Serious Case Review
Executive Summary
Re: Child T

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Childcare Management Systems

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1. Introduction

1.1 This report is a summary of the findings of a Serious Case Review (SCR) that was undertaken to critically examine the role of agencies involved with Child T and his family between 1st January 2008 and 10th November 2009.

1.2 At the time of Child T's death, the guidance on whether to conduct a SCR was provided in Working Together to Safeguard Children (2006) at 8.5. This requires the Local Safeguarding Boards to undertake a SCR:

'When a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death. This is irrespective of whether Children's Social Care (CSC) is, or has been, involved with the child or family.'

1.3 Though the cause of Child T's death remained unascertained following a post mortem examination, there were concerns that neglect may have been a contributory factor. It was also the case that Child T had been the subject of a S.47 (Children Act 1989) enquiry in October 2008 and had received support via a Child in Need (CiN) plan from November 2008 until June 2009.

1.4 The circumstances of Child T's death were considered at the Manchester Child Death and Critical Incident Panel (CDCIP) on 20th November 2009 where it was agreed that the criteria for conducting a SCR were satisfied. A recommendation to proceed with a SCR was made to the Chair of the Safeguarding Board and Ofsted were notified on the same day.

1.5 When Ofsted were informed of the decision to conduct a SCR, an expected date for completion was set for 20th March 2010.

1.6 On 19th January 2010 the Serious Case Review Manager wrote to Government Office North West (GONW) to inform them of the need to extend the timescale for the completion of the Review to 31st May 2010. The reason for the extension was to allow Individual Management Review (IMR) authors the time they needed to complete their Reviews to an acceptable standard following some additions and amendments to the original terms of reference for the SCR.

1.7 The Serious Case Review Manager wrote to GONW again on 16th April 2010 to inform them of the intention of the Panel to extend the timescale for completion of the Review to 31st July 2010. The reason for this extension was to allow Mrs E and members of her family the opportunity to contribute to the Review.

1.8 When the SCR began, Mrs E was in custody awaiting trial for neglect offences. It was not known at that time how Mrs E would plead and the advice from the Crown Prosecution Service (CPS) was not to contact her or any members of her family so as not to compromise the outcome of the criminal proceedings.

1.9 In the event Mrs E pleaded guilty to a charge of neglect and once she was convicted, the need to protect evidence no longer applied and she and members of the family could be invited to contribute to the SCR. The Panel was of the view that Mrs E and her family had the best insight into the sequence of events that led to Child T's death and could contribute significantly to the learning from this Review. It was agreed that the potential value of this information was worth extending the timescale for the Review for a further period. GONW were notified that the new completion date for the SCR would be 31st July 2010.

1.10 The Overview Report was received by MSCB on 15th July 2010 and its findings and recommendations were accepted in full. The Executive Summary was available for consideration on that date, but a decision was made not to table the report pending the comments of the Board Members on the Overview Report.

1.11 At the conclusion of the Board meeting the MSCB Chair suggested that the Executive Summary could be received by the Executive Committee of the Board so that the original date for submission could be met. This suggestion was declined as the consensus was that, given the important and powerful messages from the SCR, it would be preferable for the whole Board to receive and consider the content and recommendations of the Executive Summary in full.

1.12 As a consequence it was decided to delay the submission of the SCR until 16th August 2010 and GONW were notified accordingly.

2. Circumstances that led to the Serious Case Review

2.1 Child T first came to the attention of CSC on 14th October 2008 when he was referred by Greater Manchester Police. The Police had been called to an incident at Mrs E's home and had found her in a highly intoxicated state in charge of Child T who was, at that time, three weeks old. He was found on the floor by the Police in front of a gas fire and surrounded by combustible material. Mrs E was arrested and Child T's welfare was secured by the Police using their Protective S.46 (Children Act 1989) Powers.

2.2 Child T remained looked after for a short period during which time a S.47 enquiry was completed. It concluded that although Child T had been exposed to likely significant harm through his mother's actions, due to Mrs E's commitment to make the changes that were necessary to safeguard Child T, the likelihood of further significant harm was low. On the basis of this assessment Child T was returned to his mother's care and arrangements were made for support to be offered via a 'Child in Need' (CiN) plan.

2.3 Following her arrest Mrs E was bailed with the condition that she attended the Community Alcohol Team (CAT) for assessment. She attended on two occasions. At the first session the CAT Worker assessed Mrs E's alcohol misuse as harmful and at the second session it was concluded (based on Mrs E's self-report of her drinking habits at that time) that the likelihood of harm to herself or Child T in future was low.

2.4 CiN planning commenced on 25th November 2008. The main focus of the plan was to provide Mrs E with support via the CAT to allow her to address her alcohol misuse difficulties and to signpost her towards services to allow her to deal with the emotional and psychological problems that she experienced. Child T remained the subject of a CiN plan for 7.5 months. During this time his weight fell from the 9th centile to the 0.4 centile (this was not reported to the CiN meeting nor was a paediatric review considered), Mrs E missed a number of health appointments, Child T's immunisation programme was delayed and there were repeated expressions of concern about Mrs E continuing to drink, including one occasion when she was reported to CSC as being drunk in charge of Child T and another occasion when, from the evidence available, it was likely that once again she had been drunk while caring for Child T. During this period also Mrs E withdrew from the counselling support she had been offered as she found it too painful to reflect on her earlier life experiences.

2.5 Despite the lack of evidence of progress, the CiN planning group considered that Mrs E was able to offer a 'good enough' standard of care to Child T without additional support and he ceased to be the subject of a CiN plan on 4th June 2009.

2.6 Child T remained an open case to CSC until 4th September 2009. During this period:

- An anonymous referral was received that Child T was being left unattended by his mother. CSC made a number of unsuccessful attempts to contact Mrs E and when contact was established eight days later, she denied the allegation.

- Mrs E was involved in a fight with a relative while she was holding child T. She was seen at hospital and drink was noted to be a factor. The matter was referred to CSC who advised that Child T could be returned home, but there was no follow-up response from CSC.

- A friend of Mrs E's reported that she (Mrs E) had been drunk in charge of Child T and had had an accident at home two weeks earlier. This was followed up two days later with a telephone call from CSC. Mrs E denied the allegation that she had been drunk.

Child T's case was closed by CSC on 4th September 2009.

2.7 On 4th October 2009 there was an incident at Mrs E's home which involved two of her relatives who alleged that Mrs E was drinking around Child T and was neglecting him. The Police were called and the situation was calmed. The Police Officers involved inspected the premises and saw Child T, and although there was no immediate cause for concern, they referred the matter to CSC as Mrs E appeared to need assistance. An initial assessment was undertaken on the following day which confirmed the GMP observations – that the home appeared in good order and Child T appeared to be well. A decision was made to close the case.

2.8 On 3rd November 2009 an anonymous call was made to CSC alleging that Child T looked small and undernourished and Mrs E's mood and behaviour were erratic. These concerns were passed to the HV who agreed to look into them in the course of a visit she had intended to make at that time. The HV hand-delivered a letter of appointment for 5th November 2009 to Mrs E's address. This appointment was cancelled by Mrs E and rearranged for 12th November 2009.

2.9 On 6th November 2009 the anonymous caller contacted CSC again to check on the progress of the initial referral and to report that Mrs E had been seen with Child T at her place of work (she was on sick leave) and she smelled of alcohol. Before any action could be taken on this additional information, Child T's death was reported on 10th November 2009.

3. Process of the Review

It was agreed by the CDCIP that the Serious Case Review would:

3.1 Cover the period from 1st January 2008 (i.e., the early stages of Mrs E's pregnancy) until 10th November 2009 (the date Child T's death was reported).

3.2 Appoint an Independent Chair and separate Independent Author of the Overview Report. This is consistent with the guidance contained in Working Together (2006). The Chair of the Review Panel was a retired Senior Police Officer. He has had extensive experience in safeguarding work and has been the author of a number of Overview Reports and is the Chair of a Joint Child Death Overview Panel in another authority. He had no contact with Child T's family before or during the SCR.

The Overview Report Author was an independent consultant with 25 years' experience in child protection work and extensive experience in writing Overview Reports. He had no previous involvement with or knowledge of Child T and his family.

3.3 Consider to what extent family members were able to contribute to the Review and what form this should take. At an early meeting of the Panel it was agreed that there would be value in seeking contributions from Mrs E, Mr E, Mr F, Child 2, Ms K, Mrs H and Miss G. However, the Panel was advised to delay making contact with any of these people pending the outcome of the criminal proceedings against Mrs E.

These concluded in early 2010 and contact was made with the people identified. Mrs E, Mr E and Ms K responded and were seen and interviewed by the Independent Overview Author. It was the view of the Panel that their involvement made significant contribution to the understanding and subsequent learning from this case.

3.4 Receive Individual Management Reviews from the following agencies:

- NHS Manchester (Provider Services)
- Greater Manchester Police
- Sure Start
- University Hospital of South Manchester
- Housing Trust
- North West Ambulance Service
- Connexions
- Manchester City Council Children's Social Care Services
- NHS Manchester (Commissioning)

In addition to the IMR's above, the Panel also received information from:

- Safeguarding Manager (Education) relating to Child 2's education record
- Counselling Service that provided Mrs E with support between January and April 2009
- NSPCC regarding the anonymous contact on or about 30th October 2009

The Panel also received correspondence from the CPS relating to the progress of Mrs E's criminal proceedings and from the Coroner's Office enclosing all the evidence held by the Coroner on Child T's death.

The Overview Author also had sight of the following documents:

- Post-mortem examination report on Child T
- The Judges case summary and judgement in Mrs E's trial
- Pre-sentence report prepared by Greater Manchester Probation Service
- GMP 'time-line' used in preparation of Mrs E's case
- Court bundle from Mrs E's criminal proceedings containing all witness statements

In order to promote transparency and independence, none of the IMR Authors had any direct line management responsibility for the practitioners involved in this case and none had had previous contact with Child T and his family.

3.5 Convene a SCR Panel with the following membership:

- Mr David Hunter, Independent Chair
- Designated Nurse and Consultant Nurse (Safeguarding), NHS Manchester
- Designated Doctor and Consultant Paediatrician, NHS Manchester
- Detective Inspector, SVPU, Greater Manchester Police
- Strategic Lead Worker for Children and Families, Manchester Alliance for Community Care
- Principal Manager for Safeguarding, Manchester City Council Children's Social Care Services
- Alcohol Strategy Manager, Drug and Alcohol Strategy Team

Mr Michael Muir, the Overview Report and Executive Summary Author also attended the Panel in the role of participant/observer.

The Chairperson of the Manchester Safeguarding Children's Board is Mr Ian Rush.

3.6 Consider the following case specific terms of reference:

1. How were issues and allegations of neglect responded to and managed by agencies?

2. Were the assessments that were completed on Child T and his family 'fit for purpose' and did they accurately identify need and risk, informing appropriate intervention strategies?

3. How did agencies take into account Mrs E's previous history, family and social relationships, when assessing her parental capacity? Were the concerns about parenting abilities, as expressed by the extended family, fully appreciated and taken into account?

4. How did Mrs E's difficulties with alcohol misuse impact on her ability to safeguard and promote Child T's welfare?

5. How were the cultural, linguistic, ethnic, religious and disability needs of Child T and his family taken into account?

6. Did agencies communicate effectively and work together to promote Child T's welfare?

7. Were inter and intra-agencies' policies and procedures followed in this case?

8. Was the management oversight and supervision in this case adequate?

In addition to these case specific issues, the Panel also considered whether:

There were any similarities between this SCR and others that had been undertaken, both locally and nationally?

and

From the information available could Child T's death have been predicted or prevented?

3.7 The Review Panel met on the following dates:

- 15th February 2010
- 2nd March 2010
- 10th March 2010
- 6th April 2010
- 28th April 2010
- 4th May 2010
- 10th May 2010
- 7th June 2010
- 29th June 2010

All of these meetings were well attended by Panel members. Each meeting lasted approximately four hours.

4. Family Composition & Profile

Subject	:	Child T
Age	:	14 months
Ethnicity	:	White British
Mother	:	Mrs E
Age	:	40+ years
Ethnicity	:	White British
Half-sibling	:	Child 2
Age	:	15+ years
Ethnicity	:	White British
Maternal Grandmother	:	Mrs H
Age	:	60+ years
Ethnicity	:	White British
Maternal Aunt	:	Miss G
Age	:	20+ years
Ethnicity	:	White British
Maternal Aunt	:	Ms S
Age	:	40+ years
Ethnicity	:	White British

Significant Others

Father (Child T)	:	Mr E
Age	:	30+ years
Ethnicity	:	White British
Father (Child 2)	:	Mr F
Age	:	40+ years
Ethnicity	:	White British
Paternal Aunt	:	Ms K
Age	:	20+ years
Ethnicity	:	White British
Mrs E's Friend	:	Ms P
Age	:	N/K
Ethnicity	:	N/K

4.2 Family Profile

4.2.1 Mrs E had a difficult childhood. Both her mother and stepfather had serious alcohol misuse difficulties. Mrs E said she was introduced to alcohol by her stepfather who encouraged her and two other children to 'out-drink' each other until they were drunk. Mrs E was eight years old at the time.

4.2.2 Mrs E was removed from her mother's care when she was ten years old and she was made a Ward of Court because of concerns about physical abuse. She remained in care for the rest of her childhood, initially in a residential placement and then in foster care. Mrs E said she had hardly any contact with her family throughout this time.

4.2.3 She left care when she was 18 years old and moved to independence for a time. This arrangement did not work out and Mrs E returned to the family home for a period during which time her stepfather died. Mrs E was badly affected by this and took a serious overdose as a consequence.

4.2.4 Mrs E met Mr F when she was 19 years old. Child 2 was born when Mrs E was 22 years old and the relationship with Mr F ended three years later. Mrs E, who by this time was estranged from her family, brought up Child 2 alone for the next four years. Mrs E said she had become depressed in the course of her relationship with Mr F and after she separated she began to drink more heavily. By 2005 she was drinking between one and two bottles of wine daily. She also experienced difficulties in her relationship with Child 2 who returned to live with Mr F from time to time throughout this period.

4.2.5 When Mrs E left Mr F she went to live in a three-bedroom house in a relatively quiet area of Manchester. The ethnic mix of the estate is mostly White British and there are low levels of anti-social behaviour. Mrs E has worked for most of her adult life and at the time of the incident on 14th October 2008 she was employed locally.

4.2.6 On New Year's Eve 2006 Mrs E alleged she was raped by an acquaintance of one of her friends. She reported that the experience was devastating for her and she became even more depressed and began to drink more heavily. She estimated that at this time she was drinking two or more bottles of wine each evening. Child 2 was living with his father by this time.

4.2.7 Mrs E met Mr E in August 2007 and he supported her through the trial of the man who she had accused of raping her. At the trial the man was acquitted. Mrs E responded to this by embarking on a drinking bout that lasted for two weeks. During this episode Mrs E reported that she was drinking 5 or 6 bottles of wine each day. Mrs E became pregnant with Child T in January 2008, but by this time the relationship with Mr E was over (due largely to Mrs E's drinking). Mrs E continued to drink throughout her pregnancy and throughout Child T's life.

4.2.8 Mrs E presents as a sad, lonely and defeated woman. The GMP IMR described her as being a 'broken woman' following the incident on 14th October 2008. This remains a reasonable and accurate description of her now. At the time of Child T's death she was estranged from her family and the fathers of both of her children. Her own experiences of being parented are poor and she has endured many negative experiences throughout her life. She appears to be an emotionally needy woman who has managed her personal distress for many years through the harmful use of alcohol.

5. Brief Summary of Events

5.1 Child T was first referred to Children's Social Care (CSC) Emergency Duty Service (EDS) by Greater Manchester Police (GMP) on 14th October 2008. The Police had been called to intervene in a dispute between Mrs E and Adult F and found Child T in a high risk situation with Mrs E intoxicated from alcohol. The Police used their Protection Powers (S.46) to secure Child T and Mrs E was arrested and removed from the property.

5.2 After some delay Child T was found a foster placement where he was to remain pending further assessment by CSC. On 15th October 2008 a strategy meeting was convened by CSC, attended by an Officer from the Public Protection Investigation Unit (PPIU) and a decision was made to undertake a S.47 core assessment. The strategy meeting was aware that Mrs E had told the Officer who arrested her on 14th October 2008 that she had been on a three-day 'bender' due to personal and family problems.

5.3 Later on 15th October 2008 a joint visit was made by a Social Worker (SW3) and a Police Officer. Mrs E acknowledged her difficulties with alcohol and said that she wanted to work with agencies and she wanted Child T to be returned to her care. On the same day Mrs E attended her GP's surgery and requested assistance with her emotional difficulties. A referral was made to the Primary Care Mental Health Team.

5.4 Following her arrest, Mrs E was bailed pending further enquiries, with the condition that she attended the Community Alcohol Team (CAT) for assessment. Mrs E complied with this condition and saw the CAT Worker (CAT1) on 17th October. The first assessment meeting revealed that Mrs E's use of alcohol was considered to be harmful but CAT1 noted that Mrs E appeared motivated and ready to address her alcohol misuse difficulties. A follow-up meeting was arranged for 6th November 2008.

5.5 On 21st October 2008 SW3 consulted with the Safeguarding and Improvement Unit (SIU). She reported on the positive observations of Mrs E's contact with Child T, her expressed wish to work with agencies to effect change, the fact that there had been no previous concerns about Mrs E's parenting of Child 2 and her (SW3's) view that Mrs E's episode of excessive drinking was an isolated incident brought on by recent pressures and difficulties. The outcome of this consultation was a decision for support to be offered via a Child in Need (CiN) plan. Child T continued to be looked after through a Section 20 agreement until his return home on the 23rd October 2008.

5.6 On 6th November 2008 Mrs E attended the CAT for her second appointment. At this meeting Mrs E provided an account of her drinking habits. She said that she had, on occasions, been drinking to excess over the past 12 months, but at the time of the assessment (by her own report) she was drinking approximately one glass of wine per week. On the basis of this information CAT1 concluded that the risk of harm to Mrs E and Child T was low.

5.7 Mrs E was referred to the Sure Start and Early Years Commissioning Team on 6th November 2008 and on 25th November 2008 the first CiN meeting was held. It noted that Mrs E's alcohol use was under control and that she had responded positively and engaged well with the help she had been offered. The meeting agreed that Mrs E was providing good quality care to Child T and he was developing good routines. There had been a visit made by the Health Visitor (HV) on 11th November when Mrs E had smelled of alcohol, but this was not reported to the CiN meeting. On the same day as the CiN meeting, Mrs E's sister reported to CSC that she (Mrs E) had been passed out drunk on the previous day. SW3 visited to discuss this allegation which was denied by Mrs E.

5.8 The second CiN meeting was held on 13th January 2009. There was a new Social Worker (SW2) now involved with the family in addition to a Sure-Start Support Worker (SS1). The meeting was aware that Child 2 had returned to his mother's care and this had increased the pressure on Mrs E. No specific intervention objectives were set at this meeting and Mrs E's engagement with services was described as sporadic.

5.9 On 23rd January 2009 Mr E reported that Mrs E had visited his office (with Child T) and that she had been drunk and abusive. This referral was followed up by SW2 who visited Mrs E. She denied that she had been drunk, but acknowledged that she had had a drink that morning. SW2 took no further action.

5.10 There was a third CiN meeting on 18th February 2009. There had been further incidents of Mrs E drinking and SW2 had spoken to her about the possibility of convening a child protection case conference on Child T. During the time between the CiN meetings and following an initial assessment by a Mental Health Practitioner, Mrs E had accessed counselling to address her emotional difficulties. She attended two sessions, but complained that they made her feel worse and inclined her to drink more. At the CiN meeting Mrs E was unhappy with SW2 (because of the perceived threat of a child protection conference) and also wanted the support from the Family Support Worker to be withdrawn. The HV reported Child T had outstanding immunisations. The minutes of the meeting record that 'Mrs E had made positive steps to reduce the amount of professional support offered to her'.

5.11 There was a domestic incident on 14th March 2009 between Mrs E and Child 2 in which the Police were involved. The record of the visit indicates that 'alcohol on behalf of Mrs E is noted to be a factor'.

5.12 The fourth CiN meeting was held on 8th April 2009. There had been no direct contact from CSC with Mrs E since the previous meeting in February. Mrs E reported that she had ceased attending counselling sessions (as they made her feel worse and increased the risk of her drinking).There were positive reports from CAT1, HV and Sure Start. The meeting concluded that CiN planning would cease at the next review (June 2009) if progress was maintained.

5.13 On 29th April 2009 Mrs E attended a review at Child T's Childminder's home. She was reported to be upset and emotional, dishevelled and to smell of alcohol. This was reported to CSC and the Social Work Student (SWS) that was now involved made a home visit. The record of the meeting confirms that Mrs E looked untidy, smelt strongly of alcohol and that she had said she had drunk wine that morning before the meeting. SWS visited Mrs E the following day when she said that she hadn't been drinking for some time and didn't know why she had drunk on the previous day. Mrs E complained that she was being punished for being honest about her drinking behaviour. CSC took no further action in response to this referral.

5.14 At the final CiN meeting on 4th June 2009 it was agreed that Mrs E had made sufficient progress for Child T to be no longer considered 'in need'. This view was supported by CAT1, and SWS (SW2, the supervising Social Worker and HV did not attend the meeting). The case was closed to the CAT and Mrs E was advised to contact the HV if she needed further support.

5.15 On 22nd July 2009 CSC received an anonymous call that Mrs E may be leaving Child T unattended. CSC made a number of unsuccessful visits and did not make contact with Mrs E until 30th July 2009 when she denied having left Child T alone.

5.16 There was an incident on 4th August when Mrs E attended hospital having been injured in the course of a fight with a relative. Mrs E had been holding Child T at the time and while she had been injured, he had not. Mrs E attended hospital for treatment for herself and to check Child T had not been harmed. The Nurses that treated Mrs E smelled alcohol on her and referred Child T to CSC. GMP also referred the domestic incident. CSC did not make contact with Mrs E until 14th August 2009. On 4th September 2009 Child T's case was closed by CSC.

5.17 GMP was involved with Mrs E on 4th October 2009 following a call from her that she was being harassed by two of her relatives. The Police visited the home and were told of the relatives' concerns about Mrs E neglecting Child T and drinking around the baby. The Police referred the matter to CSC and on the following day a strategy meeting was convened which involved CSC and a PPIU Officer. The strategy meeting agreed that SW5 would visit Mrs E alone and undertake an initial assessment. The outcome of the assessment was that there were no concerns about Child T's care. SW5 advised Mrs E to consult her GP about her medical problems and he agreed to contact the CAT on Mrs E's behalf, but there is no record that he did so.

5.18 Another relative made an anonymous referral to CSC on 3rd November 2009 expressing her concerns about Mrs E's erratic mood and Child T's possible neglect. The referral was received by First Response Team (FRT) who noted that an initial assessment had been concluded within the past month. The FRT worker contacted HV and was informed that it had been her intention to visit Child T in the near future. It was agreed that HV would make this visit and re-refer if there were safeguarding concerns or complete a Common Assessment Framework (CAF) assessment if the circumstances warranted. HV hand-delivered a letter of appointment to Mrs E's home arranging to visit on 5th November 2009. Early on that day Mrs E phoned HV to say the visit was not convenient and an alternative date for the visit was arranged for 12th November 2009.

5.19 On 6th November 2009 Mrs E's relative called CSC again for an update on the progress of her first referral of 3rd November 2009. She was informed the matter had been passed to HV. The relative was reported to be happy with this response and provided further information that Mrs E had been drinking and smelled of alcohol when she visited the place where she worked. There is no record that this information was passed to HV.

5.20 At 6.55am on 10th November 2009 Mrs E called 999 and reported to the Police that Child T was dead at her home. An ambulance was called and Child T was found at Mrs E's address. He was strapped into a buggy and he was placed close to a gas fire. He was taken to a local hospital where he was pronounced dead on arrival. The post-mortem examination revealed that Child T had been dead for a number of days. Mrs E confirmed to the Police that she had been drinking to excess in the days before Child T's death.

6. Further Issues

6.1 From the information that was available, could Child T's death have been predicted or prevented?

6.1.1 The post-mortem examination that was completed on Child T on 11th November 2009 concluded that the cause of death could not be ascertained. As a consequence, it is not possible to determine whether it could have been predicted or prevented. It is reasonable to comment however, that whatever the cause of death, Child T's situation was not helped by Mrs E's state of inebriation and consequent incapacity to attend to his needs in the days and hours before his death.

6.1.2 The question then is whether the neglect which Child T experienced (which led to the finding of the post-mortem examination that he suffered chronic failure to thrive) could have been predicted or prevented.

6.1.3 When Child T first came to the attention of GMP and CSC on 14th October 2008 it was due to concerns about Mrs E's misuse of alcohol and the danger to which Child T had been exposed. The issue of neglect (apart from the charges that were considered by GMP and then not pursued) was never raised. While Child T was the subject of a CiN plan from 25th November 2008 until 4th June 2009 Mrs E continued to drink and there was evidence that Child T was failing to gain weight, was behind on his developmental checks and immunisation programme (through missed appointments), yet the issue of neglect was never raised at any CiN meeting. Child T was felt no longer to be in need on 4th June 2009 'because Mrs E had made such good progress'.

6.1.4 Referrals from the Childminder to HV expressing concern about Child T's small size and developmental delay did not prompt a consideration that he might be the victim of neglect. The referral from Mrs E's relatives which alleged that Child T was being neglected elicited an initial assessment from CSC that was opened and closed in a day. The concerns from another of Mrs E's relative's that alleged Child T was undernourished were passed to HV who was unable to make contact with Mrs E before Child T died.

6.1.5 The reason for Child T's neglect and occasional exposure to danger was Mrs E's unresolved difficulties with alcohol misuse. Because Mrs E never took up the support she was offered to bring her use of alcohol under control she continued to drink heavily and occasionally chaotically. That being the case, and in the absence of any recognition of the impact this was having on Child T's welfare, health and development (which should have prompted a protective response), Mrs E continued to drink and to neglect Child T. From the information that was available, this was an entirely predictable course of events (though the incident on 10th November 2009 could not itself have been predicted).

6.1.6 There were two opportunities, which had they been taken, would have prevented Child T suffering the neglect that he did throughout his life. The first opportunity was missed when CSC failed to take appropriate protective action following the incident on 14th October 2008. The failure to act was based on an incorrect formulation of risk and a belief that the likelihood of significant harm in future was low. Had Child T remained looked after pending the outcome of a parenting assessment and an assessment of Mrs E's misuse of alcohol, then an appropriate protective strategy could have been implemented which would have prevented Child T's neglect.

The second missed opportunity occurred on 29th April 2009, following Mrs E's presentation at the Childminder Review smelling of alcohol and in an emotional state. The SWS who saw her several hours later commented that she appeared dishevelled and upset and smelled strongly of alcohol.

The information that SWS reported back to SW2 and TM2 gave rise to sufficient cause for concern (particularly in the light of the events of 14th October 2008 and repeated reports of Mrs E drinking) for CSC to undertake a S.47 enquiry. Had this happened and the concerns about likely significant harm been substantiated, this would have prompted a protective response from CSC and Child T's ongoing neglect would have been prevented.

6.2 Similarities with other Serious Case Reviews and relevant research

6.2.1 There have been a number of SCR's concluded in Manchester over the past five years which have identified similar issues and themes that have emerged through this Review. These included:

- The failure of professionals working with adults to regard their clients as parents and to make the connection between the adult's difficulties and vulnerabilities and the effect that these have on their parenting capacity .
- Poor quality, superficial assessments that relied heavily on the self-report of those who were being assessed .
- Evidence of parental mental health and alcohol misuse directly impacting upon the safety and welfare of children .
- Adults missing health appointments, disengaging from services and being hard to locate .
- Poor inter-agency communication and evidence of limited collaborative working (silo practice) .
- Taking the word of parents at face value and not considering the lived experience of children exposed to parental difficulties with mental ill-health or alcohol misuse.

6.2.2 In addition to these local themes and issues, there are a number of similarities between this case and the findings from 'Learning lessons, taking action': Ofsted's evaluations of SCR's from 1st April 2007 to 31st March 2008. The most relevant of these in relation to the issue of the management of neglect include:

- No single agency had a complete picture of the family and a full record of all the concerns. There was an opportunity for this to happen in this case which was missed because the CiN planning lacked rigour and the causes for concern were not clearly articulated.
- Agencies tended to respond reactively to each situation as it arose, rather than seeing it in the context of the case history. Evidence of this would be the failure of agencies to develop a picture of growing concern in the face of repeated reports of Mrs E's continued drinking.

Other examples would be the outcome of the initial assessment on 7th October 2009 and the responses to the concerns raised on 3rd and 6th November 2009.

- Too much reliance was placed on what parents said, and on supporting parents, rather than seeing the situation from the child's perspective and experience (see earlier).

- Families were subject to multiple assessment and plans without any clear expectations of what needed to change for the children, and what the consequences would be if these changes were not forthcoming. This point echoes the criticism of the CiN planning process contained in the CSC IMR and the Overview Report.

- There was little evidence of any attempt being made to evaluate the quality of the attachments between parents and children, a critical feature of 'good enough' parenting. Mrs E was never the subject of a parenting assessment. Given her own early life experiences (and the eventual outcome for Child T) it would have been reasonable to conjecture that there would be attachment issues that needed to be considered. There is no reference in any IMR that Child T's attachment to his mother was ever thought to be an issue or cause for concern.

The section in the Ofsted document relating to neglect concludes with two points that are particularly relevant to this case. These are:

- Regular inter-agency meetings are not sufficient to safeguard children if they do not involve high quality analysis which includes assessment of attachment and a comprehensive chronology of events.

- When there is insufficient evidence of demonstrable change in relation to children's circumstances and well-being, agencies must act decisively to safeguard children.

6.2.3 Pieces of research which were felt relevant to this Review were:

WHO Classification of Diseases (ICD-10) quoted in Models of Care for Alcohol Misusers (MoCAM)
National Treatment Agency for Substance Misuse (2006)

J Tunnard
Parental Problem Drinking and its Impact on Children
Research in Practice 2002

L Blom-Cooper
A Child in Trust
The Report of the Panel if Inquiry into the Circumstances Surrounding the Death of Jasmine Beckford (1985)
London Borough of Brent, Middlesex

Cleaver, Unell, Aldgate
Children's Needs – Parenting Capacity
The Stationery Office, 1999

Ruth Gardner
Developing an Effective Response to Neglect and Emotional Harm to Children
UEA and NSPCC (2008)

Calder, M
Risk Assessment, Analysis and Management Model (RAssAM)
Russell House Publishing, 2003

Dalgleish and Drew (1989)
Risk Indicators: The relationship of child abuse indicators to risk assessment in courts' decisions to separate

J Warner, Journal of Social Work, 2003
An initial assessment of the extent to which risk factors are taken into account when assessing risk in CP cases

Ann Hagell, Bridge Child Care Development Service (1998)
Dangerous Care: Reviewing the risks to children from their carers

Understanding Child Abuse
Jones, Picket, Oakes, Barbor
Palgrave McMillan (1987)

Kemshall, Hazel (2008), *"Actuarial and Clinical Risk Assessment: contrasts, comparisons and collective usages"*, Ch 11 of Contemporary Risk Assessment in Safeguarding children edited by Martin C Calder, Russell House publishing

Hollows, A (2003) *"Assessment in Childcare: using and developing frameworks for practice"*, Ch 5 of Contemporary risk Assessment in Safeguarding children edited by Martin C Calder, Russell House publishing

Dovata Iwaviec
The Emotionally Abused and Neglected Child
Wiley Publications (1995)

Failure to Thrive Revisited
Child Abuse Review May/June 2006
Wiley/Blackwell

Brandon et al
Understanding SCR's and their Impact
A Bi-annual Analysis of SCR's 2005-2007
DCSF (2009)

Children Living at Home: The Initial Child Protection Enquiry
Ten Pitfalls and how to Avoid Them
NSPCC (1994)

Bottling it Up
The effect of Alcohol Misuse on Children, Families and Parents
Turning Point (2006)

Coleman R and Cassell D
Parents who Misuse Drugs and Alcohol (1995)
Routledge Press

Dale P et al (2005)
Child Protection Assessments following Serious Injuries to Infants – Fine Judgements
John Wiley & Sons Ltd

Depanfilis D (1999)
Intervening with Families when Children are Neglected
Neglected Children: Research, Practice, Policy
Sage Publications

7. Summary

7.1 It was the view of the Review Panel that Child T's case was poorly managed throughout. The Panel was concerned that Child T had been known to agencies for his entire life and had been the subject of CiN planning for over half of that time, yet he continued to be neglected by Mrs E and this neglect was both predictable and preventable. Of particular concern was the fact that Child T was known to agencies because of Mrs E's misuse of alcohol, yet 17 expressions of concern (four of which alleged she was drunk) failed to trigger a reconsideration of the initial assessments by CSC and CAT that the likelihood of future significant harm was low. As a consequence, the intervention strategy for Child T was never reviewed.

7.2 The Panel considered that no single agency was responsible for failing to protect Child T from the chronic neglect which he suffered at the hands of his mother, but rather he was the victim of the multiple failures of all those agencies with whom he was involved (with the exception of GMP) to recognise the risks to which he was exposed and to take appropriate protective action. These failings included University Hospital South Manchester staff not challenging Mrs E's denial that she used alcohol at the booking-in appointment, the flawed initial assessments of risk by CSC and CAT, Mental Health Practitioner's failure to convey concerns about Mrs E's self-neglect to CSC, the lack of purpose and direction of the CiN process, HV inaction in the face of increasing evidence of neglect, the Nursery Nurse's failure to plot Child T's weight accurately and to consider a further paediatric assessment when his weight was found to be on the 0.4^{th} centile and CSC taking insufficient action following a number of clear expressions of concern about Child T's safety and welfare.

7.3 There was evidence of poor practice throughout which included both single agency failings and generally poor inter-agency communication and collaborative working. Practice was considered to be adult rather than child focused with interventions aimed mainly at providing support for Mrs E to help her with her misuse of alcohol and emotional difficulties.

The interventions themselves were undemanding of Mrs E and there was clear evidence of 'rule of optimism' thinking about the effects of those interventions on her parenting capacity. There was no evidence that at any time did any practitioner consider the world from Child T's perspective.

7.4 The IMR's from each agency are of a generally good standard and each has identified clear lessons from their involvement with Mrs E and Child T. These have been translated into realistic and achievable recommendations which, when implemented, will improve the quality of the services provided to children and families in Manchester.

7.5 In addition to the single agency issues, the process of the Serious Case Review has identified the following key messages:

- The failure to recognise neglect

  Child T's neglect began before he was born through Mrs E's persistent heavy drinking during her pregnancy which was likely to have been a contributory factor in Child T's prematurity and low birth weight. Shortly following his birth, Child T was exposed to danger (evidenced by the events of 14th October 2008) and then was persistently neglected throughout his life (evidenced by the chronic failure to thrive that was noted in the post-mortem examination). There were clear signs of neglect present in this case throughout, including Child T's failure to gain weight, developmental delay, missed health appointments, delayed immunisation programme and developmental checks, erratic attendance at Childminder's and Mrs E's elusiveness and gradual withdrawal from services. However, because of a combination of factors, including the failure to recognise risk, silo working, parent-focused practice, 'rule of optimism' thinking and a lack of clarity about the purpose and intended (child focused) outcomes of the interventions with Mrs E, practitioners lost sight of the impact of her behaviour on Child T. They failed to recognise the neglect that he was suffering and they failed to take action to protect him.

- The need for practitioners from all agencies to understand risks

  Only some agencies are required to assess risk of significant harm to children. Practitioners from these agencies need training and support to complete assessments to a 'fit for purpose' standard. They need to recognise the vital importance of the initial formulation of risk and this needs to be tested for accuracy, error and bias through effective, challenging supervision.

  Practitioners from other agencies need the skills to recognise risks, to record these properly and to report them to those agencies whose responsibility it is to undertake assessments.

  All practitioners need to be aware that risk assessment is a dynamic not a static process and that risk assessments need to be reviewed in the light of emerging evidence.

- The need for practitioners from all agencies to understand the impact of substance misuse on parenting capacity

  This Review has demonstrated the direct link between Mrs E's misuse of alcohol and the chronic neglect suffered by Child T. The fact that Mrs E drank was never in dispute, but the impact of this on her parenting capacity was underestimated and never properly understood and taken into account throughout the time agencies were involved with Child T.

  Given the growing concerns about substance misuse generally and its established link with adverse outcomes for children, it is important that practitioners from all agencies are aware of the impact of substance misuse on parenting capacity and are provided with guidance on how to manage concerns should they arise.

- The need to keep the child at the centre of practice

  There was clear evidence of parent centred practice in this case. Intervention strategies were aimed primarily at helping Mrs E with her personal difficulties and they were uncritical, undemanding and there was clear evidence of 'rule of optimism' thinking by practitioners. As a result, the impact of Mrs E's alcohol misuse on her parenting capacity was overlooked and Child T continued to be neglected.

  In order to be child-centred, practitioners need to actively avoid being adult-centred. This requires them to see the world from the child's point of view and imagine the lived experience of being exposed to the behaviours of adults which result from their personal difficulties, vulnerabilities and circumstances. This perspective will then direct practitioners to seek outcomes that are best for children, not most acceptable to adults.

- The need to take seriously information provided by family and friends.

  The people who are likely to know the most about adults whose behaviour can compromise the safety and welfare of children are their family and friends. There were a number of contacts made with agencies by Mrs E's family and friends expressing concern about her drinking behaviour and the impact it had on Child T. There were also other members of her family that had information about Mrs E's drinking habits, but these people were never contacted.

It is important that practitioners from all agencies recognise the significance of information about adults which is offered by their friends and family, and that wherever possible, these people should be spoken to directly and what they say should be taken seriously.

- The need for key agencies to be adequately staffed

  In order to provide effective safeguarding services it is essential that the key agencies are appropriately established with sufficient numbers of staff with the necessary skills and experience to ensure 'fit for purpose' safeguarding practice. This requires there to be enough practitioners to do direct work with children and families and for their work to be overseen by enough (experienced) managers who are able to offer support and stretching, challenging supervision.

7.6 In order to address these key messages and the issues identified earlier in this Report and the single agency IMR's. The Review Panel agreed the following single and multi-agency recommendations.

8. Single Agency Recommendations

Greater Manchester Police.

1. Greater Manchester Police Domestic Abuse Policy to include the need to identify, communicate and assess the personal and physical circumstances of persons who have been a party to a domestic abuse incident but have left the scene prior to Police arrival to fully complete an informed risk assessment. This should be achieved by the 30th June 2010.

University Hospitals of South Manchester.

1. The Regional Neonatal Networking Team to review the Service Level agreement between the different acute Trusts City Wide in terms of the Neonatal Outreach Service.

2. Every baby born in UHSM to have a set of notes generated at birth and any information about the baby including issues identified in the ante-natal period should be accurately reflected within the notes.

3. A formal summary of all actions and assessments be sent out to all key professionals involved with a family and that this should be filed within the child's hospital notes.

4. All patients attending the trust to be asked routinely about dependants that they are responsible for.

Connexions.

1. To ensure PA's complete the Parent/Carers and Family section of CAPIR on instigation of assessment process.

NHS Manchester.

1. It is recommended that NHS Manchester devises an immediate action plan to address the identified issues within the health visiting service.

2. It is recommended that NHS Manchester ensures health visiting assessments/standards which are clear to staff, audited and form part of a care pathway.

3. It is a recommendation that the Safeguarding Children Case Planning Supervision Policy for Nurses (March 2008) is reviewed.

4. It is a recommendation that supervision and management oversight of members of health visiting skill mix team is reviewed.

5. It is a recommendation that the assessment tool used by the Community Alcohol Team is reviewed to include a specific question which explores in more detail how parental alcohol use affects parenting, and a further question which explores family background and family history of alcohol use.

6. It is a recommendation that the Community Alcohol Team develop a system to notify the GP routinely of assessments undertaken.

7. It is a recommendation that the Primary Care Mental Health team review the initial assessment tool to include a specific question which explores the potential impact of parental mental health on parenting capacity, and develop a system of informing the health visitor or school nurse routinely when the client is parent/carer of children.

Manchester Children's Social Care.

1. Review the consultation process with SIU to ensure that a clear analysis of risk is recorded prior to a decision being made as to whether the threshold is met for a CP conference.

2. Clarify line management responsibility for social work students and their case work to ensure clear oversight and lines of responsibility for case work.

3. All staff need to understand the impact of alcohol abuse on adults and how that might impact on the care of children.

4. Briefings for managers to ensure transfer and closure summaries are properly and effectively completed.

5. The CiN meeting process and agenda to be reviewed to ensure any risks to the child are identified and plans for the management of that risk identified.

6. Develop standard of response to reports of children left Home Alone.

7. Review management capacity within the context of a review of social work caseloads.

8. Revise procedures to ensure social workers speak directly to family members as part of assessments.

9. CSC to devise a strategy to ensure anonymous referrers who are expressing concerns about safeguarding issues speak directly to a Social Worker on the FRT.

Parkway Green Housing Trust.

1. An action is in place to improve the way in which PGHT collects customer profiling information and this will enable us as an organisation to address any diversity issues; vulnerabilities and highlight any concerns for a tenant or member of their household.

2. For regular liaison meetings to be held with CFSC (Children Families & Social Care) and Adult Social Care Services.

3. Safeguarding Contact Cards with details of who to contact with concerns

Sure Start and Early Years.

1. CCT to have written guidance to use when ceasing funded childcare.

2. CCT to have key agency involvement at meetings when setting up, reviewing and ceasing funded childcare

3. All Manchester childminder's to gain full information and contact details of key agencies/ professionals who support the children/families in their care.

4. CCT to provide parent/.carer with information about resources available through local Sure Start Children Centre's when implementing, reviewing and ceasing funded childcare agreements

5. CCO's to have refresher Safeguarding training.

North West Ambulance Service.

1. Maintain implementation programme of children safeguarding policies and procedures. Also, consider whether or not NWAS can add value by providing known information regarding vulnerable children prior to the commencement of any SCR.

NHS Manchester Commissioning PCT.

1. The PCT to request NHS North West review staff support arrangements across the region, with reference to the Police Welfare Service, and in collaboration with Government Office North West.

2. The PCT is to decide what level of health visiting service is to be commissioned in Manchester given the risks re caseload size and complexity that are detailed in the NHS Manchester (Provider) IMR.

3. A citywide protocol for the transfer, safe storage and retrieval of midwifery notes to be developed. This must include sharing of information with GPs and HVs.

4. Accepting that training re record keeping is ongoing in all trusts.
   A recommendation that each trust reviews the reasons why record keeping continues to be an issue in all Serious Case Reviews taking into account:
   i. Training
   ii. Policies
   iii. Caseload size
   iv. Supervision
   v. Standards
   vi. Fit for purpose records
   With a view to developing an action plan.

5. Commissioning PCT to ensure that the training and supervision of the community neonatal outreach service is compliant with minimum safeguarding requirements as part of the contracting process.

6. PCT commissioners to review the neonatal midwifery service in terms of capacity and accountability.

7. NHS Manchester as the commissioning PCT is to seek assurance that a set of hospital notes is generated for every baby born at a Manchester maternity hospital.

Multi-Agency Recommendations

- MSCB to amend its Multi-agency Safeguarding Procedures to include:

  'For all children under the age of 18 months who are the subject of S.44 orders or S.46 powers, a paediatric consultation **must** be included in the enquiry. For children over the age of 18 months, the need for a paediatric consultation will be at the discretion of the workers undertaking the enquiry'.

- MSCB to amend Safeguarding Procedures to ensure checks with NWAS and A&E are undertaken as part of S.47/Core Assessment enquiries where substance misuse, mental health difficulties and domestic abuse are key features.

- MSCB to commission a specific piece of multi-agency training based on the learning points from this case relating to adults' harmful substance misuse and its impact on parenting capacity. The training to be targeted at Social Workers, Police Officers, Drug and Alcohol Workers, Health Visitors and EIT Workers.

- MSCB should ensure that Safeguarding training for all agencies includes specific, detailed reference to risk recognition in relation to substance misuse and significant harm to children. Risk recognition to be based on a combined chronology.

- MSCB must ensure that the multi-agency Child in Need planning process explicitly identifies the risks and purpose of the intervention. The risks must be reviewed at subsequent CiN review meetings.

- All agency's members of MSCB **must** inform the Board if vacancy levels in any service area are potentially compromising the effective implementation of safeguarding policies.

- MSCB will monitor the progress of the individual agency action plans and ensure the implementation of the multi agency action plan.

Date of Completion: 16th August 2010

Signed on behalf of MSCB

Position: Independent Chair of MSCB

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Independant Author: Mick Muir

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