THE EXECUTIVE SUMMARY

SERIOUS CASE REVIEW
IN RESPECT OF CHILD K AND CHILD L

AND

DOMESTIC HOMICIDE REVIEW
IN RESPECT OF MLK

Commissioned by Trafford Safeguarding Children Board and Safer Trafford Partnership

Author: Pamela M Shelton
Independent consultant
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CONTENTS

Introduction

Summary of events leading to the Reviews

1. In the early hours of Monday 19 September 2011, MP broke into the house of his ex-partner, MLK. She and her daughter (Sibling 1, aged 18) and 15-year-old son (Child L) came out of their rooms on hearing the noise, leaving her four-year-old son (Child K) asleep. They saw MP climb the stairs, dowsing them with fuel from a container he carried; then retrace his steps, dowsing himself as he went. They tried to stop him but to no avail. MP then lit the fuel. Immediately, he, MLK and Child L were engulfed in flames. Sibling 1 was also caught in the fire but managed to open a window and was pulled out by a neighbour who also rescued MLK. Child L made his own way out, and fire fighters rescued Child K.

2. MP never regained consciousness. Child L had very serious burns from which he died on 21 September. MLK also had very serious burns and died in hospital on 25 November. Child K was burned from the intensity of the heat rising into his bedroom but has since been discharged to the care of his father. Sibling 1 survived her injuries but required extensive hospital treatment.

3. The Trafford Safeguarding Children Board, chaired by Bob Postlethwaite, agreed in October to conduct a serious case review in view of the death of Child L and injuries to Child K. Sibling 1 was not included as she is an adult. When MLK died, the Safer Trafford Partnership, chaired by the Chief Superintendent in Trafford, agreed that the death fell within the criteria for conducting a domestic homicide review. The guidance for undertaking serious case and domestic homicide reviews is similar so it made sense to combine them in this instance. Terms of reference and the membership of the panel were agreed. The time span for the reviews was set: from the beginning of 2001 for MP, at the point his marriage ended, to 20 September 2012; and from January 2011 for MLK, Child L and Child K. The timescale for completing the reviews was the end of July 2012 to take account of the breadth of the reviews and number of agencies involved across four local authority areas, including Trafford, Manchester, Bury and Lancashire.

4. The purpose of the reviews is to establish what lessons are to be learned about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children and safeguard victims of domestic violence; and agree action to promote change as a consequence. It is not the business of the reviews to inquire into how a child died or was injured or who is responsible for the domestic homicide, or to reinvestigate the crime or apportion blame. These are matters for the coroner and criminal court to decide.

The review panel

5. The members of the Review Panel are included in the chart below. In addition, an independent policy advisor on domestic violence was appointed to assist the Panel. A consultant forensic psychiatrist was also available to the Panel and provided a written report and attended one Panel meeting.

6. The independent author of the overview report (and of this summary) is Pamela Shelton who attended all the Panel meetings. The independent Panel chair was Colleen Murphy. Both have extensive experience of working in children's social care, as practitioners and managers; and more recently on an independent basis undertaking a range of assignments. Both of them have had considerable experience

of undertaking Serious Case Reviews. The requirement to undertake domestic homicide reviews dates from April 2011 and hence few have been completed.

Position	Agency
Colleen Murphy	Independent Chair of the Panel
Associate Director of Governance	Manchester Mental Health and Social Care Trust
Team Manager	Safeguarding and Improvement, Manchester City Children's Services
Head of Service	Multi-Agency Referral and Assessment Service, Trafford Children and Young People's Service
Deputy Director	Trafford Education and Early Years Service
Designated Nurse, Safeguarding	Trafford Children and Young People's Service (Trafford Health Economy)
Designated Doctor	Manchester and Trafford
Station Commander	Greater Manchester Fire and Rescue Service
Detective Chief Inspector	Public Protection Investigation Unit, Greater Manchester Police
Assistant Chief Executive	Greater Manchester Probation Trust
Divisional Manager	Greater Manchester Victim Support
Business Manager	Trafford Safeguarding Children Board
Solicitor	Trafford Legal Services, Advisor to Trafford Safeguarding Children Board

Parallel processes

7. Manchester Mental Health and Social Care Trust, to whom MP was referred for his mental health problems, has undertaken an internal Serious Incident Review and the report was made available to the Panel. The Independent Police Complaints Commission has also investigated the incident and Greater Manchester Probation Trust has conducted its own Serious Further Offence investigation.

8. The South Manchester Coroner's Office will be holding inquests in November 2012 in respect of Child K, MLK and MP in order to establish when and how the parties concerned died, and to record a verdict.

Involvement of the families

9. The Panel was clear that it was an essential part of the review process to hear the views of family members wherever possible, as their perspective would provide an additional dimension and different perspective to those of the professionals involved. As part of the process of setting up the reviews it was agreed which family members should be approached and much effort was put into establishing contact with them.

10. The Panel Chair and Business Manager together made visits to the parents of MLK; the father of Child K; MP's mother; and SC1 (MP's stepdaughter and mother of Child 4). Despite considerable effort, it did not prove possible to see Sibling 1, the father of Child L or MP's former wife (MPFP). The information and insights provided by family members has indeed given another perspective on events. The reports of those visits are fully reproduced in the overview report; and are incorporated into the

analysis and conclusions. This summary makes brief reference to them as appropriate.

Summary of events

This section summarises the very lengthy summary of events section in the overview report. The latter is itself based on the 14 individual management reports received from the agencies who had substantial contact with MP and MLK and her family, and the combined chronology of events. Only key events are included here.

Summary of events January 2001 - December 2010

11. MP, his wife (MPFP), their two children (Child 1 and Child 2), and MP's two stepchildren (SC1 and SC2) were living together in Manchester until early in 2001 when the relationship broke down. MPFP returned to Bury, initially leaving the children in the care of MP. It was at this point that SC1 says that she (aged 13) and MP started their sexual relationship; and that she assumed care of the children. Once MPFP had secured a tenancy, the children went to live with her. However, SC1 only stayed in Bury briefly before returning to live with MP in Manchester.

12. MP took what he perceived as MPFP's rejection of him very badly; his behaviour became erratic and he said he wanted to die. He took an overdose of tablets in March 2001 and went to Wythenshawe Hospital where a psychiatric assessment was undertaken. There was no evidence of mental illness. This incident became part of a pattern of behaviour over the following years.

13. During 2003, the GP referred MP to the Primary Care Mental Health Team but MP did not attend the appointments offered. This too became a pattern during the rest of his life.

14. In 2004, MP's ex-wife and mother of SC1 contacted Greater Manchester Police (GMP) to report SC1's disclosure to her of a consensual sexual relationship with MP. There followed a joint Police and Bury Children's Social Care (CSC) investigation (SC1 having returned to live in Bury) but SC1 (aged 15) refused to cooperate and there was no evidence on which to proceed. Bury judged that SC1's mother was able to protect SC1 sufficiently, although SC1 denied that the relationship was abusive. She subsequently moved back and forth to live with MP during 2005 and 2006.

15. MP was briefly admitted to hospital following a suicide attempt after the disclosure to Police of his relationship with SC1.

16. In 2006, the GP referred MP to the Community Mental Health Team but he failed to attend. MP sought help from the A&E Department, claiming that he had attention deficit hyperactivity disorder (ADHD) for which he required medication. He continued to insist on this diagnosis, despite psychiatric assessments to the contrary, and treated himself with illegal substances.

17. SC1 (aged 18) became pregnant to MP towards the end of 2006 and moved to her own tenancy in Bury. Bury CSC became involved because of her vulnerability and MP's continuing involvement with her that included abusive elements. On Bury's advice, SC1 reported the relationship with MP to Greater Manchester Police in Bury but made it clear that it was not a complaint; rather she was concerned that MP might abuse her child were it female. The Police could not consider a prosecution for

underage sex because, under legislation in force at that time, a complaint had to made within 12 months of the alleged offence.

18. Early in 2007, MP failed to attend hospital for assessment of a heart condition. His relationship with SC1 fluctuated between periods of separation and reconciliation. Social workers in Bury were concerned by SC1's reports of his emotional abuse of her and requested MP to leave. He took an impulsive overdose and was admitted to hospital overnight. He failed again to take up the offer of counseling from the Primary Care Mental Health team after another referral by his GP. SC1 moved back to live with him in Manchester shortly afterwards.

[redacted]

20. In August, MP had an outpatient psychiatric assessment in Manchester but no evidence of mental illness was found and a further appointment was made for psychological support from the Primary Care Mental Health Team. He had a further assessment in October and discussed his daily use of cannabis and amphetamines to calm him down and treat his self-diagnosed ADHD. The consultant advised referral to the Community Drug Service provided by another Hospital Trust in Greater Manchester. MP attended at the Drug Service later in the year and was discharged following a further appointment, as his drug use seemed under control.

21. In November 2007, at a further outpatient appointment, the psychiatrist diagnosed MP as having a personality disorder with unstable emotional elements. MP was upset by this outcome and stormed out. Meanwhile, he underwent investigations for chest pains, which proved to be ischemic heart disease.

22. SC1 moved in August 2007 to Lancashire, she said to escape MP. [redacted].

23. At the end of May 2008, [redacted] MP [had [redacted] unsupervised access to Child [redacted] He [redacted] sent [a] [redacted] text stating that he intended to kill both himself and Child 4. Lancashire Police eventually located them in Bury and judged that no offence had occurred. As a consequence, they did not inform their GMP colleagues. However, there was evidence of drug-use and MP referred to his mental health problems so officers took him to the local hospital. Clinicians found no evidence of mental illness and referred him back to Manchester mental health services requesting an informal admission to hospital. Instead, the Crisis Resolution and Home Treatment Team visited him: he told staff that he had wanted to scare SC1 into not letting him see Child 4 because he had strong thoughts of killing her; he did not want to act on those thoughts but was fearful of losing

control. He was unable to reassure staff that he would not try to take Child 4 away again.

24. Staff decided to re-refer MP to the Community Drug Service and arrange a further psychiatric outpatient appointment via his GP. They also made contact with Lancashire social workers, who assured them that MP would not have further unsupervised contact with Child 4, and then discharged MP from their care.

25. The Community Mental Health Team received a referral from the GP and deemed MP unsuitable for their service so referred him to the Community Drug Service. The latter decided that MP's mental health problems were the priority so referred him back to the Community Mental Health Team. It is not clear what happened next.

[redacted]

27. Over the next few months, Police were twice called to MP's house due to altercations between him and his wife after which she asked him to leave. His wife was then the subject of a Multi-Agency Risk Assessment Conference as a result of her report of MP's abusive behaviour.

28. In June 2009, MP barricaded himself in an upstairs room of his house with a knife and threatened to use it if approached. Police from GMP moved his wife (with whom MP was again reconciled) and the children out. After two hours, MP emerged in a calm state. He was arrested and eventually charged with a minor offence of criminal damage, as he had not effectively threatened anyone.

29. The next day, MP told his GP that he felt like kidnapping his daughter and killing her and had thoughts of suicide. The GP referred him to the Community Mental Health Team, although did not believe that MP had any intention of carrying out his threat. A clinician visited MP at home to make an assessment the following day. The incident in May 2008 regarding Child 4 was noted and referred to as a kidnapping. MP spoke again of thoughts of killing Child 4 because she was not living with him. He agreed to a referral to clinical psychology for help with anger management. The CMHT later discussed on two occasions whether MP should be referred for a forensic assessment because of his potential risk to others and young females in particular. No such referral was made.

[redacted]

31. In November 2009, MP was sentenced to a Community Order with 12 months supervision by Probation. His attendance at appointments was variable. [redacted].

32. MP told his probation officer about his new girlfriend, MLK, but would not give her name. He later said that MLK had children but refused to provide any further information. The probation officer confirmed with GMP that there were no recent recorded incidents of domestic abuse involving MP but learned of six earlier incidents relating to his ex-wife. MP later said that the relationship with MLK had ended.

33. Over the next few months, MP was very unsettled: [redacted]; he had broken up with MLK and lost his home; he was misusing drugs and alcohol and was self-harming. His mother told the probation officer how worried she was about him and did not know what to do. In July, MP spoke by phone to a mental health nurse and said he was in the mood to injure or kill someone, then ended the call. In view of his history, the nurse reported the matter to GMP, and also referred to MP having made similar threats in 2008 towards his daughter (Child 4); and that in June 2009 he had "kidnapped the child". Officers visited MP and found him calm: he said he had no intention of harming anyone but had felt very angry. GMP logged the incident indicating concern for the welfare and mental health of an adult and a referral was made to Adult Social Care.

34. Shortly after this incident, SC1 (MP's stepdaughter) reported to Police that MP had threatened to kill her. Officers assisted her next day to collect items of property she had left at MP's house and closed the matter as a domestic incident. A month later, MP told GMP that he felt like hurting or killing the person who he believed to be sexually abusing his stepson's children. An officer visited him, assured him that the matter was being dealt with and facilitated MP in having contact with the Samaritans.

35. The Community Mental Health Team agreed at a meeting to undertake a risk assessment of MP. He failed to attend the appointment and they closed the case. MP had an outstanding appointment to attend the psychology service in the Primary Care Mental Health Team.

Summary of events January 2011 – 20 September 2011

36. In January, MP was driving his car in an intoxicated state and collided with several vehicles outside his house. He refused to provide the Police with a blood or urine sample for analysis. Later that month, he threw a frying pan towards his son whilst in an intoxicated and aggressive state, and fat splashed on his son's girlfriend's face. This led to another Multi-Agency Risk Assessment Conference at which MP's unpredictable and aggressive behaviour was noted, alongside his heavy use of drugs and alcohol. During this period, the GP referred MP to the specialist alcohol unit in Manchester.

37. In February, MP was sentenced to a 12-month Suspended Sentence Order under the Probation service, and was required to attend a programme designed for impulsive drinkers who exhibit angry and violent behaviour. The probation officer referred him to the Addiction Dependency Service in March; he failed an appointment at the Alcohol Unit but attended the Community Drugs Service, along with MLK and a young child. Clinicians from the Drugs Service informed his probation officer of the involvement of MLK and her child.

38. In April, MP asked GMP for help not to commit suicide after another break-up with MLK. He was intoxicated and went to hospital accompanied by MLK. A psychiatric nurse made a full assessment; learned that MLK knew about MP's history of child abduction (although MP had threatened rather than carried out an

abduction); recorded potential safeguarding concerns in relation to MLK's children but noted that MP had no current thoughts of harming a child. The probation officer later challenged MP again to provide information about MLK but he refused; as did MLK when she accompanied MP to a further appointment with the officer, save to confirm that she had three children. MP then saw the probation officer's manager to ask for a change of officer, and disclosed MLK's address. At his next appointment, the probation officer said a referral would be sent to Trafford Children and Young People's Service informing them of the relationship and the potential risk to MLK's children.

39. In May, MP was made subject to a further 12-month Suspended Sentence Order plus a three-month curfew requiring him to be at his home address between 8.00pm and 6.00am.

40. In June, MP's application to change his curfew address to MLK's home during the week was granted by the private firm who supervised curfew arrangements. The change went ahead without reference to the probation officer, MP's solicitor having confirmed the suitability of the address. MP attended at Probation and confirmed that he would be staying at MLK's house on Monday and Tuesday and she would come to his house for the weekend. MP attended the cardiology clinic: he had stopped taking his medication; his blood pressure was high; and he was referred for possible cardiothoracic surgery.

41. In July, MP broke his curfew by staying with MLK beyond the agreed times. He was admitted to hospital having taken an overdose of drugs and alcohol and cut his arms; and was referred for a psychiatric assessment. A mental health nurse undertook the assessment in hospital and a community psychiatric nurse assessed him after his discharge home: the assessment confirmed that MP had an emotionally unstable personality disorder; that there was no role for the Community Mental Health Team (CMHT); and, at MP's request, that the GP should refer him for a specialist ADHD assessment. Later in the month, the CMHT agreed there was no role for them and referred MP for an outpatient appointment with the psychiatrist, which was subsequently confirmed for early September.

42. In early August, the probation officer learned that MP had attended the Alcohol Unit with MLK and Child K; and Unit staff had informed the school nurse, with MP's signed agreement, because of concerns for the child's welfare. MP later told his probation officer that attending the Unit was a waste of time.

43. The probation officer then contacted Trafford Children and Young People Service (CYPS), as indicated to MP in the previous April, to refer the concerns about MP: his history of drug and alcohol misuse, domestic violence and mental health problems; the sexual abuse of his stepdaughter in the context of his current relationship with MLK; that he was staying at MLK's house overnight and had regular contact with her children; and was known to both Manchester and Lancashire children's services. He sent the same information in writing. However, the referral was made to a family support team rather than the Multi-Agency Referral and Assessment Team (MARAT) and this delayed it by a day. MARAT received an exceptionally high number of referrals that day relating to the riots in Greater Manchester, which took priority. As a consequence, the team did not consider the email from Probation until the next day (11 August).

44. MARAT obtained information that same day from Lancashire Children's Social Care who additionally advised Trafford about the incident in May 2008 when "MP was found to be threatening his stepdaughter and himself". This was in fact

Child 4. Manchester Children's Services would not provide information over the phone and sent details the following week.

45. The following day (Friday 12 August), the MARAT manager decided, in the light of the information received thus far, that the team should make an urgent visit to MLK: to assess the extent of MP's contact with her children, and what MLK knew of MP's history and the risk he presented to her children. The email received from Probation was forwarded to Trafford Public Protection Investigation Unit (PPIU) with a request for any information about MP held by GMP. They responded the following Monday. The allocated senior social work practitioner (SSW1) made no direct contact with the PPIU at this stage because the intention was to make an initial assessment of the situation rather than an enquiry under child protection procedures.

46. SSW1 arranged to visit MLK that afternoon and asked to see her on her own. She and another social worker (SW2) arrived at the house to find MP there along with his mother and a friend. The social workers confirmed that MLK would prefer to speak with them on their own and the others left, albeit reluctantly, and returned later. The social workers reported that MLK was relaxed in their presence; she listened to the information they had learned about MP and indicated that she knew the facts although hearing them from the social workers made them sound different. She also said that MP justified his behaviour by saying that his ADHD meant that he was not responsible for his own actions. However, she asserted that MP did not behave with her in the way described in his previous relationships. The social workers were concerned that MLK was thus minimising what MP had done and the risks he posed to her children.

47. MP's daughter (Sibling 1, aged 18) then described how uncomfortable she felt in MP's presence, and added information about the effect of MP on Child L (aged 15). This information caused the social workers more concern. MLK confirmed that when she had tried to end the relationship, MP had harmed himself; she also acknowledged domestic abuse in her previous relationships. She then referred to a family holiday, which included MP, which was due to start the next day. The social workers decided that MP posed an immediate sexual and emotional risk to the children and Sibling 1 on the basis of his sexualised comments to Sibling 1; his controlling style of behaviour; MLK's own history of domestic violence that made her more vulnerable; and her minimisation of the risks that MP posed to her children.

48. After lengthy discussion, MLK acknowledged that MP's behaviour was unacceptable and indicated that she appreciated better the risk that he posed to her children. She signed a handwritten agreement to the effect that she would not allow MP into the house or to have contact with the children; and would report to the Police any threats or attempts by him to visit the home. She agreed to cancel the holiday and understood that the social workers would involve the local Police in potentially removing the children if she did go away with MP.

49. The social workers then invited MP back into the house and, at MLK's request, explained to him what had happened. MP was at first very calm and then became, according to the social workers' subsequent report, frighteningly aggressive, at which point they asked him to leave. MP, his mother and friend drove away in what MLK said was her car. She and Sibling 1 said that MP had had similar aggressive outbursts previously. With MLK's agreement, SSW1 contacted GMP. She reported subsequently that the call taker focused on the theft of the car rather than the safeguarding concerns. A transcript of the call indicates that SSW1 did not restate her primary concerns about the safety of MLK and her children, as well as herself and colleague, and allowed the conversation to focus on the car theft.

50. Two officers came to the house, neither of who would normally respond to such an incident, the “summer riots” having diverted many officers away from their usual duties. However, one officer had recently undergone training in the work of the PPIU. On arrival, the social workers took the lead in explaining the situation and the more experienced officer decided to speak to MLK on her own. The officer was reportedly confused by what she considered to be the contradictory information she had picked up from GMP records about MP against what she was hearing from the social workers. MLK then told the officer that she felt intimidated and threatened by the social workers; and had only agreed to comply with their requests because she was terrified about losing her children. She also said that MP had given her the car to drive because he was banned as a result of motoring offences.

51. The officer contacted MP by mobile phone and confirmed that he would be returning the car; he was calm and coherent. The officer said she would not be proceeding with a criminal investigation. After further discussion with the social workers, she was not convinced of their view that MP was dangerous. On her return to the station, the officer consulted the Detective Sergeant who was on duty in the PPIU. On checking the record relating to MP, they found nothing to justify the social workers’ level of concern. The closing log for this incident includes reference to concern for the safety of persons 17 years and under so was referred on to the Serious Sexual Offences Unit, where the Sergeant recorded satisfaction that Trafford CYPS was handling the matter.

52. MP was extremely unhappy about the turn of events and his mother reported that she had great difficulty in calming him down. Over the following weeks, MP approached his probation officer; spoke twice to managers in Trafford’s MARAT; and three times contacted GMP. On each occasion, he was seeking to clarify what had happened and seek a resolution that would allow him to see MLK and the children again. To that end, he asked GMP whether he could be arrested and dealt with for his offence of underage sex with his stepdaughter. On each occasion, he received, from his viewpoint, no satisfaction and was advised to stay away from MLK and the children. His mother has since queried why he did not receive more help in view of his mental health problems and his previous negative reaction to the breakdown of relationships.

53. Over the next few days, the social workers gathered more information and visited MLK to check on her level of compliance with the agreement made at their first visit. Trafford CYPS held a strategy meeting chaired by the MARAT manager on 18 August to discuss MLK’s situation, six days after the visit by the social workers. SSW1 attended along with the probation officer and Trafford’s named nurse safeguarding children. No one came from the children’s schools or the school nursing service because the schools were closed for the holidays. The team manager of the Family Support Team was unable to attend. Very late on, GMP emailed to say that no officer could attend - the only one of 19 such meetings held by Trafford CYPS during August. However, they sent an attachment with detailed information about their involvement with MP, including a recent incident when MP called GMP because he said he was in the mood to injure himself or someone else; and the historical incident when “he barricaded himself in his home address armed with a knife and also kidnapped his child”.

54. The strategy meeting was long and complex. Participants discussed in detail the information known about MP, including the probation officer’s view that he was manipulative, controlling and aggressive; did not engage well with direct work; and was obsessed with his self-diagnosis of ADHD, for which he blamed all his problems.

They then considered MLK's ability to withstand any future advances from MP, and concluded that she had demonstrated her capacity to protect her children. It was, therefore, agreed to manage the case under child in need procedures rather than convene a child protection conference.

55. As a result of the strategy meeting, SSW1 referred the case for a Multi-Agency Risk Assessment Conference, which was put down for discussion on 21 September. She referred MLK to an Individual Domestic Violence Advisor at Victim Support, who provided immediate support with practical matters (such as ensuring that the locks on MLK's house were changed; and that GMP placed a marker on her address to indicate the need for an immediate response to any calls for assistance from MLK); and emotional support, such as understanding the insidious nature of MP's abuse of her.

56. SSW1 advised the Manchester mental health service and the GP involved with MP about his aggressive behaviour towards professionals, and that the children would be removed if MP returned to the household. She completed the initial assessment and arranged the transfer of the case to the local family support team for completion of a more detailed (core) assessment, and ongoing supervision and support of MLK and the children. She indicated that the new social worker would need to contact the children's schools once they re-opened in September. (In fact, MLK informed the primary school head teacher before the social worker made contact.) She also emailed the PPIU about the outcome of the strategy meeting although it had been agreed at that meeting that there should be a face-to-face meeting. The need to convene a multi-agency child in need meeting was noted.

57. GMP subsequently had contact with MLK because of text and phone messages from MP and, on one occasion a letter, which she reported to them as advised. GMP served a notice on MP relating to harassment. However, when MP breached the notice MLK did not want action to be taken against him because the messages were not threatening and she feared MP's reaction should she make a complaint leading to his arrest.

58. At the end of August, MP was admitted to hospital following a heart attack. Medical staff referred him for a psychiatric assessment because he was agitated and would not comply with medical assessments and treatment. The following evening (29 August), the senior house officer (SHO) on duty in psychiatry assessed MP on the ward. (The Manchester Mental Health and Social Care Trust provides the psychiatry service to the hospital.) The assessment was thorough and included a statement from MP that he had thought about harming himself in the days prior to this admission, including setting fire to himself, but had no money for petrol; he also had thoughts of harming others, namely police officers and social workers. By the time of the assessment MP was calm; the SHO recorded on the ward notes and her own Trust's electronic record what MP had said; and provided advice to the medical staff about his management on the ward; she made no mention to ward staff or psychiatric colleagues about the threats of self-harm and harm to others.

59. Next day, the medical team requested further psychiatric help because MP was refusing bypass heart surgery. The (different) on-call SHO advised the doctor to assess MP's mental capacity to refuse treatment. The medical team sought further advice the following day from the on-call consultant psychiatrist who arranged for another assessment and advised MP's psychiatrist of the contact. There was no reference to MP's thoughts of fire setting or harm to others. MP discharged himself against medical advice without the benefit of heart surgery or a further psychiatric assessment.

60. The following week MP attended the earlier planned psychiatric appointment and saw another SHO who conducted the interview under the observation of MP's own psychiatrist. There was no evidence of thought disorder or serious mental illness. The SHO discussed the diagnosis of emotionally unstable personality disorder and attempted to plan help for MP. However, the SHO assessed that MP's motivation in seeking help was to restart his relationship with MLK. Neither the SHO nor consultant reviewed MP's earlier record and, therefore, did not pick up MP's comment about setting fire to himself.

61. Events on Monday 19 September are set out in the first section of this summary report.

Analysis and conclusions

Key issues arising from the case

62. The analysis in the overview report relates to the seven terms of reference for the review with a conclusion at the end of each section. This summary focuses on the key issues that emerge from the analysis. The first relates to **the quality of the assessments made by agencies and, in particular, the effectiveness of the assessments of risk**.

63. There was evidence of thorough assessments being completed; for example, Bury CSC's assessment of the risk to SC1 from MP; and Trafford CYPS's initial assessment of MLK and her family. However, shortfalls in practice were also evident. There was a tendency to downplay the seriousness of incidents and not complete effective risk assessments such as when:

- There were early indications that SC1 and MP were having a sexual relationship when she was a young teenager, which were not thoroughly enough assessed or acted upon.

- MP refused to return Child 4 from the contact visit in May 2008 and threatened her and his life. When mental health clinicians in Manchester later assessed him, he repeated the threat, which they took seriously. However, the clinicians did not undertake a further risk assessment – as required in their own Trust guidance; draw up a care plan for him, in line with national guidance for people with a personality disorder; and ensure ongoing oversight by one of their services. Although, Child 4 came to no harm, the threat was very serious and, in the view of the independent forensic psychiatrist, set him apart from people with an emotionally unstable personality disorder; and was not related to that disorder. As such, in his view, it required the involvement of criminal justice agencies.

- The probation officer did not refer MP's relationship with MLK to Trafford CYPS until four months after becoming aware of its resumption, despite MP's worrying behaviour during this period and having told MP of the intention to do so.

- MP made a specific threat to his GP in 2009 about kidnapping and killing his daughter. There was again an insufficient response from

mental health clinicians to assessing the risk of harm from MP, including liaison with GMP. Consideration was given to referring him for a forensic assessment of risk but this was never followed through. It would have provided clear guidance about the level of risk that MP posed.

- Whilst in hospital at the end of August 2011, MP indicated his intention to set fire to himself and to harm social workers and police officers; and refused life-saving surgery. The relatively inexperienced senior house officers who assessed him did not seek advice from a more senior colleague or supervisor, and did not appear to recognise the significance of what MP was saying. At the subsequent outpatient psychiatric appointment, there was no reference to the historical record that included MP's recent statements about setting fire to himself and of harming professional staff.

- Officers in the GMP Public Protection Investigation Unit did not take an overview of MP and his many presentations to the force, or did not view sufficiently seriously the emerging pattern of his threatening behaviour. They also did not interrogate misinformation about MP's alleged kidnapping/abduction of his daughter, although it did not feature as an offence on their database. Rather, they assessed and categorised his risk following individual incidents and made referrals to Adult Social Care and Children's Social Care.

64. The second key issue is **the effectiveness of communication between agencies across sector and local authority boundaries; and the use of historical information to inform assessments and the inter-agency communication.**

65. There is evidence of regular and appropriate communication within and between agencies: both in conversations between practitioners, clinicians or officers, and in sending emails and other documentation. This includes communication across local authority boundaries. However, there are occasions when crucial information was not passed on to other sectors or agencies; and agencies did not come together to share information and plan how to manage the case. In addition, there was a failure at significant junctures to make use of the available historical information in relation to MP in order to analyse emerging patterns of behaviour and, crucially, instances where his behaviour deviated from what was normal for him.

- Lancashire Police did not pass on information about the incident in May 2008 to their colleagues in Manchester, and Lancashire Children's Social Care did not convene a strategy meeting to review the risk of harm to Child 4 and potentially other children.

- Following the incident in May 2008 when MP made further threats towards Child 4, Manchester Mental Health and Social Care Trust did not inform GMP of the situation and involve them in developing a collaborative risk management approach for MP.

- In 2009, clinicians in Manchester Mental Health and Social Care Trust did not pass on crucial information about MP's further threats to kidnap and harm his daughter to GMP; nor, in August 2011, his threats to harm social workers and police officers and set fire to himself. They did not plan MP's care on an inter-disciplinary or multi-

agency basis, or provide other agencies with an assessment of the risk that MP posed.

- Mental health agencies and Children's Services in Manchester did not review MP's history when they received new referrals. They did not, therefore, recognise and respond to the emerging pattern of his behaviour but dealt with each incident as a new event. Crucially, Manchester Mental Health and Social Care Trust did not take account of the threats made by MP in August 2011 at his next assessment early in September.

- The Probation Trust recognised the complexity of MP's needs and appropriately referred him to services aimed at addressing his alcohol and drug problems and mental health difficulties. It did not consider whether a planned coordinated response from the various agencies would have been more successful in supporting MP.

- MP did not reach the threshold for being managed under Multi-Agency Public Protection Arrangements and this undermined a multi-agency planning approach. MP did not have a serious record of offending but his range of difficulties in relation to alcohol and drug misuse, his emotionally unstable personality disorder, domestic abuse and sexual abuse of a minor made for a toxic mix that required a multi-agency approach: to share information, assess the level of risk of harm and agree a plan for managing him.

- Trafford CYPS did not hold a child in need meeting in a timely fashion (it had not been arranged by 19 September 2011) despite the serious nature of MLK's situation and absence of key agencies from the strategy meeting. The draft status of the Children in Need Policy suggested that children in need cases were not viewed or managed with the same degree of urgency or priority as that given to cases managed under child protection procedures.

66. The third key issue is **the knowledge within agencies of the indicators and impact of domestic abuse, in particular at the point of separation**.

67. There is evidence of a sound knowledge base about domestic abuse within Children's Services, the Probation Trust and Greater Manchester Police; but a lower level of knowledge within Health services. However, Health agencies within both Trafford and Manchester have commenced action to increase staff awareness and provide prompts for asking patients about the possibility of domestic abuse. Action taken to protect MLK and her family by the social workers and an individual domestic violence advisor from Victim Support following the visit in August 2011 was prompt, wide-ranging and entirely appropriate. However, the focus of attention was wholly upon MLK and her family and no attention was given to MP's needs at what was a critical juncture.

68. The independent forensic psychiatrist said that the enforced separation of MP from MLK and her family would have been a serious loss to him, and would have triggered an emotional crisis that exacerbated his personality disorder, including "impulsivity and frequency/presence of suicidal and/or homicidal ideation". MP's mother described in vivid terms the adverse effect of the separation on MP, and is

critical of the manner in which the social workers handled the matter, particularly in view of his mental health problems.

69. Agencies did not give due consideration (indeed any consideration) to the effects of the separation upon MP; they focused upon him only to the extent that he posed a threat to MLK and her children. This was compounded by subsequent missed opportunities to respond to his obvious (in retrospect) high level of distress, frustration and growing sense of injustice that was translated into threats of serious harm against self and others. MP ceased to count; no one listened carefully to him or heard what he was saying. The response by agencies to MP after 12 August was insufficient.

Priorities for learning and change

Assessment of risk

70. There are examples within mental health services and children's social care of failures to make assessments in respect of MP on the basis of historical information as well as the current situation. Incidents were treated as new events with no regard to prior information. Individual incidents may not occasion a strong response but the cumulative effect of incidents of the same behaviour, or uncharacteristic nature of the behaviour compared to historical incidents, should alert practitioners and clinicians to undertake a thorough review; and reach a judgement, based on an analysis of the evidence, on the level of risk indicated.

71. Bury, Lancashire and Manchester children's services did not undertake thorough enough assessments of the risks faced individually by SC1 and Child 4 at different junctures in their lives. In each instance, there was insufficient regard to the case history and an underplaying of the seriousness of the current risk.

72. Manchester Mental Health and Social Care Trust clinicians did not have sufficient regard to the specific threats made by MP on more than one occasion to harm Child 4. These incidents should have led to a further risk assessment and to a specialist forensic assessment of the risk that MP posed. In addition, the Trust should have decided whether or not MP's threats were related to his mental disorder, advised GMP accordingly and agreed a collaborative risk management approach. The Trust was made aware of MP's enforced separation from MLK by the social worker but clinicians did not take account of its effect upon MP when assessing him after that date. In addition, they did not consider the significance of MP's statement about setting fire to himself and his threats made towards social workers and police officers; and did not pass on this information to GMP or Trafford CYPS.

73. MP was rightly categorised as a vulnerable adult by the Public Protection Investigation Unit (PPIU) within GMP on the basis that he was a risk to self. Although lacking the benefit of an assessment from Manchester Mental Health and Social Care Trust about the risk he posed to others, nevertheless the PPIU had accrued a body of intelligence relating to MP's threats to harm others. However, this intelligence was not assessed or given due weight; in particular, incorrect information (regarding the alleged kidnapping of Child 4) that potentially indicated an even higher level of risk to others was not interrogated. At no time did the Unit seek expert mental health advice. Action taken on the basis of individual and cumulative incidents was not sufficient: it required collaboration with other agencies to ensure that information was shared; an assessment of MP's risk of harm to others made; and joint plans for his management agreed.

74. MP was desperately seeking help following his last, enforced separation from MLK but no one heard him. The focus stayed on MLK and her children, and there was much positive work undertaken to support and protect her and her family. In this respect, national guidance does not assist agencies in having due regard to the perpetrator. MP's needs were overlooked, despite the research finding that the period following separation represents a more dangerous time for the victim, and this ultimately proved catastrophic. The response to MP mirrors other research indicating that agencies ignore the role of men despite the crucial part they play in families' lives – whether beneficial or not.

Multi-agency cooperation

75. Manchester Mental Health and Social Care Trust has no specific service provision for people suffering from a personality disorder. As a consequence, MP was referred between teams and disciplines with no one service assuming responsibility for planning his care. Such practice is outwith national guidance and failed MP.

76. The multi-agency public protection arrangements (MAPPA) did not apply to MP because his level of offending did not reach their threshold. However, there has to be a means of managing by way of multi-agency planning individuals who fall below the criteria for MAPPA but present a risk to self and others on the basis of a full analysis of their history and current status.

77. Manchester Mental Health and Social Care Trust failed to work with other agencies through inter–agency meetings in order to share information and plan the management of MP. Such inter-agency meetings require a higher priority within the Trust. Equally, Trust clinicians were not invited to the strategy meeting in August 2011 despite their substantial involvement with MP.

78. There were instances of children's services underplaying the risk of harm that MP presented and failing to hold strategy meetings to share and mitigate that risk.

79. The draft status of Trafford's Children in Need Policy undermined its standing with and acceptance by the relevant agencies. In turn, this devalued the status of the category of child in need. It presents a significant risk to planning for and managing cases that are serious but deemed to fall just below the threshold for instigating child protection arrangements. However, the policy has been finalised and accepted by the Trafford Safeguarding Children Board during the course of this review.

Recommendations and action plan

1. Trafford, Manchester, Bury and Lancashire Safeguarding Children Boards and the commissioning body for mental health services in Manchester must take immediate steps to ensure [1] that staff understand the crucial relevance of the case chronology to an assessment of the current situation; and [2] that record-keeping arrangements in the Boards' constituent agencies facilitate access to the history of a case. In addition, the Manchester Mental Health and Social Care Trust must draw up an agreement with the University Hospital of South Manchester regarding its provision of mental health services, including access to and maintenance of patient records.

2. The Manchester Mental Health and Social Care Trust must, as a matter of urgency, reinforce its advice to clinicians about threats by its patients to harm others, and ensure that such advice is heeded and appropriate action taken, including instigating strategy meetings with Greater Manchester Police and Adult or Children's Services.

3. Greater Manchester Police should review the practice of the Public Protection Division and support officers [1] to recognise patterns of incidents that indicate an escalation or changed direction in an individual's behaviour; and [2] in the light of an assessment, take steps to mitigate any risk by means of strategy meetings and multi-agency planning.

4. The Safer Trafford Partnership must review the response of agencies to individuals with a complex range of problems who pose a risk of harm to self and/or others including, in particular, perpetrators of domestic abuse.

5. Trafford Safeguarding Children's Board must take immediate steps [1] to implement its Children in Need policy fully and [2] consider what continuing organisational support is necessary to ensure that implementation is and remains effective.

Overarching Actions (from SCR/DHR Overview Report)

Trafford Safeguarding Children Board (TSCB)

1. Message regarding the importance of chronologies to go to all staff
2. Each agency to confirm to TSCB that record –keeping arrangements facilitate access to the history of a case.
3. Child In Need Policy to be approved, placed on TSCB website and implemented.
4. Development Day to review implementation of the Children in Need Policy and organisational support. Actions from Development Day to be agreed
5. Performance Framework to be revised to ensure that effectiveness of Children In Need policy is maintained

Manchester Safeguarding Children Board (MSCB)

1. MSCB to ensure that the key recommendation re relevance of case chronology is presented to the Manchester Mental Health Clinical Board - as commissioners of mental health services in Manchester
2. MSCB to seek assurance from all partner agencies that record keeping arrangements facilitate access to the case history.

Lancashire Safeguarding Children Board (LSCB)

1. Issue of chronologies to be included in next SCR newsletter for all practitioners (August 2012). To be reinforced through SCR briefings delivered every two months, and to be strengthened in all relevant training courses.
2. Letter gone to all constituent agencies on 13.08.12 requesting confirmation by 14.09.12 about record keeping. Will be monitored by SCR sub group

Bury Safeguarding Children Board (BSCB)

1. All appropriate agencies to ensure that their staff are aware of the need and value of chronologies and confirm to the Board that they are used in practice
2. Each agency to confirm that record –keeping arrangements facilitate access to the history of a case.

NHS Manchester

1. As part of an ongoing Quality Assurance Framework Commissioners will require evidence from MMHSCT that staff understand the importance of case chronology in conducting risk assessments and utilise these in clinical formulations.
2. Commissioners will require an assurance from MMHSCT that all staff comply with full casenote recording on the Case Recording System (AMIGOS) via an independent audit and installation of surveillance for compliance.

Manchester Mental Health and Social Care Trust

1. Meet with UHSM to determine approach to sharing/accessing patient records.
2. Agree protocol for future working
3. Advice issued to clinical staff regarding appropriate action to take if threats are made to harm others.
4. Ensure clinical risk assessment training encompasses issues of harm to others

Greater Manchester Police

1. All Triage staff to be aware and recognise patterns, volume and escalation of incidents.
2. Neighbourhood teams to recognise patterns of incidents and vulnerability and refer to the PPIU to conduct joint strategy meeting .
3. Update manual of guidance to include specific chapter on vulnerability and Neighbourhood policing

Safer Trafford Partnership

1. Safer Trafford Partnership to hold development day to agree specific actions and time -scales for agencies' actions
2. Incorporate the agreed actions as a STP standing agenda item until signed off as complete or sufficiently in progress

Overarching Actions (from Health Overview Reports)

Trafford Health Overview Report

1. All providers to ensure that the lessons learned are incorporated into training, policies, procedures and guidance where appropriate
2. All providers should report on the progress of their IMR action plan to NHS Trafford
3. The review of the school nursing service should take into account the statutory responsibility placed on health organisations to safeguard and promote the welfare of children
4. The Trafford Clinical Commissioning Group (CCG) should demonstrate how it will satisfy Domains 4 and 5 of the CCG authorisation guide.

Manchester Health Overview Report

1. Manchester Commissioners to review services provided by mental health for patients with personality disorder against available best evidence standards, and to address any identified gaps in service to support GPs and community mental health services in the management of these patients.
2. Manchester Commissioners to require all services they commission to demonstrate that they have clear communication pathways between providers to manage the totality of a patient's needs.
3. Manchester Commissioners to demonstrate that the new drug treatment provider services and alcohol treatment provider services have systems which are aligned with mental health providers, to deliver holistic care.
4. Manchester Commissioners to work with GPs and community services to ensure that all understand the referral pathways to the MO:DEL Service.
5. Manchester Commissioners to ensure that there is ongoing quality monitoring of SUIs, and thematic analysis by trusts of cases undergoing review in order to ensure lessons are learned and risks identified.
6. Manchester Commissioners to demonstrate that they use Commissioning services for women and children who experience violence or abuse – a guide for health commissioners (DH 2011) to ensure that they commission services that can recognise and manage cases where domestic abuse is a factor.

Individual Agency Actions

Strategic Responsibility: Trafford Safeguarding Children's Board

Trafford Children and Young People's Service (Children's Social Care)

1. All relevant agencies inclusive of children's schools should be informed about the department's involvement with families and about known areas of risk. All relevant agencies should be routinely consulted by practitioners when completing initial and core assessments.
2. All staff to be reminded of the need for Family Support meetings to be convened within 30 working days of the completion of the Initial Assessment.
3. Trafford's Child in Need Policy does not currently, adequately reflect the use of Child in Need process's to manage cases where there is a significant level of risk. The guidance needs to be reviewed and amended to include specific guidance on the use of Child in Need processes to manage such cases.
4. All practitioners who are managing cases relating to children who are affected by domestic violence should consider interventions which: hold the perpetrator to account, provide him with opportunities for support, provide him with opportunities to change.
5. A resource pack to be developed for practitioners working with children who are affected by domestic violence. The pack should identify within it resources for perpetrators of domestic violence.
6. All completed assessments should be discussed by practitioners, directly, with parent's carers and children. The current practice of simply posting completed assessments to parents should be reviewed.
7. All Practitioners to be reminded of the importance of ensuring that children are routinely consulted during the course of the completion of Assessments.
8. Trafford's Supervision Policy to be amended to reflect the requirement of managers to: review the progress of key actions and recommendations from meetings, give specific timescales for the completion of actions.
9. All training delivered to Practitioners should emphasis the risk to the children at the point of separation by the mother from the violent partner.
10. Trafford's Domestic Violence Protocol to be reviewed to include referencing the increased risk to children at the point of separation by the mother from the violent partner.
11. Practitioners to give consideration to referring, perpetrators of domestic violence who present a high level of risk to MAPPA

Trafford Children and Young People's Service (Education)

1. Inclusion of specific information highlighting the indicators and impact of domestic abuse to be included in schools child protection policies
2. To improve and ensure good quality logging, recording and record keeping in schools
3. To improve multi-agency working with families where domestic abuse is a concern

Trafford GPs (NHS Trafford)

1. The RCGP toolkit should be promoted for use in GP practices in Trafford

2. GPs in Trafford should receive training which addresses issues of domestic abuse and the role of the GP
3. GPs should have a clear communication pathway with other health professionals (for example Health Visitors and School nurses)
4. GPs should be engaged in early intervention strategies and be able to understand the work of their local family health support teams.
5. GPs should be able to receive electronic information from MARAT and the health safeguarding children team about patients registered at their practices where there are concerns regarding risk

Trafford CYPS Community Health (Bridgewater)

1. Health Visitors will routinely enquire and document about domestic abuse at first contact as a minimum.
2. Health Visitor records will demonstrate evidence of health visitor routine enquiry at first contact as a minimum
3. There are clear expectations of best practice for health professionals regarding children in need
4. The school nurse and health visitor records ensure health issues are identified and action plans including evaluation are documented in a structured way.
5. The school nurse and health visitor record review elements of diversity to ensure they are captured in the assessment
6. School health services are reviewed regarding the gap in service delivery in school holidays

Strategic Responsibility: Safer Trafford Partnership

Greater Manchester Police

1. The force should undertake a review regarding the existing use of Police Information Notices and their use within the context of the Stalking and Harassment Act
2. GMP to actively engage in the Home Office consultation into stalking and harassment
3. GMP should look to impress upon all PPIU staff engaged in intelligence sharing with partner agencies the importance of validating uncorroborated intelligence albeit from reliable sources such as partner agencies
4. The implications of domestic violence markers and their effect on the 'Graded Response' policy should be examined by PPD and OCR management. A clear directive should then be issued to all OCR staff and supervisors.

Greater Manchester Probation Trust

1. To reinforce the importance of sharing safeguarding concerns with Children's Services in a timely manner
2. Examine current levels of compliance with the Safeguarding Policy and Practice Directions throughout GMPT
3. To ensure that information regarding children is recorded in line with the Safeguarding Policy and Practice Directions
4. To review and update OASys when new information regarding safeguarding and domestic abuse concerns are identified

5. To reinforce the importance of considering historical information regarding safeguarding and domestic abuse concerns when completing OASys
6. To examine whether the Domestic Abuse Policy and Practice Guidelines which is currently being reviewed is explicit enough in relation to the completion of SARA for service users where the index offence is not domestic abuse
7. For the Trust to explore opportunities to enhance Offender Managers knowledge regarding managing service users with mental health difficulties especially personality disorders

Victim Support

1. To ensure all IDVAs employed by Victim Support replicate the good practice found in this case in terms of recording work undertaken with clients and partner agencies.

2. To ensure rationale behind key decisions is recorded, and where necessary information should be substantiated with partner agencies. IDVAs should demonstrate they have not made assumptions; that they have challenged and explored opinions or information expressed by the client.

3. To ensure rationale behind key decisions is recorded, and where necessary information should be substantiated with partner agencies. IDVAs should demonstrate they have not made assumptions; that they have challenged and explored opinions or information expressed by the client.

4. Agree and implement a more formal procedure for covering IDVAs work during sickness absence.

5. Increase the use of risk assessments by the IDVAs to consider more flexible support options for clients.

Strategic Responsibility: Manchester Safeguarding Children Board

Greater Manchester West

1. The Trust should review all safeguarding policies, procedures and training to take account of the lessons learned from this incident.
2. The assessment procedures and practices of the MOD:EL team and the drugs service should be reviewed and audited to ensure safeguarding issues are considered routinely and risk assessed.
3. Safeguarding training records for MOD:EL team and drug services need to be reviewed to ensure that the targets for all staff are being met, with a view to ensuring existing safeguarding training plan is delivered as necessary.

University Hospital South Manchester

1. Review the agreements between the Manchester Mental Health and Social Care Trust and UHSM. The aim of this is to strengthen agreement between the two Trusts regarding working arrangements to improve shared knowledge about patients and aid information sharing, additionally to ensure that accountability for documentation is clearly understood.

2. All members of the multi-agency Team within UHSM, in particular Nurses and Doctors document within the same part of the hospital record

NHS Manchester GPs

1. To improve record keeping for patients with mental health needs
2. To improve assessment of risk of violence in Primary Care
3. To improve diagnosis and management of Personality disorder in Primary Care
4. To identify a lead GP for patients who have mental health problems/chaotic users of service

Manchester City Council Children's Services

1. Strengthen practitioners understanding of how historical information should be incorporated into assessments.
2. Practitioners need to further their understanding of domestic abuse and the associated risks and impact on children.
3. Strengthen the current information sharing procedures.

Manchester Mental Health & Social Care Trust

1. The Trust information system needs to be revised to ensure that the historic risk assessment is prominently available
2. All staff are expected to use the electronic record system appropriately by looking and considering recent contacts prior to an appointment or assessment.
3. The Trust should review its strategy for personality disorders including implementation of NICE guidance and include commissioners in this process.
4. The Trust should establish a review system for service users who repeatedly present at A&E so that a recognised procedure is developed for escalating referrals when there have been several referrals or significant events causing concern, to ensure that a senior clinician undertakes the assessment and that a suitable care plan is agreed.
5. Safeguarding training needs to include the need for staff not to accept on `face value ` the word of a parent when there are potentially serious risks apparent to children
6. Issue guidance to staff on features of domestic abuse and key risk factors .
7. The Trust will develop a Did Not Attend policy that will cover all services provided by the Trust and that will ensure an appropriate response to the different levels of risk relating to non-attendance
8. The Trust will disseminate good practice regarding information sharing from the Brian Hore Unit to all services
9. The Trust will develop a system so that staff dealing with emergencies have routine clinical supervision in relation to the emergency work.

Strategic Responsibility: Bury Safeguarding Children Board

Bury Children's Social Care

1. Ensure all Child in Need cases are regularly reviewed and receive appropriate management oversight.
2. Ensure that the salient issues from assessment visits are made available contemporaneously on the electronic Social Care record and that the Service ensures adherence to timescales for pre-birth risk assessments.
3. Ensure Social Work assessments take account of the impact of the absent parent and that plans incorporate engagement and interventions with the absent parent where this is appropriate and necessary.
4. Improve Social Workers' recognition and response to the safeguarding needs of children who are ordinarily resident in other Authorities.

Strategic Responsibility: Lancashire Safeguarding Children Board

Lancashire County Council

1. Initial and Core Assessments must include significant adult males within the family to ensure their role is understood.
2. The LSCB should ensure that front line workers have the skills and confidence to work with hostile and non engaging families.
3. Recommendations from Child Protection Conferences should be sent to team managers and a problem resolution process developed to ensure recommendations are monitored and implemented in a timely manner.
4. Opportunities for reflective practice need to be established as part of staff supervision.
5. When working with families consideration needs to be given to any potential communication difficulties.