SERIOUS CASE REVIEW

Child P

Report for publication

Sharon Hawkins

1 INTRODUCTION- Initiation of this Serious Case Review

1.1 This Serious Case Review is about the services provided to Child P and her family. In early September 2018 Greater Manchester Police (GMP) attended the home address after a telephone call from North West Ambulance Service who had received a call from a child in the family; on arrival they discovered that the father had used a knife to cut the throats of the Mother and youngest of the children, Child P.

1.2 During the assault the Mother sustained a cut to her neck and defensive wounds, whilst Child P had a deeper cut to her neck and had to undergo surgery. Whilst Child P's injuries were not life threatening, the traumatic impact of being attacked with a knife by her father was considered as serious harm. The assault and aftermath were also witnessed by her two siblings.

1.3 Father also sustained and was treated for his injuries at the local hospital and following this he was subsequently charged with attempted murder. The father pleaded guilty at court and he is currently awaiting sentencing.

1.4 Prior to this incident there had been three reported domestic abuse incidents spanning a two-year period. Only two of these incidents were recorded as domestic abuse incidents on the police systems.

1.5 In In the first incident which came to agencies attention in 2016; Mother informed the GP that the father had a knife in his hand whilst shouting at her. The police had recorded an incident in which Mother informed the response officer that he was shouting whilst washing up. At a subsequent multi-agency meeting, practitioners assumed that these incidents were one and the same.

1.6 The family had also suffered 3 bereavements over seven years, and during this time the focus of support had been with the Mother and father's needs were overlooked.

1.7 The Father had visited the GP on several occasions with low mood and had been referred for counselling.

2. PUBLICATION

2.1 This report has been anonymised to protect the identity of the child and family involved; the subject child shall be known as Child P.

3. REASON FOR THE SERIOUS CASE REVIEW

3.1 In England, Regulation 5 of the Local Safeguarding Children's Boards (LSCB) Regulation 2006 sets out the functions for LSCB's. This includes the requirement for LSCB's to undertake reviews of serious cases in specified circumstances. How LSCB's undertake the review is not set out in statutory guidance however "Working Together to Safeguard Children 2015"[1] identifies that

"Reviews are not the ends in themselves. The purpose of these reviews is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children."

3.2 Working Together 2015 requires SCRs to be conducted in such a way that:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings

3.3 Following the incident there were several safeguarding concerns and vulnerability factors identified and a referral was made to the Oldham Safeguarding Children's Board for consideration for a Serious Case Review.

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3.4 In September 2018 following a recommendation by the Serious Case review panel a decision was made to initiate a Serious Case Review by the Chair of the Local Safeguarding Board and ratified by the National Panel. The Serious Case Review was to consider the services received by all three children.

4. SPECIFIC TERMS OF REFERENCE

4.1 The Review will focus on the following key lines of enquiry:

- Did the decisions and actions in the case comply with the policy and procedures of the named service and Oldham LSCB?

- Was there effective interagency working and service provision for the child and family?

- Did effective information sharing take place between the Police and Health and Oldham Children's Services?

- Determine the extent to which decisions and actions were child focussed.

- Was previous relevant history and information about the family and young person considered in professional's assessment, planning and decision making in respect of the family and their circumstances?

- When new safeguarding concerns were identified was appropriate action taken to address them? Establish if there was clear evidence of a risk of significant harm which was not recognised by agencies or professionals in contact the family, or not shared with others, or not acted upon appropriately.

- Were there any obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This should include consideration of both organisational issues and other contextual issues?

- Were there any relevant factors affecting the service at the time (demand, capacity, expertise, experience etc)?

- Did all involved exercise professional judgement appropriately, given what was known and knowable to them at the time?

- Were the responses following the two still births and bereavement of their second child proportionate to the needs of both parents. Did practitioners lose sight of the needs of the father when supporting the family?

- How robust was the Single Assessment which was completed by CSC and did it include the views of all partner agencies involved with the family?

5. TIMESCALE

5.1 The timescale for the active period of the review is from September 2016 until September 2018.

6. FAMILY INVOLVEMENT

6. 1 The Father is currently awaiting sentencing and has been contacted via the Probation service. He does not wish to take part in the review currently.

6. 2 The Independent Reviewer has attempted to contact the Mother unsuccessfully.

7. PARALLEL PROCESSES

7. 1 Child P's father has been subject of criminal court proceedings, these have now concluded, the father pleaded guilty and is currently awaiting sentence in the Spring of 2020.

8. INDEPENDENT REVIEWER AND PANEL

8.1 **I**ndependent Reviewer, Sharon Hawkins was commissioned to undertake this Serious Case Review. Sharon qualified as a Social Worker in 1994 and after 18 years of being employed in Local Authorities in the North West of England she became an Independent Safeguarding Consultant in 2012. Sharon has 25 years of experience of both social work and management at various levels including Head of Service and Assistant Director in frontline children's services. She is experienced in completing Serious Case Reviews, Managed Reviews and reflective learning reviews and completed the national training programme for Independent Reviewers in 2013.
Chronologies were requested from the following agencies:

- Greater Manchester Police
- Children's Social Care
- Primary School
- Oldham CCG for General Practitioner
- Bridgewater for Health Visitor and School Nurse
- Early Help Services- Project Choice

8.2 The members of the Serious Case Review Panel for Child P comprise of representatives from the key statutory agencies who have had no direct involvement with the case. The panel members identified authors within their own agencies to complete the chronologies. The role of the panel was to actively manage the review and to provide oversight and scrutiny through all aspects of the process. The Independent Reviewer chaired this panel.

8.3 The following agencies were represented on the Panel.

- Children and Young Peoples Service- CYPS
- Greater Manchester Police
- Education
- CCG's

9. PROCESS AND METHODOLOGY

9.1 The Serious Case Review Panel met to consider the timeframe and Terms of Reference for the review. This review was undertaken using a systems approach and is compliant with Working Together 2015[2] and 2018[3]. The review adopted a systems-based approach, which aimed to meet the learning and improvement requirements of statutory guidance. The review sought to understand precisely who did what, through development of agency chronologies and review of relevant documentation

9.2 The review sought to identify the underlying reasons that led individuals and organisations to act as they did, each agency with knowledge of the family has completed a Chronology of their involvement and this was utilised alongside a Learning Event with practitioners. The Learning Event was an integral part of the review, ensuring that the voice of practitioners was heard and that they had the opportunity to actively contribute to the process. Using a systems approach, the emphasis of the Learning Event was on understanding what happened, why some decisions were made and what learning could be captured. The Learning Event was based on the Welsh Child Practice Review Model[4].

9.3 The report is concise and concentrates on the findings and recommendations. To protect the Mother and children within the family, information identified as unnecessary to the findings and recommendations has not been included.

10. Family Composition, Ethnicity, diversity and cultural issues

Name / Acronym	Relationship	Age at time of incident
Child P	Subject Child	5

[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/729914/Working_Together_to_Safeguard_Children-2018.pdf

[4] Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012

Name / Acronym	Relationship	Age at time of incident
Sibling 1	Sister	14
Sibling 2	Brother	7
Mother	Mother to all children	
Father	Father to all children	

10.1 Child P and her Siblings and the parents are of British/ Bangladeshi heritage. The father is believed to have been born in the UK however the Mother was born in Bangladesh and came to the UK when she married the father. The family lived together in a property in an area where their cultural needs could be met, and the children attended the local primary school.

10.2 The Mother had limited support locally and although born in Bangladesh she did have family in another part of the UK. The children attended schools locally but neither parent was involved in local school activities and Mother was only known via collecting and dropping the children to school.

Background Narrative as Known to Agencies

11.1 Child P and her family had been known to universal services for many years via midwifery, health visiting, school nursing and GP services.

11.2 In August 2016 Greater Manchester Police received a call from the Mother via the 999-call system. The Mother was reporting that her husband was suffering from depression and that he had in recent minutes been shouting at her. She went on to say that he had a knife in his hand when he was shouting at her. At the time of calling the Mother alerted officers that her husband had left the property. Officers attended the property and spoke to the Mother. She expressed concern regarding her husband's mental health stating he was depressed but would not access support or medication. The Mother advised officers that this was not the first time he had been angry and that when he was stressed, he would become angry and aggressive.

11.3 A couple of days later Children's Social Care received a referral from the General Practitioner. Mother had attended an appointment and alleged that the father had depression and was refusing to access any support services. Mother advised the GP that five days prior to her appointment the father had threatened her with a knife, he had also slapped the eldest child sometime in the preceding two months. Mother advised the GP that she had contacted Greater Manchester Police but did not wish to pursue a complaint against the father and wanted to remain with him but needed support.

11.4 On receipt of the referral by CSC a decision was made to initiate a multi-agency Strategy Meeting due to the allegations that the children had suffered significant harm. The Strategy Meeting took place the following day and was attended by representatives from Health, Education, Early Help, GMP and Children's Social Care. GMP shared that Mother had reported only one recent domestic incident. Further family vulnerabilities were identified within the family due the bereavement and still births of three children

11.5 Health shared that Mother had previously experienced low mood due to bereavement; she had loss of three children, one baby died aged 5 months. The other children during pregnancy. As the assumption had been made that the incidents were one and the same, information from GMP contradicted what had been shared with the GP. The strategy meeting minutes indicate that the police information that was shared did not include that mother had stated that father had a knife in his hand. Mother presented a less worrying picture to attending officers than she did to the GP and there was discussion at the Strategy meeting as to whether Mother was providing more detail to the GP in an attempt for her husband to access services. The outcome of the Strategy Meeting was not to recommend a Section 47 investigation but for a Single Assessment to be undertaken to identify any unmet needs. The assessment was completed within timescale and concluded that Mother and father had demonstrated capacity to change, and that they could seek their own support without a continuing role for CSC at that time.

11.6 The Father attended the GP in October 2016, it was noted that he presented as passive aggressive. The Father had been suffering from halitosis had struggled with this and lack of progress made in resolving the problem. The Father was demanding

treatment and threatening to go to a solicitor. Later that same month the Father sent a letter to GP apologising but frustrated with the lack of response to his health issue that was worrying him. Letter was rambling and mentioned past illnesses when a child in Bangladesh and current health problems such as depression.

11.7 At the end of October 2016, a telephone conversation took place between the social worker and the school nurse. The social worker was requesting health information for Sibling 2 as part of the single assessment that was being completed. Social worker informed school nurse that decision had already been made to close the case.

11.8 The GP contacted the Mother in November 2016 enquiring how the family was progressing. The Mother informed the GP that the family were well and that she had met with CSC on a couple of occasions and had been given the option of the case closing but she wanted the children's cases to be kept open and support to be ongoing.

11.9 Between the beginning of November 2016 and end of January 2017 several enquiries were undertaken by the school of Sibling 2 to ascertain if the case was still open to a social worker and to speak to the social worker for an update.

11.10 On the 28th October 2017 the father contacted the police stating that he had an argument with his wife, he alleged that she was going to call the police and claim he had raped her. He stated that they had argued because his 4-year-old daughter had touched him in the groin area. He stated that he had asked his wife 'who had taught her to do that' and this had led to the argument. The call operator documents that a female can be heard in the background calling the father 'mental'.

11.11 Following the call from the father, police attended at the home address; both parents were spoken too separately. Police concluded that this incident was a civil matter between the two. The civil matter was in relation to the occupancy of the property as neither party wanted to leave the house. The Mother had explained that the father had been unhappy and the reason for the argument on this occasion was due to the father believing that the Mother had taught one of the children how to curse using the middle finger. The Mother denied this; father disclosed feeling unhappy in the relationship and he had sought any support or spoken to anyone regarding his feelings. Advice was given to the father and Mother regarding having some space for a short while to resolve

the difficulties. The Mother reiterated that she felt that the father had mental health problems.

11.12 This incident was not coded as a Domestic Incident and therefore was not referred to partners. At the time this incident was reported the agreed referral criteria was as follows:

- 3 or more PPI incidents in 6 months.
- Child caller to Police/ Emergency Services.
- Victim/ Perpetrator is known to be pregnant.
- Child abuse marker on address.
- Incident involves perpetrator subject to licence or Community Order.
- Crime committed (Violence/ Risk to the child).
- Professional Judgment (e.g. poor home conditions.)
- Serious Incident (inc MARAC)**.**

11.13 A month later the father attended the GP surgery due to his long-term health concern. He reported that he was finding it upsetting and didn't want to leave the house or talk to customers at work. The father also spoke to the GP about an illness he had suffered in Bangladesh as a child. The father informed the GP that he wanted a diagnosis and was upset that this could not be given. He refused the offer of a second opinion.

11.14 In early January 2018 GMP received a telephone call from the Mother via the 999 system. The Mother stated that the father had been shouting at her and he was being mentally abusive to her. She informed the call operator that he was mad. Police attended at the home address and the couple reported that they were in the process of separating. The three children were observed to be safe and well by the officers. The father stated that he was suffering from anxiety and depression, neither party was willing to leave the family home which may have alleviated the tensions. The DASH[5] risk assessment was completed, and the incident was graded as medium however when reviewed this was changed to standard by the triage officer.

[5] https://whatworks.college.police.uk/Research/Documents/Risk-led_policing_and_DASH_risk_model.pdf

11.15 In June 2018 the father attended the GP surgery and presented as depressed. The GP noted that the father had ongoing mental health problems which had been present for the last two years. The father informed the GP that he had previously had three Cognitive Behavioural Therapy sessions two years ago that these had helped but that recently he had lost enjoyment in things and continued to be insecure about his halitosis. The father reported that his low mood has resulted in him having a poor relationship with his wife and children. The GP noted that the father was well presented, gave good eye contact and was chatty and engaging during the consultation. The father agreed to attend counselling.

11.16 Two months on from the GP appointment the father attended two appointments with a counsellor. It was noted that he had engaged in the sessions. He failed to attend his third session.

11.17 Four days later a call was received by GMP via the ambulance service. The ambulance service had received a call in the afternoon from Sibling 1 stating that her Mother and sister had been assaulted by her father and sustained injuries to their neck. The father was still at the property in the back garden. Sibling 1 had been at the corner shop, came home and saw her father outside. Sibling 1 took the knife from him and put it in the sink.

11.18 The Mother had serious bleeding from her neck and defensive wounds after being cut with the knife by her husband; he had also cut the neck of their five-year-old daughter Child P who had run in after hearing her Mother's screams. The cut to Child P's neck was deeper and required surgery to close the wound. The wounds were classed as serious but not critical, both Mother and daughter had injuries approx. 3 inches across and at the centre of the neck it was quite deep; on Child P this was to a greater depth. The father had also attempted to cut his own throat and required hospital treatment.

11.19 A Strategy Discussion took place that same day between CSC and GMP and a decision was made that the two other children would stay with a relative, after satisfactory checks had been completed. The father, upon his discharge from hospital, was arrested on suspicion of attempted murder.

11.20 The following day a multi-agency Strategy Meeting took place and was attended by all the key agencies apart from schools. Those in attendance included CSC, GMP, Project

Choice, Health and Probation Services. Health information shared with the custody health practitioner included the father informing that he had experienced severe depression and had a pornography addiction which his family may have been aware of. GMP shared the plans to video interview Mother and two of the children. Father had been interviewed but made no comment throughout. GMP advised of their intention to seek approval from the Crown Prosecution Service to charge and remand the father into custody given the seriousness of the incident. It was also shared at the meeting that the Mother had experienced six pregnancies; however only four resulted in live births and one of these children died.

11.21 The S47 investigation concluded; during the investigation, the Mother had indicated that she wished to leave the relationship but had been unable to do so; she had limited knowledge and information about available support, this was in part due to language barriers. Mother was clear with agencies that she would be moving to a new Local Authority, in which she had family support, and had been observed preparing to do so. The case was heard at MARAC and an action was set for CSC to provide a change of address form once her new address was established for MARAC to be transferred.

12. Response to the Key Lines of Enquiry.

Did the decisions and actions in the case comply with the policy and procedures of the named service and Oldham LSCB?

12.1 Following the first strategy meeting in 2016, where domestic abuse was identified, actions were recorded to make referrals to the IDVA and Families Greater Together; neither of these actions were completed which is not in line with policy. At this point the family were engaged with services and would have benefited from support from more specialist provision to address the domestic abuse and family difficulties in respect of father's mental health.

12.2 Within the health record there was references to safeguarding supervision having taken place however the completed documents were not available within the child's health records. This was not in line with the trusts safeguarding supervision policy.

12.3 During the Strategy Meeting in 2016 the information regarding father having a knife in his hand was not given any real analysis at the meeting. The strategy meeting was well attended but the GP was not in attendance and Mother had provided far more detail to the GP than she had to GMP. Without the GP being present the effectiveness of the Strategy Meeting was diminished.

12.4 The Single Assessment completed in 2016 was not completed in line with Working Together 2015. Agencies did not fully contribute to the assessment and were only contacted for their views when the decision had been made to close the case.

Was there effective interagency working and service provision for the child and family?

12.5 There are several occasions which indicate that interagency working was not as effective as it should have been. Effective interagency collaboration and communication is essential to safeguard children. During the Learning Event it was identified that the school had not been invited to the Strategy Meeting in 2016. There was an assumption that this was the school holiday period and therefore there was no attempt to contact the relevant person, who would have had access to their emails during this period.

12.6 During the Single Assessment which was being undertaken by CSC the views of agencies was only sought when the decision had been made to close the case. This was poor practice and the views of agencies were not used to guide the plan to keep the children safe.

12.7 Practitioners at the Learning Event identified that given the difficulties identified in the family during their contact with various health professionals which included domestic abuse, parental mental health, language and communication difficulties and bereavement it would have been appropriate for support to have been offered to the family via early help services and a CAF. This would have enabled the Mother in particular to have access to services which would have helped her to gain an understanding of her options. Mother did not have the support networks or knowledge to understand that she could leave the relationship and access housing and benefits in her own right.

Did effective information sharing take place between the Police and Health and Oldham Children's Services?

12.8 Father had extensive contact with the family GP and at times his presentation was a cause for concern. The GP did not have a working knowledge of the family history of bereavements as the family had been under another practice, the information was contained within the families records but not fathers. The GP did note on a few occasions that the father presented with passive aggression and was anxious about his ongoing health issues and low mood.

12.9 The GP did share information effectively with CSC when the Mother came to see him in 2016 and shared concerns regarding the father shouting at her with a knife. This rightly prompted a referral to CSC and subsequently led to a multi-agency Strategy Meeting. However, the information contained in this referral regarding the father holding a knife had been held by the police for the preceding six days (assuming this was the same incident) and was still awaiting a review when the request was received by GMP to attend a Strategy Meeting. At the Learning Event it was discussed that in 2016 it was not unusual to have several incidents awaiting review/triage. Within GMP the senior leadership team would be updated daily and would mobilise resources if these backlogs reached a critical level. Since this time there has been improvement within the processes including a daily risk management meeting (in which key agencies meet daily to share information and manage risks) which does reduce but not eliminate this reoccurring.

12.10 At the Strategy Meeting there was evidence that information sharing was not as good as it should have been by GMP regarding the information contained in the incident report in respect of father holding the knife. This was not shared at the Strategy Meeting by the officer attending as the officer was not in possession of the police incident report. The DA officer had printed off the short history[6] of the call and the circumstances as reported by the attending officer. This did not contain the information contained in the initial call regarding the knife; the Mother did not raise concerns regarding father hitting the children with the police in either the initial call or when officers attended the home

[6] This report has a character cut off that did not allow for the full circumstances of the call.

address. CSC had arranged the Strategy Meeting on the back of the referral from the GP, this was a written referral which included disclosures around DV and the mother's concerns about being threatened with a knife and a child being slapped.

12.11 It is not unusual for a Domestic Abuse Victim to give a different account to the police, as the consequences are very different. There was an assumption at the Strategy Meeting that the Mother had exaggerated her report to the GP. Agencies did not appear to consider that Mother may have played down what had happened to the police as the consequences would have led to the arrest of her husband, which she had informed the GP she did not want. There was the possibility that the version given to the GP was the correct one, but this was not considered. At the Learning Event the representative from CSC identified that there was a lot of vagueness about the timescale of when things happened, such as the children being hit and that a S47 investigation should it have occurred, would have picked up more detail. Following the Strategy Meeting there was no mention of the knife in the social workers assessment notes.

12.12 The history of bereavements in the family and the lack of support for the father was discussed during the Strategy Meeting and an action set for contact to be made with mental health services but this did not occur.

Determine the extent to which decisions and actions were child focussed.

12.13 The children were seen on a regular basis in school, via health agencies and by the social worker during the Single Assessment. Within the school environment the children did not stand out as in need of additional support in 2016 Sibling 1 and 2 were noted to be quiet and shy, their attendance was excellent. Following the incident in 2018 the school again identified that there was nothing in respect of these children that raised concerns. Their attendance had remained good and they were always clean and well presented. Both Sibling 1 and Sibling 2 had friends, they were children who never complained or spoke about their home life. Academically they made good progress.

12.14 During the Single Assessment in 2016 the children were spoken to by the social worker, this only appears to have been on the one occasion. Sibling 2 commented to the social worker that he did not like it when his parents argued and that this scared him. Sibling 1 also commented about her parents arguing, stating it did not happen a lot, but she wished it did not happen at all. Sibling 1 was anxious about her parents

splitting up and did not want this to happen. Both children denied they had been physically assaulted by their father.

12.15 Despite Sibling 2 showing anxiety regarding the exposure to domestic abuse and stating he was scared, triangulated with information from school during this same assessment period regarding him showing anxiety on occasions should in my opinion have led to a referral for support via an early help offer rather than the case being closed.

Was previous relevant history and information about the family and young person considered in professional's assessment, planning and decision making in respect of the family and their circumstances?

12.16 The Single Assessment undertaken in 2016 does not refer to the family history and how this was impacting on the parents. More significantly the health visiting records did not have details of the significance of the family losses to the father. There are references to the Mother's low mood but the reasons potentially for this are not explored or recorded. The GP also did not have oversight of the family history and thus it did not influence the services he made available to the father, mother and children.

12.17 *When new safeguarding concerns were identified was appropriate action taken to address them? Establish if there was clear evidence of a risk of significant harm which was not recognised by agencies or professionals in contact the family, or not shared with others, or not acted upon appropriately*

12.18 The first reported domestic abuse incident in 2016 did not receive as robust a response as required. The delay in the information sharing between the police and CSC was a significant safeguarding concern and had the GP not been visited by the Mother and subsequently referred the family then the delay may have been even greater. This was then compounded at the Strategy Meeting when all agencies assumed that the incidents were one and the same and GMP did not share the information regarding the knife, which was present in the initial call to the police from the Mother. The police did not have knowledge of the allegation of physical abuse re: the children as this information was shared with the GP. The GP who could have provided context regarding this was not present at the meeting. The Strategy Meeting

was not fully informed of the family circumstances and thus the decision to progress to a S17 Single Assessment was flawed.

12.19 The third domestic abuse incident in January 2018 was viewed in isolation. The attending officer was aware of the relevant history. The previous two incidents to the police were not considered in the Enhanced Risk Assessment and a referral was not made to CSC.[7] At the Learning Event it was discussed with practitioners about responses to domestic abuse at this time. Most calls primarily from the mother but not always, reporting some complex issues between the parents, e.g. alleged rapes, children touching the father inappropriately, and father thinking that the Mother was putting them up to it, this information was never passed onto the school or CSC. The second incident was not recorded as a domestic abuse incident and as it currently stands this wouldn't have met the criteria for a referral to CSC. In other areas all incidents of domestic abuse where children are involved are discussed at the daily risk management meetings. There was discussion regarding this at the SCR panel as to whether a referral should have been made under the criteria of professional judgement.

Were there any obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This should include consideration of both organisational issues and other contextual issues?

12.20 At the time of the referral in 2016 staffing in CSC at the '*front door'* was not as robust as it is currently. Screening of contacts also took place differently. In 2016 the MASH[8] was in its infancy; information sharing and case discussion between agencies was not routinely undertaken, processes and procedures were not in place or as developed as they are now. A daily risk management meeting now takes place each morning to discuss high risk cases that need immediate action, based on robust information. Whilst this is progress this is an area that could be further strengthened. In other districts in Greater Manchester the meeting format has changed to the DACC

[7] This may have been because there were duplicate nominals in relation to the parents. Therefore, the incident was viewed in isolation as it was the only one visible to the triage officer

[8] Multi-Agency Safeguarding Hub

Domestic Abuse Child Concern Meeting and this meeting includes a discussion re all DA incidents were children reside in the home.

12.21 Communication and information sharing between partner agencies is well established which was not in place at the time of this case review. Decision making is informed by robust information gathering.

12.22 GMP historically had an issue regarding the timely triage review of medium risk domestic abuse and with the volume of referrals generated in respect of domestic abuse callouts. Practitioners reported that additional resources were only mobilised during this time when delay in dealing with these would reach a critical level.

12.23 At the time school were not routinely informed when there had been a domestic abuse incident in the home. Operation Encompass[9] should ensure in future that school is aware of all DV incidents. This would result in more conversations of which there would be an opportunity for information to be shared.

The only area it could be argued that professional judgement was not exercised appropriately was in 2016 when the information regarding the knife was not shared at the Strategy Meeting by GMP, which in turn impacted on the multi-agency decision not to progress to S47. However, the decision made not to invite the referrer to the strategy meeting assumed that the incidents from GP and Police were one and the same. It was the GP referral that referred to the knife.

12.24 The majority of the SCR Panel also felt that the decision in 2017 by the response officer to not make a referral to Children's Social Care was also evidence of flawed professional judgement.

Were the responses following the two still births and bereavement of their second child proportionate to the needs of both parents. Did practitioners lose sight of the needs of the father when supporting the family?

[9] https://www.operationencompass.org/

12.25 It is fair to say that knowledge of the family's losses was not widely known to agencies working with the parents and children. The information had been shared at the strategy meeting in 2016 but did not feature within the Single Assessment completed by Children's Social Care. During the information sharing meeting for this Serious Case Review agencies currently involved with the children first became aware of this information, had this been analysed within the previous assessment it is likely that other agencies may have had this information. From the records it was clear that mothers need for support was well considered however the fathers less so and although initially offered bereavement support which he refused this was never revisited with him. Father was considered in terms of how he was supporting the Mother.

How robust was the Single Assessment which was completed by CSC and did it include the views of all partner agencies involved with the family?

12.26 The Single Assessment was delayed and didn't fully commence until three weeks after the referral had been received from the GP. This was due to sickness by the allocated social worker. The Mother, father and children were seen at school. There was not an interpreter present and Mother was not signposted to support services for domestic abuse where she would have been able to receive independent advice and support.

12.27 Father disclosed several pressures to the social worker but then advised that these had settled of late. The Mother was clearly concerned about his mental health but there seemed to be little weight attached to her views.

12.28 During the second assessment session the parents presented as more reflective and were able to articulate that their arguments were having a detrimental impact on the children and they advised the social worker that they would arrange for marriage counselling and father would attend the GP. A decision was made by the social worker to close the case due to the parents demonstrating a capacity to change. This was overly optimistic and there was no evidence to back this up.

12.29 The assessment completed did not consider the views of the multi-agency and at the Learning Event both the children's school and health practitioners raised concerns that

their views were only sought once the social worker had decided to close the case. This was poor practice.

13. APPRAISAL OF PRACTICE

Introduction

13.1 This section will provide the overview, appraisal of practice, analysis of the key lines of enquiry and the findings of this serious case review, with recommendations for Oldham Safeguarding Children's Board and its partners. The findings relate to what has been learnt about the strengths and developmental areas in the multi-agency system.

13.2 The findings of this serious case review do not indicate that inter-agency practice nor the practice of any individual or organisation could have altered the outcome of this case. Inevitably, in any review where a child has been seriously injured there will be lessons to be learnt. In this case there are several areas where practice could have been better, but this is unlikely to have altered the outcome for Child P and her siblings. The actions of the father on the day in question could not have been predicted.

13.3 A Learning Event took place and was attended by practitioners from the main agencies. Some key information was shared during the Learning Event which clarified information already provided by agencies via the agency chronology and contextual information regarding the family was shared. Attendance at the practitioner event was good and those attending participated actively in assisting with analysis of events and identifying learning from the case. Practitioners at the Learning Event identified several missed opportunities and areas where practice could be improved. They all agreed that although there were missed opportunities this would not have impacted on the outcome for Child P.

Analysis of Events during the period under review.

Theme: Cultural Competence

13.4 In this case there were many opportunities where practitioners could have been more culturally attuned to the family's needs. English was not mothers first language yet on several occasions when professionals engaged with her the initial conversations did not take place with an interpreter present. Without this the professionals from Police,

health and CSC were unable to fully understand the nuances of the language or understand the cultural norms within the community the family lived. There was a belief that the Mother spoke English to a good enough standard; practitioners at the learning event who knew the mother acknowledged and this was not accurate perception of her understanding.

13.5 During the learning event a practitioner from Project Choice provided a very powerful example about how language can be misunderstood without a skilled and competent interpreter present who understands the dialect and norms of the community. She described how in the Bangladeshi community if someone has a headache, they will use a phrase which if translated precisely would indicate that the person was being hit on the head with a hammer. A skilled interpreter who understands the dialect and norms would know she was referring to a headache. The lack of an interpreter showed a lack of cultural awareness in many of the key agencies.

13.6 Professionals also did not understand how the impact of ethnic, religious and cultural influences added layers of complexity to what were already complex family relationships. This was an area explored in the learning event with practitioners.

Theme: Responses to Domestic Abuse.

13.7 GMP identified at the Learning Event that the Police Log of the incident reported to them in 2016 does make mention of the father having a knife in his hand whilst shouting at the Mother. The mention of the knife was in the initial call out report. This information was not raised at the Strategy Meeting and it has been difficult to ascertain why this occurred but likely to the printing of the domestic abuse history report which did not contain details of the initial call from Mother would be the reason. It must ultimately be attributed to the judgement of the attending officer. This strategy meeting was a key missed opportunity to engage with the Mother and family proactively. The information regarding the knife was shared in the GP referral but there was an over-reliance on the Police report rather than the professional information from the GP.

13.8 A domestic abuse incident in early 2018 was also another example of poor interagency working and evidenced that responses to domestic abuse were not a robust as they

should be. During this incident the father was shouting and being abusive. Mother initially contacted GMP but passed the telephone to Sibling 1. On attendance the issues identified included father's mental health and parents struggling to live together. Advise and services were offered by officers and the incident was graded as a medium. This was then reviewed and downgraded to standard. The officer reviewing this matter was unaware of the previous incidents because of the number of duplicate nominals for the parents. This meant that no referral was made to CSC. The information had been looked at in isolation and at the Learning Event GMP practitioners acknowledged this was not the right decision and that this has been addressed and that there is a more robust process now in place for screening domestic abuse. However, the referral criteria used to make a referral to CSC at that time is still in use today and it is unlikely a different response would be made to this information.

13.9 The responses to domestic abuse evidenced that there was a lack of a joined-up approach to dealing with this in Oldham at that time. Information sharing between the key agencies has now improved.

Theme: Impact of bereavement

13.10 The family suffered three traumatic losses prior to the period under review however the impact of these losses was significant and could have been a contributing factor to the mental health difficulties the father was experiencing. In 2006 their son died in hospital whilst under observation for failure to thrive he was a small baby at the time and there is limited information on his siblings' records regarding him.

13.11 Mother also suffered two still births. In 2010 the Mother suffered a still birth following the intrauterine death of her baby at 36 weeks gestation. She was extremely upset and was referred for bereavement support however little is recorded in respect of the father apart from the fact he was supportive of Mother. He was not referred on to any support services.

13.12 At the Learning Event practitioners identified that working with families where there had been bereavement was an area of development across the partnership. Practitioners did not have the knowledge or skill base to support families and children.

Theme: Working Effectively with Fathers.

13.13 In 2006 following the bereavement of their son the health visitor completed a visit to the family home. The father was noted to be extremely angry. He was angry that a postmortem examination had been carried out on his son and that he had refused consent for this to take place but that this had been ignored. His anger was directed towards the hospital where his son had died. He was also angry that communication had been poor following the postmortem. He advised the health visitor that he was too angry to talk about the loss of his son. The Mother was noted to have support from the extended family but there was no exploration of what if any support was needed in respect of the father.

13.14 Fathers anger could have had roots in his Islamic faith whereby it is believed that the dead body is sacred and that rituals are an important part of paying respect to the dead including bathing and shrouding the body. “Breaking the bone of a dead person is similar (in sin) to breaking the bone of a living person[10]” Many Islamic scholars would frown upon a post mortem and it is not clear if fathers’ beliefs in part could explain some of his anger however, he did inform a health worker that his beliefs were that the child would feel pain in a post mortem. This would be an extremely distressing thought for any parent.

Theme: Effectiveness of multi-agency working.

13.15 Multi-agency working is about providing a seamless response to children and families with multiple and complex needs. In this case there is little evidence that the multi-agency working across the partnership had an impact on the outcomes for the children.

[10] https://www.central-mosque.com/fiqh/postmortem1.htm

13.16 The failure to undertake a S47 investigation as an outcome of the strategy meeting in 2016 was made based on the information presented. The multi-agency partners in attendance presumed that the Mother had exaggerated events to the GP so that her husband would access services. There was no challenge to this view. The outcome was to progress to S17 assessment.

13.17 Working Together 2015[11] and Working Together 2018 describe assessment as a a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child. Good Assessments bring together information from the child and their family and from relevant professionals this would include teachers and nursery staff, health professionals and police.

13.18 The assessment completed was not informed by the multi-agency partnership. The decision to close the case had been made before the social worker had spoken to the school and health professionals. There was no consideration given to a coordinated early help offer for the family

Conclusion and Recommendations

13.19 Statutory guidance requires that Serious Case Reviews provide a sound analysis of what happened in the case and what needs to happen to reduce the risk of recurrence in future cases. In 1989 the United Nations Convention on the Rights of the Child (UNCRC) set out in detail what every child needs to have for a safe, happy and fulfilled childhood[12].

13.20 In this Serious Case Review there were some areas of practice which clearly could have been improved however, apart from the incident in 2016 there was little to indicate what was to happen in this case. Overall, the family were seen to be coping well and received universal services. In school the children were well kempt, polite and had

[11] http://www.safeguardinginschools.co.uk/wp-content/uploads/2015/03/Working-Together-to-Safeguard-Children.pdf
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf

[12] https://www.unicef.org/french/adolescence/files/Every_Childs_Right_to_be_Heard.pdf

good attendance. At times Sibling 2 did show signs of anxiety but without knowledge of the family circumstances this was not explored more closely.

13.21 Fathers mental health problems and unresolved grief responses did have an impact on the whole family, and he was never fully assessed in respect of this. Father was perceived as odd by many of the professionals who met him, his hostility and passive aggression evident at times to professionals, domestic abuse to his wife and paranoid concerns which he raised on occasion in respect of the children; citing them as being disrespectful to him, were all indicators of concern. However, no professional had oversight of all these concerns collectively that would have enabled them to make sense or predict what was to come.

13.22 It is clear in concluding this review that no individual practitioner nor agency could predict the actions which would be taken by the father however, as with all reviews there are areas of development and learning

13.23 It was identified at the learning event that the use of interpreters is still inconsistent. Practitioners across the partnership also were unable to evidence cultural competence when dealing with the family.

Recommendations.

Use of interpreters needs to be more consistent when English is not the family/parents first language. The Safeguarding Partnership Arrangements should ensure that there is an audit of similar cases in order that practice has improved in this area.

Ensure that practitioners from health, police, education and CSC have the knowledge to make an accurate assessment of a family's circumstances which takes into consideration their background, culture and beliefs.

13.24 The responses to domestic abuse were inconsistent and whilst a one-off incident may be viewed as not meeting the criteria for a safeguarding referral, these incidents must be seen within the wider context of the child and family circumstances. Professionals should be curious about what else is going on for the children. Although the process around screening of police incident forms has improved and schools will now receive

all contacts the current system still allows for mistakes. The second incident of domestic abuse did not trigger a domestic abuse referral at that time nor would that information be treated any differently today.

Recommendation.

The current criteria for referrals to CSC in respect of domestic abuse must be reviewed considering the findings of this review.

All GMP staff attending strategy meetings to be appropriately trained in relation to Working Together to Safeguard Children 2018 and the actions that Police should take.

Comprehensive training to be undertaken for frontline practitioners on domestic violence and vulnerability factors. This should include an understanding of what partner agencies can offer.

13.25 *The Single Assessment undertaken by CSC did not fully consider the views of all agencies and the decision had been made to close the case before the views of the health visitor and school had been sought.*

Recommendation.

A multi-agency audit to be undertaken of recent Single Assessments to ensure that the views of the multi-agency network who understand the child and family best are considered within the body and analysis of the assessment.

13.26 *There is a lack of awareness across the partnership of how to respond to Children and Families were there have been bereavements. This was an area of development identified by practitioners at the learning event.*

Multi-agency training to be delivered across the partnership to address this.