Oldham Safeguarding Children Partnership

Serious Case Review :

'CHILD O'

Executive Summary for Publication

If you have any queries, please contact the chair of Oldham Safeguarding Children Partnership

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Note from the Local Safeguarding Children's Board (LSCB):

At the time that this review was commissioned by the Local Safeguarding Children's Board the cause of death was unknown, and injuries, along with previous child protection concerns led professionals to believe that abuse and/or neglect could have been a factor in Child O's death.

However, at the time of publication the post-mortem report has been received which states,

Dr … summarises that postmortem examination neither proves nor excludes traumatic head injury as the cause for bleeds. The presence of previous fractures and bruising raises suspicions, but his underlying medical conditions predispose to such bleeds, so no final conclusion can be reached.

The final conclusion was ***unascertained."***

The Safeguarding Board has agreed to the publication of the review on the basis that valuable learning has been gained which will improve future practice.

1. Introduction

1.1 This Serious Case Review tracks Child O's journey from his arrival in the UK at age 16 months to his death 18 months later. It aims to establish the strengths and weaknesses of his involvement with safeguarding professionals and their agencies and to identify and consider critical moments in his life, key interventions and missed opportunities. The Terms of Reference period therefore spans from Child O's arrival in the UK in November 2016 to his death on 10th April 2018.

1.2 The review is systemic in its approach and aims to provide an analysis of any systemic or underlying reasons why actions were taken or not in respect of matters covered by the report[1] and to lift them into more general practice in order to identify future weaknesses within the safeguarding system.

2. Background

2.1 Child O was of Pakistani heritage and was born in June 2015 in Pakistan. Unfortunately following a difficult delivery, Child O suffered Perinatal Hypoxia[2]. He was brought to the UK to live with his father in November 2016 by his aunt, while his mother remained in Pakistan to care for her newborn and await a visa.

[1] Chapter 4 Para 36 *Working Together 2018*

[2] Perinatal hypoxia is a medical condition resulting from deprivation of oxygen at birth that lasts long enough to cause physical harm, usually to the brain.

2.2 On 11th February 2017, Child O was found to have multiple fractures with no known cause. A Section 47 enquiry was completed. At the time of these injuries, Child O was living with his father, his uncle (father's brother) and his wife (paternal aunt). His mother remained in Pakistan. Following the injuries, Child O became subject to a Care Order and his mother came to the UK to care for him. Father and paternal aunt were to have only supervised contact. Child O's cousins (children of aunt) were all placed on Child Protection Plans (CP Plans) and were taken into Local Authority Care. The eldest 4 were returned home on 7th March 2017 but the youngest 2 remained in care. Court proceedings were initiated but, after advice from independent experts, the court ruled that there was not enough evidence to definitively state that Child O's injuries were non-accidental. All contact restrictions for father and aunt with Child O were therefore removed. Aunt's children were removed from CP Plans. Child O had not been placed on a CP Plan because he was deemed to be safe in the care of his mother during the investigation.

2.3 Following the court ruling in October 2017, Child O's aunt again became very involved in his care and was present for most of his health appointments. On 31st January 2018, Child O was seen for a routine appointment by the Advanced Nurse Practitioner at the GP surgery with mother and aunt. Aunt and mother reported that Child O appeared to have a tendency to excessive bruising on his face, toes, and limbs. They suggested that the bruising to his face might be from floor play and the bruising to his feet might be from his boots. Child O was therefore referred on for further investigations but, despite the Advanced Nurse Practitioner not being concerned, there is nothing within Child O's records that suggests this reported bruising was considered in the context of previous safeguarding concerns.

2.4 In March 2018, plans were being made to remove Child O's Child in Need (CIN) Plan, but this decision was delayed as professionals raised concerns about aunt's increasing involvement in Child O's care. They reported that aunt appeared to be controlling of Child O's mother and appeared to be taking over. They also reported a deterioration in Child O's physical presentation.

2.5 On 26th March 2018, Children's Social Care (CSC) held a strategy meeting during which the decision was made that Child O's case should be escalated back to child protection. The physiotherapist working with Child O had reported that Child O's demeanour appeared to have changed and that he appeared to be fearful when his aunt approached him. It was reported that the previously happy little boy was now miserable and tearful on most contacts.

2.6 On 10th April 2018, Child O died suddenly and unexpectedly. He did have complex health needs, but these had not been thought to be life limiting. His health needs included: Perinatal Hypoxic Insult resulting in 4 limb Cerebral Palsy, Epilepsy, unsafe swallow with naso-gastric feeding, global developmental delay, visual impairment, and constipation.

3.Pen Picture:

3.1 Child O lived in a crowded home where his father, uncle, aunt and 6 cousins also lived. The house was owned by his uncle who worked long hours and was rarely seen within the home. Housing was an issue for the family and Child O's mother was keen to have a home of

her own with her husband, Child O, and their twins. Child O's uncle was considering buying another home and mother was hopeful that they might live there.

3.2 Child O's medical difficulties were complex, and it is difficult to get a picture of his character. He is reported by the physiotherapist to have been developing better in the care of his mother during the court case when he lived with her. At this time, he is described as smiling more, starting to make some sounds, and starting to bear some weight. This was described by professionals as 'amazing'. Once the court case was adjourned and Child O went back to live with his father and aunt, despite mother also being there, he was described as upset, giving few smiles and his condition deteriorating.

3.3 Child O was described by the Nursery he attended as 'well fed, chunky and happy'. He didn't like loud noises but very much liked to play with sand and other textured materials. He did have visual impairment, but his vision was reasonable, and he could certainly see his immediate environment. Nursery described him as preferring shiny objects and bright lights. He loved cuddles with his mother and especially smiled at her voice. Nursery felt that there was a good attachment between Child O and his mother.

3.4 The Paediatrician described Child O as showing no excessive crying when seen in Clinic. He couldn't support himself but was alert and aware of his own surroundings.

3.5 Many professionals noted the controlling nature of Child O's aunt. She presented herself as having parental responsibility (PR) to several professionals and this was rarely challenged. Over the phone, aunt did state on occasion that she was 'Mum' but did not do this when meeting face to face with professionals. Aunt did not, however, correct them when she was assumed to be mother.

3.6 Aunt was controlling of mother who did not speak English well. She often acted as translator for mother and would speak for her at medical appointments. Nursery raised concerns about the level of control exerted over mother by aunt, as did the physiotherapist and the social worker. Towards the end of Child O's life, more professionals became aware of the control, and aunt was challenged by the social worker and by health professionals.

3.5 A few weeks before he died, Child O's mother met with the social worker alone at Child O's nursery. This meeting had been instigated by mother. She highlighted her concerns about Child O and her relationship with her sister-in-law.

3.6 Child O died soon after this on 10th April 2018. He did not meet his twin siblings.

4.Summary of Findings:

	Finding
1.	The role of expert Court witnesses is not clearly understood by professionals. Their decisions are taken as final and may disagree with those who saw the child, worked with the professionals, and made the first assessment. The decision of the court is viewed as final by professionals and although there are ways to challenge, this is rarely carried out, mainly because the decision of the court is not routinely disseminated to

	staff involved in the case and the mechanism for challenge is not known by professionals.
2.	Greater Manchester's Bruising Protocol for Immobile Babies and Children was not used in Child O's case and is not widely known about by professionals working with children. The explanation for bruising in Child O, who was non mobile, was accepted and the protocol was not followed, leaving Child O at risk of harm, and potentially increasing the opportunity for disguised compliance by aunt. Other cases risk the same outcome.
3.	Professional challenge was lacking in this case. Aunt was allowed to translate for mother in several appointments when the choice was given rather than routinely inviting a translator. Professionals accepted that aunt had Parental Responsibility (PR) for Child O without question or challenge. When police challenged the decision to cease Child Protection Plans for aunt's children, this was not accepted. Some individuals showed tenacity and professional curiosity/challenge but currently this continues to lack co-ordination and means that the full picture for a child is not gained. The 'lived experience' of a child is not always fully known and attempts to seek this are ineffective.
4.	The thresholds for the Children with Additional Needs Team to become involved with a child are not clear and neither is the mechanism for referral. CSC tried several times to engage with the team who did not attend meetings and who felt their involvement might not be required because of the support Child O was already receiving. Front line professionals advised that it is still current practice that cases are difficult to refer to this team and the thresholds are not understood by them. This means that the most vulnerable children may not be protected.
5.	Some members of Child O's family were invisible to professionals. Father and Uncle who lived in the household with Child O, hardly featured in professional visits or assessment. Child O was assessed with only aunt as his main carer as mother was not in the UK. Professionals involved in the assessment and care of children in Oldham advised that hidden males were a systemic issue.
6.	Information-sharing between agencies is not always robust enough. Recording of detail regarding those living in the household where mother and Child O stayed during the court process was not shared between CSC and Greater Manchester Police. CSC placed Child O with his mother at a different address which wasn't shared with police and therefore no checks were undertaken and no information about those living at the address was shared with CSC. Mother being locked in at this address was also not shared. Details of how mother was related to those she stayed with were not known. Agencies had different information about who was caring for the children in Pakistan, police were not aware of the request to attend a strategy meeting, health records are difficult to gain information from because they are handwritten without detail. There were concerns held by several agencies which had not been collated and were not shared until the physiotherapist shared her concerns. Those making decisions regarding risk therefore did not have the complete picture and could not assess accurately.

5.Findings in Detail and Analysis of Practice

5.1 **Finding 1:** The role of the expert Court witnesses is not clearly understood by professionals. Their decisions are taken as final and may disagree with those who saw the child, worked with the professionals, and made the first assessment. The decision of the court is viewed as final by professionals and although there are ways to challenge, this is rarely carried out, mainly because the decision of the court is not routinely disseminated to staff involved in the case and the mechanism for challenge is not known by professionals.

How did this manifest in this case?

5.2 In Child O's case, the doctors who first saw the injuries to his legs and the x-rays showing the previous injuries (3 fractures) felt that these were highly likely to be non-accidental injuries. They raised child protection referrals, and these resulted in Child O's mother arriving in the UK to care for him away from the family home. These referrals also led to aunt's 6 children being subject to Interim Care Orders and later placed on Child Protection Plans. 4 of the children were returned home on Supervision Orders and the youngest 2 remained in foster care during this time.

5.3 The medical opinion of the Oldham doctors was that the explanation of a 14month old child falling on Child O a week earlier and causing the latest fracture was not consistent with the injury itself. The Consultant Paediatrician sought a second opinion from the Registrar Paediatric Radiologist who concurred with this assessment, feeling that such an injury would be associated with significant force, greater than had been reported.

5.4 These medical opinions are what led to the initial Care Proceedings and Child O was made the subject of an Interim Care Order in March 2017. However, the Court appointed expert witnesses to provide the proceedings with independent advice. The role of an expert witness is summarised as: 'The expert evidence presented to the court should be, and seen to be, the independent product of the expert uninfluenced as to form and content by the exigencies of the litigation. An expert witness should state the facts or assumptions upon which his opinion is based. He should not omit to consider material facts which could detract from his concluded opinion.' *Toulmin HHJ 2000*

5.5 In this case, it was clear from professionals involved that they did not understand this need for independence for the court and therefore why the original opinions of the Oldham doctors were not used in court. They were also confused as to why the expert witnesses did not speak to the Oldham doctors or seek their opinions. Professionals felt that the original view had been correct and were unclear why the expert opinions had not been challenged, asked to further explain their view, or spoken with the Oldham doctors regarding their opinions.

5.6 This concern for professionals was compounded by the understanding that the court's decision is final and cannot be challenged. In this case, many of the professionals involved in Child O's care had found out about the court ruling from aunt who had contacted them to say that the court had ruled in the family's favour and therefore the children, including Child O,

had come home. Some professionals found out about the outcome of the court case sometime later and felt that by this time it was too late to challenge. This included the Paediatrician working with Child O who had, because of his medical history, built a relationship with him and continued to work with him following his injuries.

5.7 Professionals at the front-line practitioners' meeting reported that their understanding was that courts were moving away from the role of an expert witness, instead accepting that the professionals raising the original concerns were experts themselves. Professionals were not clear that the court appointed expert witnesses had to be independent of the case and the child. Others felt that the change of decision between the Oldham Doctors and the expert witnesses came 'out of the blue' and then wasn't challenged. They felt that it was unique to Child O's case that the original evidence appeared overwhelming and then the decision was reversed.

5.8 In the case of Child O, all professionals involved felt that a post Court multi agency meeting would have been useful. This would have been a mechanism for advising all professionals of the court outcome, but also for planning of future work with Child O who still had a serious injury which was unexplained. Police tried hard to keep aunt's children on CP Plans because the family had been so unwilling to cooperate and because there had not been an assessment following Child O moving back into the household and his mother living there for the first time. This was overruled. Child O had never been on CP Plan because he was removed from the situation to live with his mother who had not been in the UK when the injuries happened. Child O was to be managed on a Child in Need Plan via the Children with Additional Needs Team, however the family refused to engage with the CIN Plan and failed to attend the first meeting. The Children with Additional Needs Team also failed to attend and professionals were unclear regarding their thresholds (see Finding 4 below). All of this meant that Child O went from an Interim Care Order following a serious injury to moving back to the household with little input and no assessment of future risk.

The Current Picture

5.9 All cases which go to Court for Care Proceedings because of a possible non accidental injury will include evidence from an expert medical witness. In Oldham, the rate of children in care equates to 68 per 10,000 of the under 18 population (*Oldham Children's Trust 2015-19*). A percentage of these will have been to court for non-accidental injuries. The number of children aged between 0-19 in Oldham in 2015 was 64,100 (27% of the population) (*Public Heath England 2017)* which is expected to rise to 65,100 by 2019. This means that there are approximately 435 children in care in the Local Authority area. The understanding of professionals involved in the case of Child O is unlikely to be different from the understanding of their colleagues working with other children. It is therefore likely that the role of the Expert Court Witness is not widely understood, leading to a feeling of frustration in professionals where they had assumed the decision to be clear, which is compounded by an inability to challenge.

5.10 Those working outside of the Court system do not understand the mechanism to challenge a Court's decision. For the Child's Appointed Court Guardian to challenge, there would need to be a pre-Court professionals' meeting to challenge the views of the Court Expert Witnesses. There is no 'post court' multi agency meeting to feed back the decision of the court to practitioners who must continue to work with the family. This means that in all cases where a medical expert witness is used and the thresholds for Care Proceedings are not met, professionals might not hear the outcome and do not know how to raise a challenge if appropriate. This is despite the original doctors feeling that injuries were non-accidental. Following court, cases are closed sometimes without further meeting because they do not meet the thresholds, but the child remains with an unexplained injury. It is likely that this continues to happen with other cases because there is no mechanism to share the Court finding with professionals involved, to look at risk management following the case not meeting the thresholds or to look at whether the Local Authority could challenge a decision made in Court.

5.11 Finding 2 Greater Manchester's Bruising Protocol for Immobile Babies and Children was not used in Child O's case and is not widely known about by professionals working with children. The explanation for bruising in Child O, who was non mobile, was accepted and the protocol was not followed, leaving Child O at risk of harm, and potentially increasing the opportunity for disguised compliance by aunt. Other cases risk the same outcome.

How did this manifest in this case?

5.12 Greater Manchester's Bruising Protocol for Immobile Babies and Children states; "Any bruising or a mark that might be bruising, in a child of any age who is not independently mobile, that is brought to the attention of any professional (including GPs) should be taken as a matter for inquiry and concern. Unexplained bruising (or bruising without acceptable explanation) in a child who is not independently mobile must always raise suspicion of maltreatment and should result in immediate referral to Children's Social Care Service as a urgent paediatric concern. 'It should be acknowledged that on occasions it can be difficult to know if a skin lesion is suspicious or not e.g., Mongolian blue spot, haemangioma. Where there is diagnostic doubt regarding the nature of the skin mark or lesion, an immediate discussion should be had between the referrer and the paediatrician on call or the child's GP. A decision should then be made about whether to proceed automatically to social care or obtain medical review (same day) first'" (*Bruising Protocol 2015*). The protocol in Child O's case was not followed and there are examples of bruising being identified in a child (non-mobile) which were not addressed by following the protocol. For example, 29th January 2018 mother and aunt brought Child O to the GP surgery because he was vomiting. While there, mother showed the nurse a small, circular bruise on Child O's cheek and one on each foot (3 bruises in total). The facial bruise was old and fading and they advised that they didn't know how he had been bruised but that he had been lying on the floor. The bruises to his feet were identical and mother and aunt suggested that they might have been caused by Child O's Pedro boots. Following wider team discussion, the GP practice shared this information with CSC but caveated this by stating that they were not worried about the bruising. A paediatric opinion

was not sought as per the Bruising Protocol for Immobile Babies and Children. Four days later, a paediatrician did review the notes for Child O and requested a child protection medical examination. Mother was asked whether Child O could stay elsewhere in the interim, but she wanted to stay with him and so an alternative safety plan was put in place and mother and Child O went to stay with a relative. During the medical, Child O had no significant bruising but in order to investigate mother's concerns about recurring bruising, a blood count and clotting screen were taken. Medics felt the bruise to Child O's cheek was unlikely to be deliberate and he was allowed to go home. The bruising does not appear to have been seen in the context of a child who had, less than a year earlier, received a serious unexplained injury while living in the same household.

5.13 Professionals involved in Child O's case felt that the bruising seen by medics had been out down to Child O's disability rather than any risk he might be facing.

The Current Picture

5.14 It has become apparent that doctors within the Pennine Acute Hospitals NHS Foundation Trust do not use the Greater Manchester Bruising Protocol for Immobile Babies and Children, instead referring to the National Institute for Clinical Excellence (NICE) guidance, *When to Suspect Child Maltreatment.* However, this guidance, while longer and covering a wider area of guidance, also states at paragraph 1.1.2; "Suspect child maltreatment if there is bruising or petechiae (tiny red or purple spots) that are not caused by a medical condition (for example, a causative coagulation disorder) and if the explanation for the bruising is unsuitable. Examples include bruising in a child who is not independently mobile".

5.15 The Bruising Protocol is not used by all staff because of different commissioning arrangements. This means it is somewhat diluted by other, wider guidance. The Protocol itself is not widely known about. Professionals who attended the multi-agency front line professionals' meeting, felt that explanations for injury in children are often attributed to equipment or disability because professionals are more ready to accept this than the possibility of abuse.

5.16 The Government guidance *Keeping Children Safe in Education 2018* has recognised the concerns for children with additional needs, stating at para 107; "Children with special educational needs (SEN) and disabilities can face additional safeguarding challenges. Governing bodies and proprietors should ensure their child protection policy reflects the fact that additional barriers can exist when recognising abuse and neglect in this group of children. These can include assumptions that indicators of possible abuse such as behaviour, mood and injury relate to the child's disability without further exploration". It seems reasonable to assume that the same should be considered for children in medical situations. This does not appear to be the case in Oldham.

5.17 **Finding 3.** Professional challenge was lacking in this case. Aunt was allowed to translate for mother in several appointments when the choice was given rather than routinely inviting a translator. Professionals accepted that aunt had Parental Responsibility (PR) for Child O without question or challenge. When police challenged the decision to cease Child Protection Plans for aunt's children, this was not accepted.
Some individuals showed tenacity and professional curiosity/challenge but currently this continues to lack co-ordination and means that the full picture for a child is not gained. The 'lived experience' of a child is not always fully known and attempts to seek this are ineffective.

How did this manifest in this case?

5.18 In this case, there were several examples of lack of challenge. On 17th November 2016, Child O attended the Paediatric Clinic for the first time. Aunt attended with him. There was no enquiry regarding where parents were or who had Parental Responsibility. Professionals are of course happy that the child has been brought to an appointment and often this is by a wider family member but agreed it would have been good practice to have asked the question about PR and to identify the person bringing the child to clinic.

5.19 On 10th February 2017 when Child O was brought into hospital by ambulance and was found to have fractures of his legs, aunt advised A&E staff that she had Parental Responsibility (PR), and this was accepted without question. Many professionals noted the controlling nature of Child O's aunt. She presented herself as having parental responsibility (PR) to several professionals and this was rarely challenged. Over the phone, aunt did state on occasion that she was 'Mum' but did not do this when meeting face to face with professionals. Aunt did not, however, correct them when she was assumed to be mother.

5.20 Aunt was controlling of mother who did not speak English well. She often acted as translator for mother and would speak for her at medical appointments. This was not challenged, neither was a translator routinely requested at each appointment because mother (who had PR) did not speak fluent English. Oldham Interpretation and Translation Unit Policy and Procedures state: "Using friends, colleagues, members of the family and children as interpreters must be avoided as this may have legal implications for the officer… all interviews and home visits must be carried out by approved interpreters through Oldham Language Shop" (*Oldham Council)*. In some cases, medical professionals were bilingual (e.g., the GP) and able to communicate directly with mother. In other cases, however, in particular where the bruise to Child O's face was seen, there was no translator.

5.21 Where the management of Child O's case was challenged, for example following the Court ruling at the RCPC meeting on 9th November, the police challenged the removal of aunt's children from Child Protection Plans, this challenge was overruled. In order for challenge to be effective, it must be well executed and accepted. In this case, the police executed their challenge appropriately within the RCPC meeting, and provided a persuasive rationale, but this was not accepted and an opportunity to monitor and therefore gain a more effective picture of life within this household for Child O and his cousins was lost. Greater Manchester Police did meet with the IRO on 30th November 17 who agreed to assess the family again, but this was not completed until January 2018, some 3 months after the court

decision was made. This meeting, while good practice, was not completed within the formal Escalation Process which might have been more effective.

5.22 Police at this time could have used Oldham's Escalation Policy which states: "At no time must professional disagreement detract from ensuring that the child is safeguarded. **The child's welfare and safety must remain paramount throughout**. There is a range of situations in which professional disagreements may occur. Examples are given below although this list is not exhaustive:

- A referral is not considered to meet the Threshold for Assessment by the MASH
- Children's social care conclude that further information should be sought by the referrer before a referral is progressed.
- There is disagreement as to whether child protection procedures should be invoked.
- Children's social care and the police place different interpretations on the need for single/joint agency response in relation to a child protection enquiry
- There is disagreement regarding the need to convene an initial child protection conference.
- **The outcome of Case conference**
  There is disagreement over the sharing of information and/or provision of services – refer to Information Sharing and Confidentiality.
- There is disagreement over the outcome of any assessment and whether the appropriate plan is in place to safeguard and promote the welfare of the child.
- There is disagreement about the findings of a health assessment.

The professionals should attempt to resolve differences through discussion and/or meeting within one working day, but if professionals are unable to resolve their disagreement, their disagreement **must** be reported by them to their managers or equivalent and logged on file with the outcome". (*Resolving Professional Disagreements 2018).* This was not formally used in Child O's case and so the children came off their CP Plans without further assessment of the changed situation.

The Current Picture

5.23 Speech and Language Services are clear that they always use translation services, and professionals felt that most families were happy to accept translators. All stated that it can be difficult to access an available interpreter and so unannounced visits are sometimes completed without one. Many of the medical staff spoke Urdu or Punjabi and so were able to communicate directly with mother. However, many of the nurses did not and where there was no-one else to translate for them, this did cause a concern. Health staff also raised the difficulty for translators when dealing with complex medical language for children with significant difficulties.

5.24 While it is not uncommon for the wider family to bring a child to a medical appointment, all health professionals were clear that they should be finding out who has PR and confirming the relationship of the child with the person who has brought them to the appointment each

time. Any concerns could then be easily raised to a proactive manager (or equivalent) and a multi-agency discussion could take place if appropriate. Most practitioners felt empowered to do this but did raise a concern that some might not have the confidence.

5.25 It is always difficult to know of the cases that should have been escalated, had PR challenged or been offered a translation service and were not. However, practitioners from within Oldham felt that these issues were not particular to Child O's case and were happening within other cases being held by them or their colleagues.

5.26 **Finding 4** The thresholds for the Children with Additional Needs Team to become involved with a child are not clear and neither is the mechanism for referral. CSC tried several times to engage with the team who did not attend meetings and who felt their involvement might not be required because of the support Child O was already receiving. Front line professionals advised that it is still current practice that cases are difficult to refer to this team and the thresholds are not understood by them. This means that the most vulnerable children may not be protected

How did this manifest in this case?

5.27 on 17th November 2016 Child O was referred to the Community Paediatrician but was not referred to Social Care's Children with Additional Needs Team. Referral process to this team appeared confusing and as a consequence the team was not approached to assist Child O who had not been in the UK for very long at this time.

5.28 Following the court case going no further, the subsequent plan was for the Children with Additional Needs Team to support Child O and his family under a Child in Need Plan. Unfortunately, the social worker on the case left the Local Authority shortly after this. However, the new social worker met the family for on 20th December 2017. She discussed a transfer to the Children with Additional Needs Team with mother who was agreeable to Child O being transferred. This had been the plan since his return to aunt's and yet 2 months had passed since moving back into the family home and the referral had not been made. A case discussion between the social worker and the team manager of the Children with Additional Needs Team was held which agreed that a referral should be made, but because of the number of professionals already involved, there was doubt from the Children with Additional Needs Team about whether a social worker was required.

5.29 Adverse Childhood Experience (ACEs) research[3] shows us that adverse experiences during childhood are linked with issues such as risky health behaviours, chronic health conditions, low life potential and early death. As the number of adverse experiences increases, so does the risk for these outcomes. Child O's childhood was full of such experience; his disabilities, leaving his mother so early, his aunt's controlling behaviour, his unexplained injuries and the overcrowded household were all adverse. Difficulty in his case

[3] Adverse Childhood Experiences, US Dept of Health and Human Services

being sited within the correct team and having a proper support plan certainly added to this sense of adversity for Child O.

The Current Picture

5.30 Practitioners attending the front-line professionals' meeting were unanimous in their view that the thresholds for the Children with Additional Needs Team were confusing and seemed somewhat higher than they should. Health colleagues felt that the Additional Needs Team often pushed children with complex medical needs back into the medical arena, whereas what was really required was social care expertise in parenting capacity and the safety of the household. They did not feel that this was an issue specific to Child O but happened in other complex medical cases. Primary health care was concerned the most about thresholds which appear confusing, especially for children with more than one medical need.

5.31 As well as the thresholds being difficult to understand, front line practitioners also reported that families receive a mixed response from the Children with Additional Needs Team and do not understand why some are placed under this team and others are not. This appears to be an issue not confined to Child O's case.

5.32 **Finding 5** Some members of Child O's family were invisible to professionals. Father and Uncle who lived in the household with Child O, hardly featured in professional visits or assessment. Child O was assessed with only aunt as his main carer as mother was not in the UK. Professionals involved in the assessment and care of children in Oldham advised that hidden males were a systemic issue.

How did this manifest itself in this case?

5.33 In Child O's case, at first, he lived with his father, his brother and his brother's wife (aunt) and their family. Child O's father appeared to delegate his responsibility as parent to his sister-in-law. He would sometimes be in the room with professionals but wouldn't participate in discussion and on occasion, turned his back. Professionals felt that he added little value as a parent within their roles and in fact provided opportunity for aunt to act as parent to a greater extent, adding 'permission' for her to engage more and more with professionals.

5.34 Uncle, father's brother, owned and occupied the house in which they all lived, but is completely invisible during assessment and appointments. He is thought to have worked long hours and been away for some time. However, very little is recorded about him and he was not part of the care of Child O despite him living in his household and being cared for by his wife.

5.35 Children's Social Care are clear that they would always try to speak to both parents of a child being assessed, but in Child O's case, this was difficult at first because mother was not living in the UK. For Child O, neither of his parents featured highly in his initial assessment or early care, which centred mostly around Child O and aunt.

5.36 The NSPCC's 'Hidden men: learning from case reviews' (2015) states that; "Professionals sometimes rely too much on mothers to tell them about men involved in their children's lives. If mothers are putting their own needs first, they may not be honest about the risk these men pose to their children. Professionals do not always talk enough to other people involved in a child's life, such as the mother's estranged partner(s), siblings, extended family, and friends. This can result in them missing crucial information and failing to spot inconsistencies in the mother's account." It goes on to state that; "Failing to identify and / or engage with fathers ignores their fundamental importance in a child's emotional and psychological development. When a vulnerable child's needs are not being met by their mother, an estranged father may be able to provide the protection and stability that the child needs." Although Child O's father was not estranged, he behaved in a similar way and professionals failed to engage with both him and his brother, both of whom were within the pool of possible perpetrators for Child O's injuries.

5.37 Children's Social Care always try to see both parents but felt that within Child O's case the biggest concern was the dynamics of the relationship between father and aunt. Potentially within Child O's culture, father saw his role in the raising of children as passive and couldn't see that he had anything to add to discussions. When challenged, or not welcoming an unexpected visit however, father would turn his back to express displeasure with a professional. Later, also when challenged, aunt displayed the same behaviour.

The Current Picture

5.38 Professionals felt that within the Oldham demographic, it would not be unusual for father to be away at work, or no longer with mother. Some health practitioners would always ask for both parents to be present at any meeting, but for others, such as the GP services, this would simply not be possible.

5.39 Professionals felt that both parents being involved in the assessment and care of a child with complex medical needs was essential. They agreed that this was often an issue as it is difficult to get fathers to engage and they are therefore dependent on the mother's (in this case aunt's) view of the men in the household. Professionals felt that the wider family was important to engage (in this case uncle) because their roles within the life of the child are important. All felt that hidden males in assessments were a systemic issue in Oldham.

5.40 **Finding 6**

Information-sharing between agencies is not always robust enough. Recording of detail regarding those living in the household where mother and Child O stayed during the court process was not shared between CSC and Greater Manchester Police. CSC placed Child O with his mother at a different address which wasn't shared with police and therefore no checks were undertaken and no information about those living at the address was shared with CSC. Mother being locked in at this address was also not shared. Details of how mother was related to those she stayed with were not known. Agencies had different information about who was caring for the children in Pakistan, police were not aware of the request to attend a strategy meeting, health records are difficult to gain information from because they are handwritten without

detail. There were concerns held by several agencies which had not been collated and were not shared until the physiotherapist shared her concerns. Those making decisions regarding risk therefore did not have the complete picture and could not assess accurately.

How did this manifest itself in this case?

5.41 In Child O's case, there were numerous times that information wasn't shared, recorded, or considered. For example, following his injuries and being hospitalised, Child O was discharged from hospital on 16th March 17 into the care of his mother on the understanding that he would not have any contact with his father, uncle, or aunt. Mother was living at this time with another relative, but it is not clear who this relative was. It is possible that the relative was a cousin on father's side. What is clear is that there was an issue regarding a member of the household having an episode of mental ill health and causing a domestic incident while Child O was living at the property. The police were called on 10th September 17 and recorded Child O being present. An urgent response marker had previously been placed at the address in August 2016 with regard to one of the occupants being suspected of firearms offences. The occupant, and 3 other relatives were in the house with 2 children age 10 and 11. The family had become concerned regarding the occupant's most recent behaviour and were concerned that he might have been taking something and might hurt himself. It does not appear that Children's Social Care were aware of, or had risk assessed all of the members of the household and had not been aware of this domestic issue which Child O was in the property, although Greater Manchester Police documented that they did send the DASH risk assessment following the incident to Children's Social Care on 11th September 2017.

5.42 While staying at the same address, on 9th June 2017, the Speech and Language Therapist attempted to visit. There was no reply and it later transpired that Child O and mother were locked in the address. The Speech and Language service stated that their concern had been raised with CSC, but it is not clear what happened at this time or how mother and Child O had been locked in and couldn't open the door.

5.43 Health records for Child O recorded that his twin siblings were being cared for in Pakistan by Maternal Grandparents. CSC records stated that they were being cared for by Paternal Grandparents. While the issues for safeguarding were not to do with the twins in Pakistan, whether or not they were being cared for by Paternal Grandparents is of importance. If not, then it is possible that the links in the address where Child O and mother were staying were with father's family and therefore potentially impacted on the coercive control over mother and the subsequent safety of Child O.

5.44 The nursery attended by Child O with mother, had good records and were concerned about the control exerted over mother by aunt. However, they did not share this until asked for an opinion by the second social worker who had identified the control and had also been contacted by the physiotherapist who was worried. At this point in Child O's case, all agencies came together to share their concerns. Up until then, each agency had collated their own concerns, some of which were not committed to record, and had not shared them in a multi-agency way. It is possible that a post Court meeting would have assisted with this information sharing.

The current picture:

5.45 For children who have not been through the court process and therefore for whom we are not recommending a post court meeting (see Recommendation 1 below) concerns may be held by several agencies and not shared. In Child O's case, there were ongoing multi agency meetings and still the information had not been shared. It seems reasonable to surmise that this is happening for other cases. Records are all kept in different ways (computer/handwritten) and so are difficult to put in one place. A consolidated chronology at the very first multi-agency meeting might help with this, as would a fixed multi-agency agenda item requesting professionals to share concerns in order to build a multi-agency picture.

5.46 Professionals on the front line expressed a concern about being able to communicate with each other outside of physical face to face meetings. The email service between paediatrics and CSC for example, is insecure and so only non-specific anonymous details may be shared. GPs can't see the child protection records for their own patients. This makes it hard for them to know whether what they are seeing in clinic would be a concern if linked with other information.

5.47 Social Care also expressed concern about being able to contact the police regarding attendance at strategy meetings. In this case, police were unable to trace any record of being asked to attend the meeting. Social Care tried hard to contact them, but this took 7 days and Child O died the day after it had been agreed. Children's Social Care feel that this is not an issue particular to Child O.

6.Good Practice

6.1 There is much evidence of good practice across agencies, despite the challenges. Although it was difficult to engage with translation services for short notice meetings, health practitioners who could speak the same language as mother were available wherever possible and this was helpful.

6.2 Early challenge by the police on aunt's children being removed from Child Protection Plans was good practice and had been clearly thought through.

6.3 Nursery had a very clear picture of Child O as a person in his own right and had taken time to record this. This is something often missing for children with severe medical needs.

6.4 The tenacity of individual members of staff who were concerned about Child O showed excellent practice. These included (but are not limited to) the second social worker and the physiotherapist. Both showed clear professional curiosity and would not be swayed in their goal of seeking information, challenging family members where necessary and keeping Child O as their complete focus. The role of the Emergency Duty Team should also not be forgotten. It is not usual practice for them to conduct a home visit for an open case, but, in agreement with

and at the request of the social worker, this took place over a weekend and was very supportive. This was the same for many professionals who followed procedure and tried hard to support the family as a whole.

6.5 Arranging to speak to mother at the nursery and listening to her concerns, taking them seriously and reassuring her that she was believed and supported was good practice.

7.Conclusion

7.1 The postmortem for Child O is now complete and may, coupled with any inquest held has not added any additional learning. However, the main learning from this Serious Care Review is that professionals need to better understand the court process and the role of expert witnesses in order to successfully protect children. Challenge to the court is not unusual and can be carried out by the child's appointed Court Guardian. However, to do this, professionals must meet prior to the hearing when all of the court reports have been received. This does not routinely happen. In the same way, after the court hearing, should the LA feel that information hasn't been taken into account, legal advice can be sought on court challenge.

7.2 A post court meeting for children who have had significant and as yet unexplained injuries would assist agencies in moving forward. The child may well still need a level of support and monitoring, especially if they have been removed from the family home during the court proceedings. In the case of Child O, and many like him, he had never been placed on a CP Plan. This is because he was classed as 'looked after' and it is not usual for a child in the care of the LA to also be on a CP Plan. However, it was not child focussed to place Child O back into the family home, this time with his mother, without further assessment or protection from a multi-agency plan. While the plan was to keep him on a CIN Plan, effectively this did not happen because the family failed to attend the meeting and asked for social care to withdraw as their presence was not adding to Child O's support.

7.3 There were missed opportunities to better protect Child O from injury. The house was overcrowded and the information regarding aunt's children previously being placed on CP Plans was not shared with health professionals responsible for the care of Child O who had been added to the family mix and had multiple, complex health needs. The fact the Child O was also without his mother at such an early age, living with a father who he had not lived with before and in the care of an aunt who had previously been alleged to have harmed her own children was not properly considered.

7.4 Concerns regarding overcrowding in the household were also not addressed, even after the court ruling where they accepted that it was possible one of aunt's children had fallen on Child O and cause his leg to fracture.

7.5 The safe placement for Child O during the court proceedings was not properly assessed and information known about the address and its occupants was not shared with CSC because they had not shared the address with police or asked for any formal police check on the address and its occupants to be carried out. Historical information could not therefore be shared. This

meant that despite the concerns at home, professionals were not properly informed as to the risk from the address where he was placed in order to be safe. Greater Manchester Police sent the DASH form for the incident on 10th September 2017 to the social worker when they realised that Child O was also at the address, but he continued to live there until October 2017.

7.6 Challenge regarding PR, use of translators and removal of Child Protection Plans did not go far enough to both protect Child O, or to provide a view of the lived experience within this household. In this particular case, it was important to be child focussed as Child O had no language and was unable to move himself away from danger or to show professionals how he felt in the way a child of almost 2 might usually be able to do. He was completely reliant on the tenacity of professionals. Despite the excellent practice towards the end of this case, when mother was met alone, listened to, and supported, no one provided her with an immediate 'out' of the situation. She was not offered a women's refuge or advised on her options as a victim of what was seen to be coercive control. It is possible that because of her culture and language difficulties, she would not have accepted such an offer, but despite this it was a missed opportunity to remove her and Child O from the situation.

8. Glossary of Terms:

OLSCB – Oldham Safeguarding Children Board
CAIT – Child Abuse Investigation Team (Police)
CSC – Children's Social Care
CP Plan – Child Protection Plan
DASH – Domestic Abuse and Sexual Harassment (assessment tool)
ICPC – Initial Child Protection Conference
IMR – Individual Management Review
RCPC – Review Child Protection Conference
SCR – Serious Case Review

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