MANCHESTER SAFEGUARDING CHILDREN BOARD

THE EXECUTIVE SUMMARY OF THE PART 8 REVIEW SUB COMMITTEE IN RESPECT OF JB

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EXECUTIVE SUMMARY PART 8 REVIEW REPORT
MANCHESTER SAFEGUARDING CHILDREN BOARD ON CHILD JB

Born: 04.04.99
Died: 01.09.05

The purpose of this executive summary is to:

- summarise the events which preceded the death of child J and outline the process following the decision of Manchester Safeguarding Children Board (MSCB) to undertake a review of child protection practice in relation to this case,
- list the key findings of the review and
- identify the action to be taken or already taken as a result of the findings.

1. Introduction

The case review was undertaken in accordance with the guidance issued by the Department of Health to Local Authorities entitled "Working Together to Safeguard Children".
The review addresses the inter-agency provision of services to both the child J who died and to the alleged perpetrator of J's fatal injuries in as far as those services to the adult took account of J's need for safeguarding.

2. Summary of Events.

J was the only child born to N and D. When he was born in April 1999 he had two older half siblings, children of his mother, and the family resided in Heywood. There had been reported domestic abuse and concern about the care of the three children, which had been reported to Rochdale Social Services.

The family moved to Manchester in late 1999. Over the next few years the concerns about domestic abuse and the care of the children continued and eventually maternal grandmother assumed the care of the two older children.

After several short separations J's parents finally separated and his mother moved to live with a new partner with whom she had two more children. J's father, who had regular contact with J obtained a Residence Order and J remained with his father on a full time basis in Manchester when his mother left.

J, who was six years old at the time of his death, resided with his father, and a lodger who had known J's father for many years. The lodger was known to have mental health problems.

On 31 August J's father went out in the evening leaving J locked in the flat in the care of the lodger. He returned the following morning and discovered J dead on the floor of one of the bedrooms. A post mortem revealed that J had died of multiple stab wounds to the head and body.

The lodger was arrested and was detained under the Mental Health Act in secure accommodation where he was psychiatrically assessed and treated. On 5th October 2005 he admitted responsibility for J's death and on 6th October he appeared in court and was charged with the murder.

Manchester Safeguarding Children Board (MSCB), decided that the death of J should be the subject of a Part 8 Review

3. The Review Process

On 14th October 2005 MSCB, via it's Serious Case Review Sub-Committee, decided to hold a Part 8 Serious Case Review. Management review reports and chronologies were requested from individual agencies involved with the family and an independent person commissioned to chair a Part 8 Serious Case Review Committee and write the Overview Report. Reports were received from all agencies requested to provide them and a multi-agency chronology was drawn up.

The Part 8 Review Committee met on 4 occasions and presented the agreed report to the MSCB on April 13 2006.

4. The Key Findings

The subject child of this Part 8 Report, J, died as a result of multiple stabbings. At the time of his death he was 6 years old and living with his father under a Residence Order. Also present in the household was a lodger who had mental health problems, primarily a diagnosed drug induced psychosis. He had known J's father for a number of years. J's mother had left the household and formed a new family with a new partner.

There had been concerns about J dating back to the year in which he was born. His parents had a volatile relationship characterised by frequent domestic abuse incidents and difficulty in maintaining adequate standards of hygiene in the home. J's two older half siblings eventually resided permanently with their maternal grandmother to whom J's mother had looked for support on the occasions when she had left J's father. J remained with his mother and father.

On several occasions there had been concerns raised by relatives about the ability of J's father to care for him and both J and the home he lived in had been described, at times, as unkempt and smelly. These concerns were investigated by Children Families &Social Care and found to be either largely unfounded or it was judged that the conditions had been sufficiently ameliorated and no ongoing work was undertaken with the family. Although visits were made by social workers, assessments of J's situation were not always undertaken.

Those who came into contact with J and his family on a less regular basis registered their concern when they felt it appropriate and information was also known in a range of agencies about unsatisfactory aspects of J's home life and aspects of the abuse and neglect to which he was exposed. These concerns were never brought together and no agency had the benefit of the full picture on which to base protective activity.

J's parents made allegations and counter allegations of domestic abuse. The full history and extent of the domestic abuse in J's life was not known as individual agencies held only part of the full picture and there were no opportunities to share information

The adult who lodged with J and his father had a history of mental health problems. His primary diagnosis at this time was drug induced psychosis though this may have masked a serious underlying psychotic illness which may ultimately have led him to fatally injure J. How far J's father was aware of the risks is not clear. He felt able to leave J in the care of the lodger from time to time, asked him to collect J from school on occasions and, on the day J was killed, he had left him all night, locked in the flat with the lodger returning at 8.25am the next day to find J with injuries from which he did not survive.

The mental health assessments undertaken in respect of the lodger did not adequately address the issue of the presence in the household of a child. On two occasions, even though a child was known to be living there, the assessment of the adult was conducted as if it was assumed he had no responsibility for the child when, in reality, he did. Additionally there was no assessment of the impact on the child of living in a household where at least one adult misused drugs and alcohol.

It is likely that no-one could have predicted specifically the very great risk to J or anticipated the trigger(s), which led to his killing, but there are lessons to be learnt from this review. These are firstly that J's vulnerability as a child exposed to domestic abuse and the risks to which he was exposed remained inadequately assessed as those agencies engaged with him treated each episode in isolation from others and no full chronology was ever available to inform action. Secondly the mental health services involved with the adult lodger

focused on his needs as an adult and not on J as a child of the household and the generalised and specific risk to J of an adult with psychotic symptoms and involved with drug abuse were not assessed.

5. The Multi – agency Recommendations

5.1 Individual agencies made recommendations for improved practice within the agency and these were all accepted as appropriate by the Part 8 Serious Case Review Committee. The following recommendations for improvements to multi-agency practice are made and, together with the single agency recommendations, they will be addressed by the MSCB and an action plan drawn up for their implementation.

5.1.1 Recommendation 1

MSCB should establish a multi-agency group to consider the interface between safeguarding services for children and mental health services for adults in order that recommendations for improved practice can be made. The needs of children and the action required to promote children's best interest should be incorporated into the policies, procedures and practice guidance within mental health services and should address the following issues identified in this review

- **When adults are in receipt of an enhanced or standard care planning approach and are not parents but nevertheless have responsibility for or significant contact with a child, the child's needs should always be considered and should be paramount in any conflict of interest**

- **When such an adult is in receipt of an enhanced care planning approach the 6 monthly review meeting should invite contributions from relevant child care agencies involved with the family.**

5.1.2 Recommendation 2

Multi-Agency group to consider the effect of current procedure in identifying and safeguarding children at risk from the effects of domestic abuse, and in addition to consider the extent of impact and make recommendations for improvement.

5.2 Children, Families and Social Care

When an initial assessment is undertaken following a referral of concern for a child's welfare, the child should always be seen by the social worker and where appropriate, spoken to alone in order that the child's own version can be ascertained.

Where there is an established history of domestic abuse between a parent and their partner and a serious injury is sustained, witnessed by a child, a core assessment should be initiated in order to determine if child protection procedures should be instigated.

Team Managers should not authorise the closure of a referral until they have evidenced that their recommendations have been carried out.

Multi agency domestic abuse procedures should be revised to establish clear assessment criteria and thresholds of concern in order to deliver consistent levels of intervention.

5.3 Early Years and Play

The Local Authority Play Service should explore the potential to increase universal play services to 5-8 year olds in identified areas of high need and low provision.

The Local Authority Play Service should inform other key agencies about the availability of provision during school holidays for children and young people 5-14 year olds (16 year olds for people with additional needs)

Local Authority Play Services should update and revise information provided to parents/carers and other agencies regarding the availability scope and suitability of Play Services.

Local Authority Play Services should explore the potential for expanding existing joint working arrangements with other agencies including the Voluntary Sector.

Local Authority Play Services will communicate with Ofsted in respect of the regulatory issues that have arisen in this case to enable Ofsted to consider any implications for regulation

5.4 Greater Manchester Ambulance Service

In cases of life threatening injuries or death of a child, where neglect or abuse is suspected, a Vulnerable Child Form should still be completed in order to facilitate communication and continuity.

5.5 Central Manchester Primary Care Trust (CMPCT)

CMPCT should devise a process for future case management, when a decision is made that it is unsafe to visit the home. A case plan for the child needs to be established in consultation with the Vulnerable Children Team and involve all relevant parties.

CMPCT should review, update and re-launch the caseload overview process so that the needs of vulnerable children are identified and prioritised.

Health Visitors should ensure records being transferred to the school nurse are filed in the "new" Manchester record, which includes an up to date chronology and case transfer slip.

CMPCT should formally request copies of A&E slips so that attendance information re attendances can be analysed in primary care.

CMPCT should review how children causing concern are discussed within primary care teams.

5.6. Education Department

Education Department should ensure that procedures for gathering information when a pupil is being admitted to a school are improved.

Education Department should continue to raise staff awareness in Schools and within the Department during supervision and training regarding appropriate case discussion particularly where there are possible child protection concerns.

Education Department should continue to raise staff awareness in Schools and within the Department during team discussions, supervision and training about personal safety.

Education Department should review its system for dealing with information provided by other agencies. This includes recording other agency involvement with a case.

Systems should be set in place to ensure Head teachers are informed where possible about potentially vulnerable children where other services are already involved.

5.7 Manchester Mental Health and Social Care Trust

MHSCT should review Induction and Mandatory Training to include section on appropriate environments for children in order to promote greater awareness and vigilance by staff to routinely consider if there is a child in the household and the appropriateness of that environment.

MHSCT should review interagency work with dual diagnosis and mental health problems in relation to child protection issues to be undertaken in order that guidelines for child protection and improved clinical safety in dual diagnosis, particularly, are improved.

MHSCT should review current cases to ensure that child protection issues have been considered.

MHSCT should revise its risk assessment system to take account of chronological risk history and child protection issues for all children

5.8 CAFCASS

When allegations of domestic violence are serious enough to consider a finding of fact necessary or to have implications for the safety of the child or parent, and where there has been a history of social work involvement, the Child and Family Reporter (CFR) should not rely on telephone contact with the social worker. The CFR should request to examine the child's file in full. This is reliant on agreement with CFSC.

Where any evidence is found to support concerns about domestic violence this should be documented for the court. A chronology as an attachment to the report may be helpful. The chronology should contain relevant information from other agencies.

When a finding of fact hearing is recommended by the CFR, the CFR should make their best endeavours to attend court for the directions hearing or hearing when this is considered. The CFR should consider sending a letter to the court when filing the report to request the court to consider the views of the CFR if the recommendation is not to be followed. If necessary protocol agreements with the courts should be developed.

Full interview notes should be kept on files (CAFCASS record keeping policy being finalised.)

There should be a debate and agreement about good practice regarding the extent of responsibility that lies with the CFR in providing information to the court on which to make findings of fact. The nub of this lies in the perception of whether this is a legal process or a welfare process on behalf of the child.

Enquiries about other people within the household who have significant care or contact with a child is recommended.

5.9 POLICE

Officers within divisional public protection investigation units dealing with domestic violence incidents, should ensure that the details of any actions taken in relation to the incident are fully recorded within the relevant section of the family support unit database. This will ensure accountability and will facilitate evaluation and risk assessment of the circumstances.

That Greater Manchester Police should ensure that appropriate training, processes and procedures are in place to enable all staff to

be best able to support the aims and objectives of the Children Act 2004 in relation to safeguarding and promoting the welfare of children. Training should include mental health issues and the recognition and response to potential risks to children.

5.10 **The recommendation within the management review from South Manchester University Hospitals NHS Trust has already been implemented as follows.**

Nursing documentation has now been designed and implemented with SMUHNT to ensure that all appropriate action/ liaison is carried out and is clearly documented. This documentation will be filed within the A&E record (which is now scanned) and within the hospital notes (if the child has hospital notes).