OLDHAM
LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD J

This report will be published in line with statutory guidance. In order to preserve anonymity for the child and family the author has:

- Used initials to represent people
- Made no reference to the gender of the child
- Avoided the use of exact dates
- Not used any details of local services which could lead to the child and family being recognised

1. **Introduction**

1.1 This Serious Case Review (SCR) concerns Child J who at the age of 7 months was found to have serious non-accidental injuries. Following a pre-birth assessment of the parent's ability to provide safe care, Child J had been placed in foster care from birth. The baby was returned to the care of the parents aged six months, with the Local Authority sharing parental responsibility by way of a Care Order.

1.2 Child J is the first and only child of mother MJ and father FJ. Both parents experienced challenges in their own childhoods; MJ had been the subject of a Child Protection Plan whilst FJ was a child in care who experienced many placement moves. Both had been exposed to domestic abuse and alcohol abuse as children. As young adults, both parents had difficulties with their own emotional health and had a history of alcohol and/or substance misuse.

1.3 When FJ presented as pregnant, the midwife made a referral to Children's Social Care. A pre-birth assessment was completed which recommended an Initial Child Protection Conference and a legal planning meeting. Child J was placed in foster care from birth and the Local Authority initiated public law proceedings. Following a period of assessment it was agreed by all parties that that Child J should return to the care of the parents subject to a Care Order.

1.4 Nine weeks after returning to the parents, Child J was discovered to have bruising to the face when further medical examination revealing a total of ten injuries and a number of fractures. Child J had three healing fractures, the timing from which indicated separate points of trauma.

1.5 A police investigation commenced, and parents charged with Causing Grievous Bodily Harm with intent Section 18 wounding, next appearing in Court for 25th November 2016.

1.6 The matter was referred to Oldham Local Safeguarding Children Board (OLSCB) for consideration of Serious Case Review. Child J had been seriously harmed and, given the significant agency involvement in baby's short life history, it was evident that there was cause for concern regarding the way in which local professionals and services had worked together to safeguard and promote the child's welfare. The

Chair of Oldham LSCB made the decision to convene a Serious Case Review and the National Panel was notified.

2. Methodology

2.1 The OLSCB appointed two Independent Reviewers to facilitate the Review and to provide an Overview Report. The Review was overseen by a panel of senior officers from participating agencies, this included: -

- Greater Manchester Police
- Oldham Council Children's Social Care
- Oldham Council Independent Reviewing Service.
- RAID Access and Crisis Team
- Pennine Care Acute Trust
- Healthy Minds Oldham
- Addiction Dependency Solutions (ADS) Services Oldham
- Oldham Council Early Years Services
- The Children's Society Oldham
- Community Rehabilitation Services
- Pennine Care
- Cafcass
- North West Concurrent Planning Service

2.2 The Review focused on the multi-agency activity over a period of sixteen months from April 2014, the point of referral during pregnancy to Children's Social Care until July 2015 when the injuries to Child J were discovered. Each contributing agency submitted a 'Timeline of Events' accompanied by a short report which contained a narrative of the single agency reflections on the issues this case raised for their organisation. The individual agency timelines were then combined to illustrate the multi-agency activity in order to establish who knew what and when. The Review authors were able to meet with a range of practitioners who provided their insight into the interventions with the family, the strengths and vulnerabilities of multi-agency working locally and in particular how they impacted upon this case. The

Panel and Reviewers reviewed the timeline along with the reflections of the practitioners and this highlighted the significant events which became the focus for analysis.

2.3 The ongoing nature of the police investigation precluded the possibility of seeking a contribution from MJ and FJ prior to the completion. It is intended however, that their contribution and views will be sought once it is legally advisable to do so.

3. What was known to Agencies

3.1 The social history of MJ and FJ was known to multi-agency professionals and considered as part of the pre-birth and subsequent child and family assessment. MJ's own recollections of her childhood were positive, she indicated that she had a happy childhood and was very close to her family as an adult. MJ had required additional support in school, and although she secured employment upon leaving this was terminated when she faced the challenges of homelessness. MJ began binge drinking which led to episodes of self-harm; this was further exacerbated by anxiety, panic attacks and low moods. Prior to pregnancy MJ had accessed services through her GP in relation to alcohol misuse, suicidal ideation and mood swings and received support from Healthy Minds and Addiction Dependency Solutions (ADS).

3.2 FJ reported to agencies that he did not have any happy memories of his childhood. He became a child in care at the age of seven a result of parental alcohol misuse and domestic abuse. FJ advised that his only memories were sad. FJ experienced a number of placement moves, which included four foster placements, a children's home and a period of time in an Independence facility before leaving care. He experienced difficulties in school and became involved in anti-social behaviour, drinking and low level crime. In common with MJ, FJ had also accessed the services of Healthy Minds and Addiction Dependency Solutions through his GP.

3.3 In the five months prior to the commencement date for this Review, the Police had received eight contacts relating to the address of MJ and FJ. Six of these contacts related to anti-social behaviour and alcohol, one related to domestic abuse perpetrated by FJ and one related to MJ knocking on the door of a neighbour whilst intoxicated stating that she wanted to kill herself. MJ had been assessed by a

Community Psychiatric Nurse (CPN) which identified that she was experiencing low mood with anxiety and alcohol misuse. MJ told professionals that she had self-harmed in the context of alcohol misuse because FJ was spending time with friends.

3.4 FJ was supervised by the Community Rehabilitation Service (CRC) with a requirement to attend an alcohol programme. FJ was supported by an Offender Manager from CRC and a Counsellor from ADS who worked together to encourage and review his progress. FJ was considered to be managing a controlled drinking regime but also experiencing untreated mental health problems. Although FJ reported symptoms associated with poor mental health he missed two appointments at Healthy Minds this resulted in him being discharged back to the care of his GP. In July 2014 he was convicted of receiving stolen goods, on this occasion a report was prepared for Court by a Psychiatrist which concluded a high likelihood that the psychotic episodes detailed by FJ were precipitated by drugs. The psychiatrist suggested an experimental dose of anti-psychotic medication.

3.5 In the early months of MJ's pregnancy, FJ continued to attend the appointments at CRC and ADS where it noted that he achieved reduced drinking apart from one relapse; however his low mood and paranoia continued to be a matter of concern. In late May 2014, FJ reported to the Offender Manager that he had split up with his girlfriend and was living with a friend, but by the following week; FJ and MJ had resumed living together. In mid-June 2014, the midwife providing ante-natal care for MJ initiated a Common Assessment Framework (CAF) because she was aware that both parents had a history of Children's Social Care involvement as children and because of their involvement with alcohol and drugs.

3.6 In mid-July, MJ reported to the CPN that she was experiencing some anxiety and mood fluctuations and that she was resentful that she has given up drinking due to her pregnancy whereas FJ was continuing to drink. MJ was approximately 21 weeks pregnant when she contacted the police to report that following an argument, FJ had said he was going to self-harm. An ambulance was dispatched to the home however FJ refused treatment. Six days later, MJ contacted the police to report that FJ had punched the wall and ripped the wire from the intercom of the flat. MJ stated she

left the flat but returned because FJ was slamming the front door and shouting, she put her foot in the door to stop him when he slammed the door on her foot causing pain and injury. FJ was arrested for assault and stated whilst in custody that he was suicidal. The police spoke with mental health services who reported that he had been assessed and did not have diagnosed mental health issues. MJ subsequently withdrew the statement of assault, however, the police continued to charge FJ with Criminal Damage and Malicious Damage, and, noting the pregnancy, made a referral to Children's Social Care. FJ attended an appointment with the Offender Manager the day following his arrest, but did not report the events of the previous day. A further referral was made by the Offender Manager to mental health services because FJ stated he was concerned about this.

3.7 Four days after the incident, a CAF meeting was held and attended by the Midwife and Children's Centre. It was agreed that the midwife would make a referral to Children's Social Care, MJ continued to access ante-natal services throughout the pregnancy and a Family Support Worker was assigned to help MJ and FJ prepare for parenthood.

3.8 MJ was 25 weeks pregnant when a pre-birth assessment commenced by Children's Social Care. The assessment was completed by a newly qualified social worker who co-worked with a more experienced colleague. A further CAF meeting took place in September, attended by MJ and FJ, the Health Visitor and the Offender Manager when FJ reported himself to be alcohol and drug free. The Offender Manager believed that mental health services were not assisting FJ as was necessary, apparently unaware that FJ had failed to attend the appointments offered. The Named Nurse for Safeguarding was made aware of this concern and contacted the mental health service. It was discovered that FJ's case had been de-activated but also that he had been recommended anti-psychotic drugs. The Offender Manager made a further referral to mental health services, which included a copy of the psychiatric report prepared for the Magistrates Court in July. The referral outlined that FJ was hearing voices telling him to harm himself and that he was assessed as medium risk of harm in relation to domestic abuse, and low risk to himself and the public. FJ was assessed by a CPN in mid-October. He reported himself to be alcohol

free for the past four to five months and he was referred to an Early Intervention Service. FJ did not attend the four scheduled follow up appointments in December, January and February and March, three whilst legal proceedings were ongoing. MJ was referred by the CPN for high intensity CBT because she was having intrusive thoughts about family members becoming harmed. She subsequently attended two sessions of CBT to address anxiety but was discharged due to the forthcoming birth of the baby, and asked to self-refer back to Healthy Minds if she needed to do so in the future.

3.9 FJ was convicted of the damage offences and was given a Community Order with a condition to participate in a course Improving Relationships Supporting Change (IRSC). Through the CAF it was identified that the parents were in need of re housing, help with debt management and that because MJ needed to understand more about the impact of domestic abuse on children she would benefit from seeing an Independent Domestic Violence Advocate (IDVA). These issues were in addition to those of mental health, substance misuse and limited parenting knowledge and skills. The Family Support Worker noted that although both parents were motivated to work with her, they required much more practical input than was usual, particularly MJ.

3.10 The Pre-birth assessment was conducted over six sessions of direct work with MJ and FJ and focused on a range of issues including:-

- parental histories of vulnerability including their experience of being parented;
- parental mental health;
- substance misuse including drugs and alcohol;
- domestic abuse;
- offending behaviour;
- practical preparations for the care of a bay.

The assessment concluded that the FJ and MJ had significant deficits in their readiness and capacity to safely care for their baby and an Initial Child Protection Conference was convened.

3.11 In late October FJ failed to attend an appointment with the Offender Manager and was issued a first letter of warning. From mid-November he was required to attend

the IRSC programme in order to address domestic abuse twice a week for two and a half hours each session. Probation records indicate that a referral was made to the Women's Safety Worker as is standard, however, there is no further information to indicate whether this received or activated. FJ attended 8 out of 12 Core Sessions, the remaining four being completed on a one to one basis with the Offender Manager.

3.12 The Initial Child Protection Conference was held in early November and was attended by the Social Worker, Health Visitor, Offender Manager, Police, and Children's Centre. The unborn baby was unanimously made subject to a Child Protection Plan at birth under the category of neglect. The Conference further recommended that a legal planning meeting be held and that a Parenting Assessment Manual Software (PAMS) assessment of the parents should be completed. [1]

3.13 The Health Visitor and Family Support worker commenced intense Parentcraft sessions with FJ and MJ, to assess the parent's knowledge and include some teaching. The possibility of the baby being removed at birth was explored with the parents. They were upset although accepting that this could happen. A Core Group meeting was held with the Social Worker, ADS Counsellor, Health Visitor, Offender Manager, Family Centre and both parents present. MJ described feeling less anxious after commencing CBT and keen to continue drop in sessions at ADS. The meeting concluded that MJ and FJ were engaging well and making progress. A second Core Group was planned to take place following the birth, however this was cancelled because Child J had become Looked After and therefore subject to reviews under Looked After Children procedures. In early January, Child J was de-activated from the Child Protection Plan for the same reason.

3.14 Child J was born safe, well and healthy. Prior to the birth, the parents had been asked to sign an agreement under Section 20 Children Act 1989 to give consent to the Local Authority looking after their baby; they agreed to do this to demonstrate their willingness to cooperate with assessments and change. The Local Authority

[1] PAMs is an assessment tool which facilitates a methodical and functional approach to assessing practical parenting. A PAMS assessment is designed to provide a clear and visual profile of family functioning that targets both parenting support needs and child protection issues.

subsequently initiated public law proceedings and made application for Interim Care Order in respect of baby J. In planning for a foster placement, Children's Social Care considered a concurrent planning placement appropriate. The Local Authority had a contract with a voluntary adoption agency to recruit and assess carers for concurrency and utilised this resource[2]. Once Child J was placed, the Concurrent Planning Team service also took responsibility for contact, which included an element of supervision and instructive development of parenting skills. Contact was initially established at three times per week for 1 ½ hours, following review at twelve weeks this was increased to 3 hours. The contact took place in a venue specifically designed and well equipped for contact; however this was a substantial distance away from the parents' home and involved a minimum of an hour and half journey on public transport.

3.15 A CAFCASS Officer was appointed as Children's Guardian to represent the interests of Child J during the proceedings. An Advocates planning meeting took place in early in the proceedings when the Children's Guardian was not in attendance. The meeting agreed that a psychological assessment should be commissioned to report on mental health and substance misuse in addition to drug and alcohol testing. The Children's Guardian visited MJ and FJ at their home on the day of this meeting and advised them of what was being asked of them which they agreed to. FJ informed the Children's Guardian that he had completed the IRSC sessions with the Probation Service and was now taking full responsibility for the domestic abuse.

3.16 MJ was observed to be lacking in confidence in contact and FJ was taking the lead. Over time however MJ's confidence increased and within a few weeks it was considered that both parents were sharing the care of Child J. Both parents are recorded as being abstinent form drugs and alcohol and FJ reported an improvement in his mental health because of this. FJ was discharged from the ADS service following the completion of his Alcohol Requirement, his engagement was considered to be positive and he reported to be alcohol free. CRC records indicate

[2] The purpose of concurrent planning is to place babies and children generally under 2 years who may ultimately need adoption, but for whom there is a possibility of being reunited with birth parents, with approved adopters able to provide foster care whilst the court decides on the child's future. Primarily, this service offers the possibility of permanency without the child incurring moves in placement.

that then FJ said he was motived to continue seeing ADS but that the Offender Manager stated in his opinion this was not necessary.

3.17 The Concurrent Planning Project reported communication with the social worker to be problematic early into the partnership. The particular complexities of concurrent placements require sensitive and careful management, and the agency did not always feel that the aims and intricacies of the arrangement were always appreciated.

3.18 The first Looked After Child Review meeting took place in mid-January with MJ and FJ present. This meeting was two weeks outside of statutory timescales and professional attendees were given just two days' notice. The Health Visitor and Contact Supervisor could not attend and there was insufficient time to prepare detailed reports. A summary report from the Concurrent Planning Team was submitted by the Supervising Social Worker. The meeting was attended by a duty social worker with the allocated Social Worker joining towards the end of the meeting. The meeting noted that FJ and MJ had attended all contact sessions.

3.19 In the last week of January FJ missed four concurrent contact sessions and advised that he was unwell with a bad cold. This resulted in a gap in contact of ten days. FJ rejoined the contact on the encouragement of the Social Worker, he left the first contact after twenty minutes. The Supervisor advised him he must take responsibility for his health and seek medical advice if needed. FJ met with the Offender Manager two days later and did not report being unwell or missing contacts, the same day; MJ attended contact alone and reported that FJ remained unwell. FJ returned to the contact, and when he was critical of MJ she was more assertive in responding to this. MJ had continued to attend all contact alone and had also attended an Aftercare/Recovery programme voluntarily at ADS. Throughout February MJ and FJ were observed to be working well together in contact.

3.20 A second Advocates Meeting took place attended by all parties' legal representatives, the Psychologist and the allocated Social Worker. The following information was significant in this meeting :

- The Psychiatrist described the parents as 'damaged and dysfunctional';

- When asked whether separate contact should be considered, the Psychiatrist indicated that given FJ's background, 3 hours of contact could be too long for him;
- Progress to date was identified with clear drugs tests and cognitive functions tests that revealed no learning disability in either parent;
- The Psychiatrist suggested that given the difficulties, a further six months would give more time to see if parents could sustain the changes they were making;
- That the parents need support as they have no meaningful support networks.

The Psychiatrist concluded that they would need 18 months to two years to apply themselves to meaningful change, and that they could do this work with a child in their care. It was considered that there was no direct physical risk to Child J but that the main risk was if the parents' relationship broke down and they reverted to their previous behaviours. The PAMs assessment concluded and assessed 5% of skills had been identified as medium priority 7% of skills identified as low priority and 88% of skills assessed as reaching the criteria.

3.21 The Concurrent Planning Team questioned the Social Worker why the introduction of some single contacts for parents were for two hours rather than the usual three. When the Social Worker advised that the opinion of the Psychiatrist was that FJ would not manage three hours, the Supervising Social Worker queried why the plan was working towards rehabilitation when 3 hours was considered too challenging for FJ.

3.22 FJ was discharged again by mental health services after a failure to attend four appointments during March, FJ reported his mental health to be stable to the Offender Manager and that he remained drug and alcohol free. A referral was made to Bridging the GAP – a sixteen week pre-employment programme delivered by ADS for people who have experienced substance misuse related problems.

3.23 In late March, following a proposed plan to transfer contact to the parent's home, the Manager of the Concurrent Planning Team contacted the Team Manager by e-mail to raise a concern about whether the view of the Psychiatrist that FJ would not manage more than two hours contact had been explored. The manager replied that the contact needed to be more than two hours because there was a need to 'see

how he will cope with his child in his care for longer periods'. Contact in the family home commenced initially for three hour sessions. This Children's Guardian met Child J for the first time whilst observing a contact at the family home shortly before the Final Hearing. The Children's Guardian concluded rehabilitation was the appropriate course of action.

3.24 A second LAC review was held mid-April. The Independent Reviewing Officer (IRO) had not seen a completed Care Plan or any of the other court bundles of evidence, which is required by the IRO statutory Handbook (2010). The IRO had no consultation with the Children's Guardian prior to the review; the Guardian's views were relayed to the meeting by the Social Worker. The Concurrent Planning Team requested that the Contact Supervisor was funded to offer continuity of support in the family home for a limited number of weeks. This request was declined by the Social Worker who indicated this would be provided by the Local Authority. The IRO noted the views of those present that the parents had made positive progress in three particular areas, no evidence of drug or alcohol use, that FJ had accessed mental health services and that contact was positive. The Care Plan was effectively endorsed without it being finalised. This Review was unable to determine exactly how decisions were made by Children's Social Care. The Social Worker recalled a care planning meeting but there are no minutes and no manager is able to recall chairing this. The Social Worker advised that she was not confident with the plan of rehabilitation but felt unheard by the Service Manager and legal advisor she recalled being present at the meeting. The parenting assessment written by the Social Worker and submitted as evidence before the court recommends rehabilitation. Given that the plan involved a child subject to a Care Order being placed with parents, it was also necessary to complete Placement with Parent Regulations. The Review has found no evidence that this was completed.

3.25 The Guardian's Report was not quality assured within CAFCASS because the Children's Guardian had 'self-filing status' due to the level of experience in private law proceedings. The Children's Guardian had however only recently commenced public law cases transferring from a private law portfolio. Children's Social Care has been unable to provide any clarity about the intended plan of support which

suggests that was not available at the time. Child J was made subject of a Care Order, with a plan for the baby to return to the parents care. The Placement with Parent regulations were not completed and no multi-agency meeting took pace to plan for Child J's return to the parent's care or devise or agree a support plan.

3.26 Following increased contact, including an overnight stay, Child J was returned to the parents care at the end of April. In the subsequent five weeks, five visits were made to the home by a Family Support Worker and Child J was seen on each occasion. In mid-May, a LAC meeting scheduled to take place within 28 days of the placement move was cancelled because the Social Worker was absent from work. In late May, because the allocated Social Worker remained absent, a statutory visit to Child J was completed by a duty social worker. The case was re-allocated and the newly appointed Social Worker made a home visit in mid-June. During May and June, four visits were made to the family home by the Offender Manager. MJ and FJ had registered Child J at the local Children's Centre, and MJ began attending baby play sessions.

3.27 MJ cancelled three planned home visits in June, two by the Family Support Worker, and one by the Health Visitor. Child J had not been seen by a professional from Children's Social Care for twelve days when the Family Support Worker visited the home and noted a bruise to Child J's face. Child J was non mobile and 7 months old. The Family Support Worker reported this to the Social Work team and concerned that she had not received the response she expected, was proactive in seeking a duty social worker to pass this information to before the end of the day.

3.28 The following day, the original Social Worker returned from sick leave. Later in the day she accessed an e-mail from the Family Support worker and duty worker advising of the bruise to Child J. The Social Worker visited the family home and found FJ alone in the house, he advised that MJ was at her mothers with the baby, and the Social Worker went to that house. The Social Worker observed the bruise and sought advice from a Senior Social Worker regarding the need for a medical examination. The Senior Social Worker was not fully aware of the details of the case, and states she was unaware of the age of Child J. The advice to go directly to the hospital if there was a medical emergency, and if not to request a medical the

following morning. This was understood by the Social Worker to mean that because the bruise was fading with no indicator of emergency, the medical examination could wait until the morning. The Social Worker said she instinctively did not agree with the advice but did abide by it. The following morning the Social Worker arranged a medical examination for Child J. The Consultant noted ten injuries and fractures highly suggestive of non-accidental injury.

4. Analysis

The analysis is structured under three distinct phases of intervention.

4.1 Pre birth

4.1.1 MJ and FJ were experiencing many problems and challenges as a couple when they became pregnant with Child J. The first trimester of the pregnancy illustrates a somewhat chaotic household and lifestyle, characterised by substance abuse and domestic abuse. That said, their response to pregnancy appeared to be wholly positive, they wanted a family life and showed an acceptance that they as adults needed to make changes and demonstrated a level motivation to do so. It should be noted that whilst MJ's access to alcohol and mental health services were on a voluntary basis, FJ's attendance at an alcohol service and programme for improving relationships were both directed by an Order of the Court and a failure to comply could have resulted in resentencing.

4.1.2 The commencing of a CAF led to a referral into Children's Social Care. This referral was accepted as meeting a threshold for pre-birth assessment, yet even when this commenced, unusually the CAF approach commenced alongside the interventions by Children's Social Care. From the parent's perspective, it may have been confusing that whilst the CAF process was developing a very positive view about their engagement and opportunities for support the assessment by Children's Social Care concluded there was significant cause for concern about their ability to safely parent their child.

4.1.3 The three most identifiable areas of risk concurred with the 'toxic trio' so significant in safeguarding children, mental health, substance abuse and domestic abuse, these

existed alongside a concern about the parent's practical parenting capacity and their ability to learn.

Mental Health

4.1.4 Both parents described poor episodes of mental health. For MJ this exhibited as anxiety and self-harm which was at times exacerbated by alcohol. MJ initiated and attended an alcohol and mental health service on a purely voluntary basis. FJ spoke of hearing voices, experiencing hallucinations and feeling paranoid. FJ would initiate referrals to mental health services but never followed though to attend appointments which compromised the effectiveness of assessments and support. FJ allowed his Offender Manager and Alcohol Counsellor to believe that he was not receiving responses. Ultimately specialist practitioners concluded that his mental health problems had a causal link with substance abuse and that once his use of drugs and alcohol diminished, his mental health would improve.

Substance Misuse

4.1.5 Both parents had developed a reliance on substances as a means of coping, alcohol use by MJ, and drugs and alcohol by FJ. MJ's pathway to specialist alcohol services was self-initiated and she demonstrated an insight into the detrimental effects of alcohol on her life. FJ's pathway to alcohol services was through an order of the court; he worked at engagement and did achieve a reduction and ultimately abstention from alcohol. Although self-reported progress, this was supported by observation of his behaviour. In speaking with the Alcohol workers allocated to each parent there is however a sense that FJ's misuse of alcohol was situational, related to age and opportunity, whereas for FJ, it was more of a dependency which could be controlled but not eradicated. FJ could be defined as a problematic drinker, meaning that alcohol and remaining abstinent or controlled would remain a significant problem throughout his life.

Domestic Abuse

From the outset of interventions, domestic abuse was a known feature of the parent's relationship. Children are often described as the hidden victims of domestic abuse, and whilst there is the obvious risk of becoming physically hurt, children including babies also suffer long-term emotional effects as a result of living with domestic abuse. MJ was in the first trimester when she contacted the police following an incident whereby FJ had trapped her foot in a door, taking account of the barriers to women in continuing relationships in supporting criminal charges against their partners, the police continued to prosecution irrespective of MJ's support to the process. FJ's conviction for criminal and malicious damage resulted in a court directed requirement to attend the IRSC course which commenced three weeks prior to Child J's birth. MJ missed session one and session three prior to the birth and session seven and eight shortly after the birth. Ordinarily more than two misses on the programme would result in the participant being removed from the sessions with a requirement to restart. Although the reasoning is not explicitly recorded, it is considered that there was an agreement to complete the course with catch up sessions by the Offender Manager because of the proximity to the birth and because MJ was considered to have participated well in the sessions attended. When an offender attends an IRSC programme, their partner should be offered a service from a Women's Safety Worker (now Partner Link Worker) and whilst agency records indicate a referral was made six weeks prior to commencement of the course, there is was no record of any feedback as to whether this was pursued or the outcomes. The purpose of the Women's Safety Worker is to provide the female victim/current partner with realistic information about the programme, contribute to promoting safety by empowering the woman and advise and assess any changing risks. The most effective way of addressing domestic abuse is undoubtedly to work with both adults in the relationship and the effectiveness of the programme was be undermined by the failure to do so. The absence of involving the work strand of the Women's Safety Service in the analysis of the impact of the IRSC is a significant omission in assessing the motivation and impact for change. As this case developed, MJ's ability to challenge and understand the risks of FJ's changing behaviour proved to be significant to Child J's safety.

Practical Parenting

4.1.6 MJ and FJ both demonstrated a willingness to work with professionals and were considered to be committed but slower to learn. The professionals working directly with the parent from Health, Children's Centre, CRC and ADS all had sympathy for the position of the parents and wanted to see them achieve their desire of family life. The role of the Social Worker in pre-birth assessment and the Chair of the Initial Child Protection Conference was significant in reviewing the facts, risk factors and potential barriers to change resulted in the plan for Child J to be looked after whilst the parents ability to maintain and out change into practice was tested.

4.2 **Post birth and Assessment**

4.2.1 The birth of Child J and decision to place in a concurrent placement indicates that Children's Social Care remained open to the possibility of rehabilitation but also prepared for permanence for the baby should this prove not possible. As part of the contracted arrangements for concurrent placements, the Concurrent Planning Team took responsibility for supporting and assessing parental contact. The observations of contacts concurred with the views of professional helping MJ and FJ prepare for the birth of their baby and the outcomes of the PAMS assessment, namely that the parents has sufficient practical parenting skills and the capacity to learn as required. Effectively this meant that three risk factors remained.

Mental Health

4.2.2 The parenting assessment noted that FJ had not attended mental health appointments but had self-reported an absence of symptoms which he believed was associated his abstinence from substances and considered himself to be stable on anti-depressant medication. A psychiatric report commissioned to support the proceedings indicated that FJ had a long standing personality dysfunction which meant it highly unlikely that he would be able to support MJ in day to day care of their child should he experience low moods in the future, or indeed prioritise the child's needs over his own. The psychiatrist warned that the impact on Child J should

this occur would be significant as MJ and FJ had a co-dependent relationship. A psychologist report, whilst concurring with the risk factors, suggested it possible the arrival Child J has given both parents a direction, motivation and purpose they did not previously have. The assessment rightly identified a concern that FJ would be unable to recognise any deteriorating symptoms and that his history of engagement in services was not a positive indicator that he would do so in the future.

4.2.3 MJ was recognized to have engaged with services, and was discharged without any ongoing treatment or medication.

Substance Misuse

4.2.4 The parenting assessment concluded that FJ was working with alcohol services but had admitted to two lapses of sobriety within the 4 months since Child J's birth, and no substance misuse. Both parents had tested negatively in routine testing. The Psychological report indicated that the parents needed to maintain abstinence, and would need the support of the local ADS team, who can offer advice, encouragement and testing to do so. Whilst MJ has stated a commitment to attending drop in sessions at ADS to support maintenance, FJ was discharged formally by the service prior to the completion of the parenting assessment and was advised by the Offender Manager that it was necessary to continue to attend voluntarily.

Domestic Abuse

4.2.5 The parenting assessment noted that there had been no further known incidents of domestic abuse but the Social Worker did record her observation that FJ maintained a controlling position with MJ, in particular with regard to working transparently and that they had told people they regretted being so open prior to the birth of Child J.

4.2.6 Although not referenced in the assessment, the completion of an IRSC programme was considered a significant factor in decreasing risk of domestic abuse. As stated previously however, the process missed the opportunity to fully engage both partners or assess the impact of the learning. The relationship between FJ and MJ is clearly identified one of co-dependence between two people who have experienced

dysfunctional lives and that this in itself presented a significant risk to agencies becoming aware if one or both parents were to relapse in any aspect of progress.

4.2.7 One of the challenges to this Review has been reaching an understanding of how and when decisions were made in Children's Social Care prior to making recommendations to the Court. The social worker recalled in detail a care planning meeting which she indicated was attended by herself, a legal representative, a team manager and a senior manager of which there is no record. The social worker advised that she was not confident that rehabilitation was an appropriate plan, however, was advised that Child J did not meet the criteria for a care plan of adoption which was the only realistic alternative and felt unable to challenge this due to her inexperience and others seniority. Whilst the assessment clearly highlights significant areas of risk it does conclude that Child J should be placed with parents subject to a Care Order. The Reviewers were advised that a final care planning meeting would consider a completed parenting assessment, have source access to specialist court reports and detailed information about the needs of the child. This cannot be evidenced in this case, nor can the completion of placement with parent regulations which should have included a specific risk assessment and consequent support plan. The allocated Social Worker was working in her NQS year when allocated this case, working in a team that would ordinarily have nine social workers, a team manager and a senior social worker. However during this period there were three vacancies on the Team, and three newly qualified social workers. Within the timeframe of the review there were at least two changes in the management structure and it is evident from conversations with the Team Manager, Senior Social worker and Social worker that there was some confusion about who was responsible for what and when within the time scale of this review. The lack of clarity about who was acting as line manager for the Social worker with regard to her supervision and support impacted on the oversight of the care plan at a critical point in time. The Social Workers supervision records demonstrate very limited support to the Social Worker, with two supervisions on the case prior to the birth of Child J, and only two supervisions following the birth, notably, there was a gap of five months when the key activities and decisions were being made in respect of Child J. This

was in breach of the supervision policy in Children's Social Care and extremely detrimental to the management of high risk case managed by a newly qualified social worker. The Social Worker was subject to an Assessed and Supported Year in Employment (ASYE) as a newly qualified social worker where a protected case load and regular supervision should be the norm. Although a little undeveloped in analysis, the Social Worker did demonstrate in the assessment a greater degree of skepticism than was reflected in the subsequent decisions.

4.2.8 The absence of supervision to assist the Social Worker with critical thinking about this case is a significant failing. There are some issues that required a deeper exploration, specifically around motivation and the cycle of change, the particular risk factors of FJ's substance misusing history, and the nature of the relation between the parents which could result in reduced safety for Child J. Munro (2008) reminds the '*best guide to future behaviour is past behaviour*' and suggests that without evidence of different dynamics or changed behaviour in families, professionals should always consider the likelihood that past behaviours will re-emerge under certain circumstances. Munro (2011) states that making '*decisions in conditions of uncertainty*' (i.e. risk taking) is a core professional requirement for professionals working with children. The challenge of assessments however, is predicting the likelihood of risk where both risk and uncertainty are key features. All the evidence would point towards a motivation for change, however, what is less clear is where MJ and FJ where perceived to be individually and together on a cycle of change moving through stages of motivation, contemplation, action and maintenance. At the very least a better understanding would have helped to develop a plan to support rehabilitation whilst maintaining a strict focus on the safety of Child J. This was particularly significant given that the Psychologist advised that the parents would need a period of 18-24 months to embed change.

4.2.9 Within the Local Authority, the primary task of the IRO is to quality assure care planning for each Looked After Child. The IRO role was introduced as a statutory function in 2004, and reviewed in 2006-7 in the Care Matters Green Paper. The role of the IRO was affirmed as one which should provide a challenging analysis of the proposals for meeting a child's needs. In the case of Child J, the child care reviews

did not support this aim. The IRO service chaired three meetings in respect of Child J, the Initial Child Protection Conference and two Looked After Children Reviews. The Conference did not have all relevant professionals in attendance however, did identify the need for a plan of protection and the need to consider legal intervention to secure this and place a framework on planning for permanence. The first Looked After Child Review should be held within 28 days of placement, this was in breach of regulation by occurring two weeks late and no explanation is recorded. A late notification of the review resulted in relevant people being unable to attend. An electronic notification is now in place which sends alert to ensure timescales are adhered to.

4.2.10 The second Looked After Child Review was planned shortly before the Final Court hearing. This was a critical review and an opportunity for the IRO to challenge and scrutinize that appropriate plans was in place to safeguard Child J before endorsing the Final Care Plan. It would appear that IRO did not have sight of the Care Plan or any other Court documents as required by the IRO Statutory Handbook DFE 2010, nor had there been any direct communication with the Child's Guardian as would be expected. The Review provides no clarity as to the decision making process in Children's Social Care and does not offer any analysis or quality check on the progress made by parents to fully understand what would be required in a plan to support rehabilitation. When the Concurrent Planning Team made a request to continue their involvement in supporting Child J's early stages of rehabilitation, and this was not supported by the Social Worker , there was and could not have been any meaningful challenge from the IRO due to lack of information available. Despite the lack of evidence and documentation, the LAC review did go on to endorse the notional care plan. The recently published Improving practice in respect of children who return home DfE (2015) outlines that IROs have a key role to play in reviewing and challenging care plans and in ensuring that decisions are made in the best interest of the child. In order to fulfill the role of the IRO, it is necessary whilst a child is subject to proceedings to take a proactive approach, keeping abreast of developments between meetings and preparing for critical Reviews well. The

approach to this case does not reflect well on the approach of the IRO Service who must use this learning and become compliant with the IRO Statutory Hand Book.

4.2.11 The role of the Children's Guardian has the function of ensuring decisions in Court are made in a child's best interests. Primarily, the focus is to ensure that children are safe and in care proceedings to check that the Local Authority Care Plan is the best possible for the child. Although there was some communication with the IRO, this was not as would be expected in accordance with the CAFCASS and IRO protocol. The process of decision making in this case has not been confidently established within Children's Social Care. However, by any standards it can only be regarded as a finely balanced decision. The risk factors were evidenced in the social work assessment and therefore any decision for rehabilitation should have been followed by a carefully considered risk assessment and support plan. The Children's Guardian advised that the support plan was a matter for the Local Authority. However, it was incumbent upon CAFCASS to be satisfied that the ongoing care plan sufficiently addressed any identified areas of risk.

4.2.12 Given the significant role of the Concurrent Planning Team, the involvement and challenge to care planning was too passive. The Team clearly thought carefully about the findings of the specialist reports in relation to contact and understood that an increased offer of support was necessary to safely support a plan for rehabilitation. The need for this should have been challenged beyond the refusal of the Social Worker; it is apparent that the service has reviewed this. The Concurrent Planning Team was relatively new when the placement of Child J was made and the learning for this Review will be used to support the development of the service. The carers, now adopters for Child J have been consulted as part of this Review. Both the service and the carers have raised issues which questions how well the ideology of concurrency was understood by other key professionals and the need to promote better understanding is critical to better partnerships to support optimised outcomes for children.

4.2.13 It is significant that throughout the period of legal proceedings there was no meeting by which multi-agency professionals came together to share and analyse information, or consider how the child and parents could be best supported through

rehabilitation. Many of the professionals that had worked with MJ and FJ were not notified that Child J was returning home other than by the parents themselves.

4.3 **Rehabilitation**

4.3.1 It is important to state that no agency indicated any dissent to a plan of rehabilitation.

The Social Worker reported a sense of unease which did not translate into any formal challenge. There is a sense that the ending of proceedings was seen as an end in itself by Children's Social Care rather than the beginning of an increased period of risk for Child J. This risk was acknowledged by all parties to the legal proceedings by virtue of the agreement to and the making of a Care Order. To Children's Social Care, a child placed with parents subject to a Care Order represents one of the highest risk cases whereby it is deemed necessary for the Local Authority to share parental responsibility, yet the child is placed with the persons who present the risk and also share parental responsibility. One would generally expect very robust planning for children living with parents subject to a Care Order. Legally, the placement of a child in care is governed by the Care Planning and Case Review Regulations and if a child is placed with parents for a continuous period of more than 24 hours, than the regulations apply and there is a defined process to follow. To reflect the enormity of the decision, such a placement can only be agreed by a service director subject to a Placement Plan. In reaching such a decision, the service director must be assured that the plan will safeguard and promote the child's welfare and that there is a clear plan as to how the placement will be monitored with a contingency in place if necessary. There is no evidence that this took place.

4.3.2 The IRO had planned a third Looked After Children review to take place within 28 days of the change of placement to ensure the parents had understood the overall care plan, however on being made aware that the Social Worker was unexpectedly absent, and after consultation with the Social Work Team Manager, this review was cancelled. As a consequence there was no scrutiny from the IRO on the return of Child J to parent's care or checks undertaken regarding the effectives of the support plan and any other issues such as the need for a multi-agency approach. It is noted

that a case tracker system has recently been introduced to the IRO service to initiate mid-point consideration of information relating to children subject to Looked After Children reviews. For a second time, the functions of challenge and scrutiny did not happen.

4.3.3 The rehabilitation of Child J resulted in an increased period of risk and the planning for this should have reflected this in action and mindset of the professionals around the child. Shortly after the return of Child J, the Social Worker became absent from work for a period of several weeks. The case was not re-allocated and no professional from another agency was asked to support the case as temporary Lead Professional. This effectively left a period of nine weeks without adequate oversight or planning for this increased period of risk. Had the IRO and Children's Guardian taken a keener approach to how the risks would be managed post rehabilitation as part of the scrutiny of care planning, this could have encouraged a multi-agency approach from the outset given that the risks required communication across several agencies.

4.3.4 It is notable that the Offender Manager made several home visits in this period, a measure of an understanding of the increased risk. The level of social work oversight was poor with only two visits made by different social workers and in the absence of any multi-agency planning meeting, Children's Social Care had little understanding of who was doing what and when. As little as five weeks after Child J returned home, there commenced a noticeable difference in the parents compliance with agencies cancelling several planned home visits by the Health Visitor and Family Support Worker. Working to a multi-agency plan with a defined and collective information sharing process could have flagged this emerging pattern. When the Family Support Worker noted the bruise to Child J's face she was immediately alerted to the significance of this in a non-mobile baby.

4.3.5 The Family Support Worker tried to contact the original Social Worker, who she believed was still the Social Worker, but when advised she was not available, pursued the duty officer in the Team. The Family Support Worker recalled having to be persistent to speak to someone. The Social Worker who took this phone call did not recognise the immediacy of the concern and the need for an investigation under

Section 47 Children Act 1989. An e-mail to the original Social Worker was an inadequate response, and it somewhat by chance that the Social Worker saw this information which had been relayed by e-mail the following day. The Social Worker recalled that she went directly to see Child J, and was immediately concerned about the state of the house and FJ's defensive attitude which was different to how had communicated with her previously. The Social Worker knew she needed to see Child J and therefore went to the home of the Maternal Grandmother where the bruise was evident. The Social Worker recalled how she instinctively felt the consultation she had with the Senior Social Worker was resulted in incorrect advice but accepted this feeling in no position to challenge. The Senior Social Worker advised that at this time, she and the Team Manager had split the duties on the team so that she focused on operational court work and the Team Manager provided staff supervision which meant that she had no knowledge of this case. The Senior Social Worker recalled receiving a call from the Social Worker early evening, and stated that prior to discussing this case she also queried a matter on another case. The Senior Social Worker was advised that the child had a yellowish bruise and that that the father had been difficult. The Senior Social Worker said that she did not know the age of the child when she gave advice to wait until the following morning; however had she known the age she would have advised an urgent medical to be arranged. There was clearly a mis-match between what the Social Worker, who thought she was relaying with regards to the seriousness of what she had found, with what was heard by the Senior Social Worker. It should be unequivocally stated however that it is incumbent on a Senior Social Worker giving advice on an injury to ask relevant questions and arm themselves with as many facts as possible before reaching a conclusion.

4.3.6 The response to the injury of Child J was wholly inadequate which resulted in Child J being exposed to serious harm for two full days after the Family Support Worker had alerted the social work team about the bruise. The fact that this information passed through several social workers indicates a significant cultural issue in recognising that the threshold is met for Section 47 investigation to be initiated, this is particularly concerning given that this is a common issue arising from previous Serious Case Reviews in Oldham.

4.3.7 Despite the knowledge that risk was present for Child J and on a finely balanced decision for rehabilitation, this knowledge did not translate in to a plan to manage risk with a process for reviewing the assessment and impact of increased pressure upon the parents. Whilst all professionals were stepping up their involvement to support and address the element of risk, there was no common plan or basis for communication which ultimately detrimental to MJ, FJ and Child J.

4.4 Throughout critical stages of this case occurred during the second and third stages and there are a number of significant factors that evidently contributed to compromised safeguarding. These included:

- Insufficient support to the Social Worker to explore and critically appraise the information available to the assessment;
- Limitations to the quality assurance functions of the IRO and Children's Guardian with regard to exploring the impact of a finely balanced decision for rehabilitation on the accountability and support systems needed to assure the safety of Child J;
- Poor evidence of management oversight in Children's Social Care to support care planning, safeguarding and exercise parental responsibility;
- Absence of multi-agency working to plan and support the rehabilitation;
- Insufficient understanding that the rehabilitation increased rather than reduced risk at the conclusion of proceedings;
- Poor recognition of threshold criteria for duty to investigate under Section 47 Children Act 1989.

4.5 It is acknowledged by Children Social Care that this case occurred within a staffing crisis which particularly impacted on the team where the Social Worker was located. The impact of vacant social work posts alongside a high percentage of ASYE staff meant that social workers were working to a higher threshold of intervention that was appropriate. This was compounded by the constant changes in management arrangements and various approaches to try and streamline how management could be used to best effect, including redirecting a Senior Social Worker from a management to operation role. It is particularly concerning that the IRO service did not fulfill its statutory function at a time most needed, and this case should provide

critical learning to the service about the potential consequences of not using challenge to effectively support safeguarding.

5. Learning Outcomes and Recommendations

The outcomes focus on how the learning from this review can be addressed to support enhanced safeguarding systems and practice.

5.1 *Responding robustly to domestic abuse within a safeguarding plan requires an approach that works with both victims and perpetrators to support robust analysis of risk and change.*

It is important that domestic abuse is addressed from three perspectives in any safeguarding plan, the perpetrator, the victim and the impact on the child. Multi-agency professionals need to be encouraged to ensure that child protection planning addresses all aspects and that engagement on all levels is considered as part of assessing potential for change and risk.

Recommendation

1. That through Board delivered training in Domestic Abuse, the role of a Partner Link Worker is re-enforced as a critical component of a safeguarding plan.
2. That the CRC provide specific guidance to Offender Managers with regard to the need to include the response of a non-abusing partner in any assessment addressing the likely impact of IRSC programme in an assessment for the purpose of safeguarding.

5.2 *Comprehensive assessment of risk and planning for children is best supported through adopting a common model of assessing motivation and capacity for change.*

The assessment of parenting capacity in relation to Child J did provide a focus on the process of change but would have benefitted from greater analysis on the stages of change and how this would be built into a plan of support. Using an assessment tool such as the commonly used Prochaska and DiClimenti Model of Change would undoubtedly have assisted professionals to place behavior in a context of dynamic

assessment of risk. Given the enduring and cumulative effects of multiple risk factors, it is vitally important to establish parental pace of change within the overall approach to risk management.

Recommendation

3. That the Board promote the use of a model of change within partnership agencies to assist single and multi-agency assessment of parenting capacity.
4. That the Board review the approach to multi-agency risk assessment with a view to developing an improved and coordinated model.

5.3 *Management oversight at critical points of assessment needs to support practitioners to utilise critical thinking techniques to draw confident conclusions and develop plans that appropriately address risk.*

The Social Worker in this case described a feeling of unease about the decision for Child J to return to the parents care, and clearly felt the opportunity to reconcile the dilemmas associated with decision making had been insufficient. In the absence of additional reflections or minutes to outline how the information was analysed to reach conclusions, it cannot be assumed that this happened with sufficient depth so as to support such a key decision. Research in Practice (Dartington and University of Sheffield) paper on Analysis and Critical Thinking in Assessment describes critical thinking as: *'purposeful; it takes a questioning (and self-questioning) attitude towards the issue or problem at hand and examines the information, ideas, assumptions, concepts and so on associated with it and considers how they act to support a particular view or interpretation of the situation. It involves maintaining an open-minded attitude and being able to think about different ways of understanding the information before you. Critical thinking also includes a process of evaluating claims and arguments in order to come to logical and consistent conclusions, assessing these conclusions against clear and relevant criteria or standards, and being able to spell out the reasons for the judgements you have reached'.* The outcome of a successful care planning meeting should ensure that the above requirements have been met to be satisfied that the right and defendable decision making has occurred.

Recommendation

5. That Children's Social Care introduce a final evidence template that is quality assured by the Agency Decision Maker with a requirement that the final care planning meeting is recorded to a standard that outlines the rationale and reasons for decisions.

5.4 Optimized safety for children will be achieved when the function of the IRO is delivered effectively to offer challenge and support to Children's Social Care

Without wishing to move to the general from the specific, the findings from this Review give rise to concern about the culture or absence of challenge within the IRO service and the compliance with statutory IRO guidance. The role is critical to the safety and welfare of children and any deficits must be firmly addressed. It is necessary to engage IRO's in the findings of this review in order to enhance practice from the learning.

Recommendation

6. IRO service to consider the findings from this Review and specifically identify and address any known barriers to compliance with IRO handbook.

5.5 For children reviewed within looked after children arrangements, systems to support multi-agency working should remain a priority where more than two agencies continue to be involved with the child and family. A Child's Looked After status should not become a reason to deviate from systems which support multi-agency working.

Hallet and Birchall (1992) summarise interagency working as requiring three terms that can be used synonymously – co-ordination, collaboration and co-operation. Once agencies stick to these principles a meaningful partnership is possible with each other and with a family. There was an assumption by some professionals that the child's review presented the opportunity for a multi-agency meeting; however this is not the purpose and function of a child's review which should clearly remain as the child's meeting. Procedurally there is less direction through common pathways to support multi-agency processes for children in care. In the case of Child

J, the Care Order in itself was not a form of protection, but a critical indicator that the child needed greater not lesser support when placed in the care of parents.

Recommendation

7. CSC to review and report to the Board how multi-agency work is promoted through systems that support children subject to Care Orders.

5.5.1 The Local Authority must carefully and robustly exercise it's parental responsibility for children placed with parents

The placement of children looked after with parents is a small but highly significant group and this Review suggests it would be prudent to ensure each child in this position has a care plan that addresses the support needs of the family and any aspects of risk.

Recommendation

8. The Board to require Children Social Care to ensure that every child for whom they share parental responsibility and is placed with Parents is subject to 'Placement with Parents regulations' reviewed alongside the child's care plan.