, when a child subject to a Child Protection Plan is to move or has already moved out of the area, whether temporarily or permanently.	2
8.	The Children's Services procedure on core assessments to incorporate a requirement to share completed Core Assessments with all relevant professionals in order to comply with Working Together Guidance.	2
9.	Children's services audit compliance with the requirement to provide a written report to child protection case conferences and reviews and to have evidenced that this has been shared with parents/carers at least two days before the date of the meeting.	2

10.	Children's Services to lead a multi-agency group in the development of a single Child Protection Report for reviews that encompasses the information, progress against the plan and analysis from all Core group members. This work to ensure that all plans are SMART	2
11.	For Children's Services to ensure compliance with procedural requirements, particularly in respect of child protection, with a clear audit and reporting process.	2
12.	For Children's Services senior managers to set out the strategy, practice standards and mechanisms for ensuring that children and young people are appropriately consulted and involved in the assessment and delivery of services that impact on them.	3
13.	Children's Services to make representation to the SSCB performance group of the need to verify that all agencies now track lack of engagement and use this information to inform their risk assessment.	6
14.	A directive is to be sent out by the appropriate Assistant Director to remind workers that all social care files are to contain a chronology.	8
15.	Children's services prioritise training on ethnicity, and cultural diversity to assist workers in achieving good quality, appropriate assessments. Senior managers to set out how the standards and expectations are to embedded into divisional thinking. (reference also recommendation 11).	9
16.	An annual report of the community's diversity needs should be produced on a ward basis setting out the ethnic, religious and cultural diversity of the child/adult population of Salford. This report should be shared with front line workers and Managers across agencies. Senior managers to set out the divisional expectations for ensuring that understanding of ethnicity/diversity issues for families become reflected in thinking and action across the service.	9
17.	Senior managers provide a strategic approach to ensuring the level of skill required for the social care workforce, including managers, is assured.	10
18.	Social Care Managers to ensure that all workers have an updated and relevant Personal Development Plan.	10

Salford Education

Rec No		ToR
19.	Schools should provide a detailed history of safeguarding concerns when sharing information with each other about children in need or children subject to plans.	1, 3 & 8
20.	Schools must provide a written report to all CP conferences. These	2, 3 & 6

	reports should enable a full picture of a child's situation to be formed. This includes risk assessment and the relationship that school has with parents.	
21.	Schools should receive details of the relevant children's services structures and pathways of accountability. Schools should ensure that they are familiar with these structures and contact the relevant managers if they consider front line staff are not responding appropriately to concerns in respect of children.	2
22.	Guidance should be provided for schools on record keeping in respect of children subject to Child Protection & Child In Need plans.	2
23.	Schools should provide a detailed history of safeguarding concerns when sharing information with each other about children in need or children subject to plans.	3 & 8
24.	Schools should record contact details for both parents and ensure they record who has parental responsibility. Schools should record the efforts they have made to engage all people with PR.	4
25.	Schools should provide written reports to managers in Children's Services if they disagree with decisions or feel there is a lack of progress re: cases. Including schools attempts and progress to engage parents in the process.	6 & 7

Manchester Children's Services

Rec No		ToR
26.	Develop procedure to support information sharing between Manchester and other Local Authorities as part of assessment and decision making.	2
27.	Ensure sibling contact is addressed and promoted as part of assessment and case planning.	3
28.	Develop and agreed standard to ensure that all meetings address the race and diversity needs of all children.	9

Greater Manchester Police

Rec No		ToR
29.	That the policy and procedure for the application of Child Abuse markers be updated to include an audit of the process and require staff to carry out checks to ensure markers are in place.	1
30.	That Fwins that are closed using the code D64 be included in the assessment process for domestic abuse specialist.	2

31.	The procedure and policy for the installation of a Homelink (RDA) alarm to include a supervisory responsibility to check on installation within short proscribed periods (12 hours or that proscribed in any risk assessment). This to include further supervision by the Operational Policing Unit Inspector who has overall responsibility for Homelink alarms on Division to ensure matters are being expedited in line with risk assessment and compliance.	8
32.	The procedure and policy for the installation of a Homelink (RDA) alarm to include a supervisory responsibility to include a clear and concise risk assessment and action plan to accompany the installation of a homelink alarm. This should be clearly visible to all Staff (Fwin) and if amended reproduced clearly for all staff. This to include further supervision by the Operational Policing Unit Inspector who has overall responsibility for Homelink alarms on Division to ensure compliance.	8
33.	The issue of safeguarding and use of the internet by vulnerable persons has explicit practical guidance and policy for staff dealing with incidents.	10

Greater Manchester West Mental Health NHS Foundation Trust

Rec No		ToR
34.	To review assessments, including risk assessments within Greater Manchester West Alcohol and Drugs Directorate	1
35.	To finalise a leaflet for staff and service users to inform them of the Trust's commitment to safeguarding children through multi-agency working, including routine notification to health visitors and school nurses (to inform them that the parent or carer is in treatment with the Trust)	2
36.	Whilst working with adults, Greater Manchester West Trust staff must constantly assess the impact of the adult on the child, and children must be considered during all interventions.	
37.	To review the drug service policy and risk assessment in relation to parents or carers who attend their facilities	3
38.	To develop guidance for Greater Manchester West Trust staff who use the Integrated Clinical Information System (electronic record keeping) to ensure that details of family members are accurately recorded	4
39.	To reinforce the role of Greater Manchester West Trust staff in the development of the Common Assessment Framework and multi-agency working	5
40.	To review The Greater Manchester West Trust policy on missed appointments	6
41.	To review the Trust Safeguarding Children Training Strategy to ensure that staff receive training relevant to their role, both within the Trust and	7

	via the Local Safeguarding Children Board	
42.	To review the Alcohol and Drugs Directorate Safeguarding Children guidance	8
43.	To develop guidance for Greater Manchester West staff with respect to effectively assessing and recording diversity issues. To review the Trust Equality and Diversity training to ensure that staff are aware of the impact of diversity issues on families	9
44.	To review the Greater Manchester West Clinical Supervision Policy	10

Great Places Housing Group

Rec No		ToR
45.	All 1 month and 9 month tenancy visits will be signed off by a neighbourhood manager or equivalent.	
46.	Review Anti Social Behaviour Policy to ensure Safeguarding issues are acknowledged and guidance to staff is included.	
47.	Where landlord references are not received/available the allocation of the tenancy must be authorised by a neighbourhood manager or equivalent.	
48.	Continue to improve Great Places duties under Safeguarding though the cross cutting Safeguarding Working Group.	
49.	Develop and deliver an internal communication plan that ensures all Great Places Staff and contractors are made aware of their duty in relation to safeguarding.	
50.	Develop and deliver a training plan that ensures all Great Places staff are fully aware of their role in relation to PFA policies.	
51.	Develop a central monitoring database for Safeguarding referral, build upon the existing database within Supporting Housing Directorate.	

Manchester NHS & Community Health

Rec No		ToR
52.	Clarification be provided and a pathway agreed in relation to access to Manchester GP notes to inform serious case reviews of children. The health overview report will comment on this in relation to Salford GPs	1
53.	The G.P safeguarding children steering group to recommend a read code to be used by all Manchester practices in relation to families	2

	where there is a child protection plan. This needs to be understood by locums. The health overview report will comment on this in relation to Salford GPs.	
54.	Communication between GPs/Health Visitors/School Nurses and cross boundary issues. See Salford Health IMR and Health Overview Report.	2
55.	The learning from this IMR to be shared with Manchester primary care commissioners and the Manchester G.P steering group and trainers particularly regarding assessing patients as parents/carers. The health overview report will comment on this in relation to Salford.	3
56.	Appropriate training for Manchester GPs to reinforce the importance of enquiring about the role of fathers and significant others when concerns about a parents capacity is identified. The health overview report will comment on this in relation to Salford GPs.	4
57.	See Salford Health IMR and Health Overview Report.	7
58.	Domestic abuse training to be publicised widely amongst GPs and uptake monitored. The health overview report will comment on this in relation to Salford GPs.	8

Salford NHS and Community Health

Rec No		ToR
59.	To improve the assessment and monitoring of the emotional and physical wellbeing of children and young people, particularly those assessed at level 3 (child in need) on the continuum of need and those subject to child protection plans.	1, 3, 4, 5, 9 & 10
60.	Develop a cross boundary safeguarding protocol and agreed information sharing plan across provider services.	2
61.	All children who attend a high school in Salford should have access to confidential, one to one advice and support from a qualified health professional without appointment.	3
62.	Development of a child in need model and tracking database for services across NHS Salford. The model will link into a child in need model.	6
63.	Implement an active case management model of practice which will facilitate a development of outcome based care packages for each child and family in Salford.	6
64.	The policy and procedures in relation to responses to failure to attend health appointments to be reviewed and updated.	6

65.	The policy and procedures in relation to responses to no access visits and the unseen child to be reviewed and updated.	6
66.	There are no direct recommendations in relation to TOR 7. However there are actions already in place regarding training for health staff in safeguarding and promoting the welfare of children. The NHS Salford training strategy and training plan for 2010 – 2011 includes maintaining a child focus whilst working with highly resistant families.	7

Pennine Acute Hospital Trust

Rec No		ToR
67.	Information sharing and communication systems especially between agencies and other health professionals	2
68.	The need to undertake a complete, ecological assessment in order to establish: a. the impact of parental mental health and substance misuse on children, b. the impact of parental disengagement with services, c. understanding the role of the fathers, d. the significance of violence within the family, e. the significance of diversity issues, f. the children's wishes and feelings	3, 4, 5, 6, 7, 8, 9
69.	Complete and accurate record keeping in order to facilitate the identification and significance of historical information.	1

Greater Manchester Probation

Rec No		ToR
70.	Examine current levels of compliance with the Safeguarding Policy and Practice Directions within Salford LDU, and throughout Greater Manchester Probation Trust.	2
71.	Ensure compliance with current safeguarding policy.	3
72.	That a decision be taken as to the level of intelligence which is useful to come from Probation Staff to inform Safeguarding assessments.	5
73.	Improve practice staff confidence in communicating their risk assessment robustly and pursuing it as appropriate.	6
74.	Reinforce importance of considering multiplicity of Service Users' diversity needs and the importance of taking account of diverse needs in supervision.	9
75.	Ensure that all practice staff and managers across GMPT are properly trained to fulfil their responsibilities under the Safeguarding Policy and Practice Directions.	10

Spurgeons

Rec No		ToR
76.	A review of the working methodology of the Family Centre should take place. Staff at the Family Centre should be working in equal partnership with Salford Children's Services and they need to feel confident in challenging decisions made by Salford Children's Services in relation to assessment work being undertaken by the Family Centre. The work also needs to be informed by appropriate information sharing and all relevant information available to Salford Children's Services should be shared with the Family Centre at the point of referral. As part of a review of their working methodology, the Family Centre need to set criteria in relation to the information they require to inform their assessment processes. A subsequent partnership discussion with Salford Children's Services should clarify and agree these processes. The review of the working methodology of the Family Centre should also explore and address the issue of whether staff have the required skills to be able to assess the impact of race, ethnicity and identity on children and families.	1 & 9
77.	Avoiding 'drift' in the work and addressing non-engagement. To avoid 'drift' in parenting assessment work where family members fail to attend, the Family Centre should have a system whereby an agreed number of missed appointments or changes to the remit of the work 'triggers' action for the Family Centre and Salford Children's Services to review the work and agree the way ahead.	6
78.	All sessions, meetings, contacts and decision made should be recorded fully and accurately in relation to all assessment work. The recording practices need reviewing and developing to ensure they are 'fit for purpose'. Recording needs to be effective in all areas including recording of: communications, sessions, meetings, supervision and case closure.	10
79.	The Family Centre Manager should authorise closure on cases once all work is complete. Cases should only be considered for closure once the outcome for the child is known. This would generally be following a Child Protection Review meeting where a Family Centre parenting assessment report has informed the decision reached in relation to the children.	10
80.	The manager of the Family Centre must prioritise staff attendance at Child Protection Reviews to ensure that the professional opinion of the Family Centre worker is represented and for staff to contribute to decisions made in relation to children, based on the work undertaken by the Family Centre. Where a staff member has a valid reason for not attending a Child Protection Review, the manager should arrange to	10

cover the attendance.

81.	Where the Family Centre worker co-works an assessment with the children's social worker it is imperative that roles and responsibilities are clear. A co-working agreement should be drawn up and signed by relevant workers that outlines the responsibility of workers in relation to what it means to be 'leading' on sessions, how decisions are reached in relation to analysis of the information and how any differences of professional opinion can be resolved.	2

Sustainable Regeneration

Rec No		ToR
82.	In all cases where Child Protection issues are raised as a risk factor in referrals received for a floating support service, the Principal Officer of the Central Access Point must ensure detailed information on the Child Protection issues are available to the service being referred to. By doing this, services will be able to accurately plan to meet the housing related support needs, in a holistic manner, and with clear understanding of the needs of children present. This will be implemented by the Service Manager in advance of the Central Access Point going live and monitored through a performance indicator being set for the Central Access Point and monitored through Sustainable Regeneration and Salford City Council structures.	1, 2 & 3
83.	Upon receipt of referrals, where child protection is raised as an issue, the Supported Tenancies Service should ensure that the role they should play in supporting parent and the children, is clarified with all agencies involved with the family. This will ensure that support offered is comprehensive and targeted, and that there is no uncertainty over where responsibility lies. This will be monitored by the management structures and through the Supporting People team's governance structures.	1, 2 & 3
84.	In order to ensure delays in the setting up of Family Action meetings are appropriately challenged, the Supported Tenancies Service will review the Supervision Policies to ensure that managers are aware of delays, and challenges to Children's Services are made.	2, 3 & 5
85.	In order to ensure that cases are effectively managed where non-engagement is an issue, and child protection has been raised as a risk the Supported Tenancies Service will implement a policy whereby cases being kept open, when the policy would suggest they should be closed, will be signed off, by an appropriate manager. This will ensure that support can be targeted effectively, and	3 & 6

	cases are closed at the right time, and child care agencies made formally aware of non-engagement issues.	
86.	In order to ensure that all staff are aware that incidents of chastisement of children is a potential safeguarding concern, guidance will be issued to ensure that such incidents are reported using the Directorate Safeguarding concern log process. This will ensure that appropriate referrals can be made into Safeguarding structures, and decisions taken by individual services reviewed by the Directorates Safeguarding Officer.	5 & 8

Salford Sure Start & Extended Schools

Rec No		ToR
87.	That where there is a Child Protection Plan which includes the provision of childcare, the specific purpose of the childcare and any requests for additional actions which will support the Plan will be shared with the placement provider.	2
88.	Reviews of the placement will be shared with and be informed by the inter-agency meetings which oversee the implementation of the CPP.	2
89.	That all placement providers for funded daycare for Children in Need prioritise attendance at inter-agency meetings to support the development and implementation of a Child Protection Plan or planning for a Child in Need.	2
90.	That for families where there is an allocated Social Worker, all injuries or incidents where a child has or may have suffered harm will be reported to the child's social worker or, if appropriate, to the Duty and Investigation Team who will decide if there is any further action required.	2 & 5
91.	That all providers of daycare which forms part of a Child Protection Plan are required to attend Child Protection Reviews without exception.	2 & 10
92.	That all daycare providers and settings provided by the local authority should be informed or reminded that their records about families and children in their care must cover all sources of information and be easily retrievable.	10
93.	That where significant information has been recorded in the nursery log, it must be clear that a manager has been made aware of and if necessary acted on the information.	10

Salford Community Safety

Rec No		ToR

94.	It is recommended that where an on conviction order is being considered against a person and it is known that the subject has child care responsibilities consultation should take place with Children's Services and others to ensure that the suggested terms of the order do not have negative implications for child safeguarding.	

Health Overview Report

Rec No		ToR
95.	In relation to this particular report there is a profound need to strengthen the role of the lead professional and the CAF process. The authors recommend that a review of the CAF process is undertaken by all participating health organisations to ensure a robust quality service is being delivered.	1,2,3,5, 9,10
96.	Health Organisations must review the mechanisms and processes of core group working with specific focus upon the process of having a child's need centred approach. There should be robust minutes, action plans, timescales and reviews. Historical and present day histories must be considered and what has not worked in the past reviewed and minutes taken in order that different strategies can be applied. The quality assurance division from each health service to initiate an audit on the timeliness of the circulation of child protection plans and core group minutes and to review effectiveness of the plans in the terms of sustained improved outcomes for children and families.	1,2,3,5, 6,9,
97.	Health practitioners to be alerted to the fact that deferred case conferences can not be closed without a conference being convened to ensure multi agency agreement. The opportunity to dissent must be afforded to agencies in order that this may be explored and recorded.	3,5,6,7, 8,9,10
98.	Adult drug and mental health services develop or revise a risk / needs assessment tool in order that practitioners must always consider the needs of children in relation to their clients as parents or care givers.	3,6,7,8, 9.
99.	Each lead safeguarding manager within health agencies review their supervision processes to ensure that there is in depth consideration of family circumstances and dynamics, in order that the impact of these findings and professional interventions upon children and young people can be assessed. This is to address an apparent need for more reflective practice.	1,3,4,5, 6,7,8,9, 10.
100.	As a priority health organisations must ensure access to training / awareness sessions for practitioners in the management of persistent non engagement of adults/carer's where there are safeguarding concerns about the children. Development / revision of a non engagement policy and an escalation process in place to manage chronic family situations that are in danger	6

	of not progressing.	
101.	A standardised pre birth risk assessment tool must be developed by all identified midwifery services and used in cases where drug, alcohol, mental health problems and domestic abuse are identified during pregnancy. Consideration must be given to the impact of these behaviours upon the child once they are born and other siblings. This assessment must be used to inform the decision as to whether a pre birth child protection case conference is required.	1,3,5,6, 7.
102.	Commissioners from Manchester and Salford review GP attendance at case conferences and in discussion with GP practice commissioning groups agree a way forward to facilitate GP's attending case conferences / writing reports.	1,2,3,5, 10.
103.	All health Trusts develop contact lists with geographical areas they cover identified. To be used as a quick reference for health/other agencies. To be sent out immediately and updated on regular basis (complements and extends recommendation 7 of NHS Salford and Salford Community Health, also section 9 no 1 Pennine Care NHS Foundation Trust section -What we learn from this case)	2
104.	Manchester and Salford school nursing services urgently review the transfer process and school nurse information sharing pathways used for children at risk of harm /vulnerable children moving school out or into area (and their health records)	1,2,3,5,
105.	Health organisations need to review the support provided to front line practitioners when a child they are working with dies and devise a formalised joined up approach to mange the trauma that staff may have experienced.	10.