Child Safeguarding Practice Review – Child 3 (28th September 2018 – 17th October 2019)
For Wigan Safeguarding Partnership
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1. Introduction

1.1. Child 3 died on 17th October 2019. A post mortem the following day found severe head injuries and a spinal fracture, indicative of a very severe high impact assault. She had sustained multiple skull fractures and a subdural haemorrhage. This had caused swelling and mid-line shift of the brain and retinal haemorrhages in both eyes. The findings were totally incompatible with a minor domestic fall or accident, such as down a few steps, which was the original story given by Child 3's Mother and the Adult Male's sister with whom mother and baby had been staying. There were curved bruises on one arm but no deep bruising beneath these, plus a minor bruise over left side of upper jaw. Pathologists noted evidence of a possible old scar left top of head. There was no other evidence of old or recent trauma.

1.2. Child 3's Mother was arrested and subsequently charged with perverting the course of justice and causing or allowing the death of a child. An Adult Male, with whom Child 3 appeared to have been left alone, was arrested and subsequently charged with murder. This Adult Male was at the time under investigation for a Section 18 serious assault on an 18 month old child. The Crown Prosecution Service ultimately decided not to charge him with respect to the injuries sustained by this child. On 30th October 2020 the Adult Male was found guilty and sentenced to a minimum term of 18 years. Child 3's Mother was found not guilty on 2nd November 2020.

1.3. In accordance with statutory requirements[1] a Rapid Review was conducted by Wigan Safeguarding Board. The Rapid Review report was concluded on 8th November 2019 and submitted to the National Panel on 15th November. The report considered information from all agencies involved regarding numerous referrals to, and contacts with Children's Social Care from February 2019 to October 2019. One key issue was the number of contacts and referrals made relating to the Mother of Child 3's capacity to provide adequate parenting and her own vulnerabilities, as well as risks around her relationship with the Adult Male that never resulted in formal Section 47 Children Act 1989 investigations. The consequence of this meant that risks were not managed at the correct threshold despite the level of concerns being made. The panel overseeing the Rapid Review determined that this should form a key part of this Local Child Safeguarding Practice Review.

1.4. The analysis for the Rapid Review concluded that risks that were clearly at a level where child protection processes should have been followed were not acted upon. There were numerous opportunities to respond to risk and intervene at the appropriate level that were missed. Accordingly the Rapid Review Panel determined that practice and system issues regarding why these missed opportunities occurred would need to be subject to

[1] Children and Social Work Act 2017. HM Government (2018) *Working Together to Safeguard Children. A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children*. London: The Stationery Office.

the further scrutiny of a Local Child Safeguarding Practice Review. It was also concluded that the focus of this review would need to incorporate key lines of enquiry regarding:

1.4.1. The timeliness and speed with which findings from health-based peer reviews of Child Protection Medicals are communicated and actioned effectively within the child protection system.
1.4.2. Whether the processes regarding response to bruising and suspicion of non-accidental injuries were being followed effectively across the primary care sector;
1.4.3. Whether Community Rehabilitation Company safeguarding checks on offenders were robust when there are changes of address;
1.4.4. The timeliness of the outcome of the police investigation into the Adult Male's previous section 18 assault charge and the outcome of the IOPC[2] investigation into this.
1.4.5. The Rapid Review and case review findings regarding the July 2018 assault on another infant by the Adult Male and impact on the learning in this case.
1.4.6. Other areas/key lines of enquiry that emerge throughout the review, discussed as appropriate within the panel meetings and practitioner event. Other key lines of enquiry have, indeed, emerged, namely:
1.4.6.1. Whether assessments by Children's Social Care were robust and decision-[3]making reasonable in response to referrals and information received.
1.4.6.2. Whether the early help offer from Start Well was sufficiently focused and thorough.
1.4.6.3. Information-sharing and liaison between Children's Social Care and Start Well.

1.5. The Safeguarding Partnership identified the following issues for immediate action:

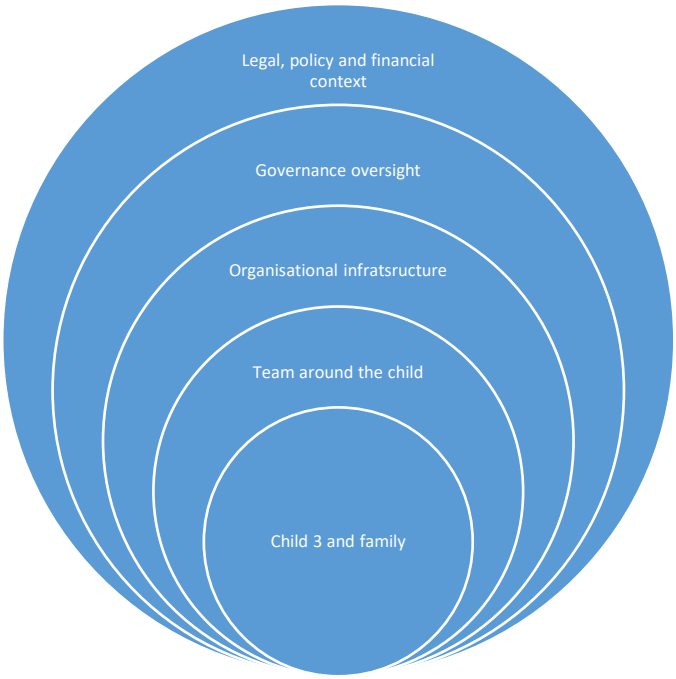
1.5.1. The degree to which practice and process issues in this case are systemic within the child protection system. The Safeguarding Partnership had identified key issues which would inform further immediate partnership quality assurance work.
1.5.2. Building on an already completed Children's Services quality assurance exercise on this case and resulting action plan and learning events.

1.6. Thus, in line with statutory guidance[4] a Local Child Safeguarding Practice Review was commissioned because Child 3 had died as a result of known abuse. The purpose would be to highlight necessary improvements to the safeguarding of children and the promotion of their welfare, including how practitioners, services and organisations work together. Timely completion of this review was delayed both by the impact of the Covid-19 pandemic but also by the need to await completion of the criminal trial and the conclusion of internal and/or independent investigations focusing on the conduct of practitioners and their employing organisation.

[2] Independent Office of Police Conduct.
[3] It should be noted that child protection medicals and peer reviews are two separate systems. Child protection medicals form a key part of children's safeguarding procedures and are well established. Peer reviews are learning opportunities within the Hospital, for which there are no formally agreed, Greater Manchester timescales. It is unusual for letters to be sent as a result of peer review; that this happened in this case is an indicator of the concerns regarding Child 3's welfare.
[4] HM Government (2018) *Working Together to Safeguard Children. A Guide to Inter-Agency Working to Safeguard and Promote the Welfare of Children*. London: The Stationery Office.

1.7. Also in line with the aforementioned statutory guidance this review adopts a systemic perspective that analyses operational practice as well as surrounding organisational structures, policies and procedures. A whole system perspective begins with direct work to safeguard and promote the welfare of Child 3, as required by Section 1 Children Act 1989, moving outwards to consider how the team around the child and family worked with them and with each other, then the culture and environment provided by organisations, working individually but also collectively to support the team around the child, and then the governance oversight and strategic direction provided by Wigan Safeguarding Board and subsequent partnership arrangements. There is also the national context to consider within which children's safeguarding is situated.

1.8. This systemic perspective is represented in the following diagram. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



1.9. In addition to scrutinising written information provided by the services that were involved with Child 3, and reading the Rapid Review, a learning event was held with practitioners and operational managers. Interviews were also undertaken with newly appointed senior managers in Children's Social Care, with some practitioners who had worked with Child 3's Mother and a manager at the time in Children's Social Care.

1.10. Invitations to contribute were extended to Child 3's Mother and Father, with the assistance of their Victim Support Officers. An invitation was also offered to the Adult Male who had been convicted of her murder.

1.11. Child 3's Mother chose to answer questions asked by the Independent Reviewer in writing, with the support of the Health Visitor and her Victim Support Officer. Her comments have been integrated into this report, in section 3.

1.12. Child 3's Father was interviewed in the presence of his Victim Support Officer, using a virtual link. He was sent questions in advance by the Independent Reviewer. He also asked questions about the review, to which the Independent Reviewer responded. The outcome of this conversation has also been integrated into this report, again in section 3.

1.13. The Independent Reviewer interviewed the Adult Male by video link. He denied being responsible for Child 3's death. He was unable to offer any points of learning for practitioners and services that had been involved with him or with Child 3.

1.14. The Independent Reviewer has been supported by a panel comprising senior staff from the agencies involved in the case.

2. Chronology and Initial Commentary

Introducing Child 3's Mother

2.1. Child 3's Mother was born in September 2000. For the majority of her childhood she lived with her grandparents. As a child and young person she and her family were known to various services.

2.2. **Commentary:** evident in Child 3's Mother's background are adverse childhood experiences. Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse.[5]

2.3. At the end of January 2018 Child 3's Mother attended her GP Surgery to see the Community Midwife and to be referred for midwifery care. Her history, which Child 3's Mother had shared with the Community Midwife, was discussed with Children's Social Care, advice being received that no referral was required unless issues arose during the pregnancy.

2.4. **Commentary:** liaison between the Community Midwife and Children's Social Care was good practice. Information submitted for the Rapid Review included a question[6] as to why a pre-birth conference had not been held. Most contributions for the Rapid Review noted that this was a teenage pregnancy. The background of adverse childhood experiences, the instability of her accommodation situation, and her documented other needs might have indicated the appropriateness of a whole system meeting to agree a risk management approach. A necessary precursor to a conference would have been a pre-birth assessment. This did not happen and was arguably a missed opportunity.

2.5. On 26th February 2018 she attended Hospital for a booking-in appointment as she was pregnant. She disclosed, when asked, her history.

2.6. Between 10th May and the birth of Child 3 on 28th September 2018, Child 3's Mother attended antenatal appointments, sometimes unaccompanied and sometimes with a sister, grandmother or undocumented family member. Before Child 3's birth she was recorded as not being with the baby's Father but as having good support.

2.7. **Commentary:** it is unclear how the judgement about good support was reached. It may have relied on self-report rather than being triangulated with information that might have been available from other agencies. Child 3's Mother had been offered involvement in the Family Nurse Partnership programme in February 2018 but in mid-March declined to participate, apparently because of the programme's intensity. Both the GP and the Health Visitor were informed of her decision.

2.8. **Commentary:** the Hospital Trust's submission for the Rapid Review[7] identifies two learning points from this point of the case, namely to ensure that there are clear records of who accompanies a young person to antenatal appointments, and to clearly document a richer understanding of parental and non-parental relationships.

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[5] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.
[6] GMP submission.
[7] Bolton NHS Foundation Trust.

2.9. In August 2018 Child 3's Mother applied on the Housing Register. The combined chronology records that she was living in an overcrowded situation with her parents.

2.10. **Commentary:** this reinforces the observations made earlier regarding accurate recording of relationships (and living situation) and the importance of addressing housing need. Elsewhere, at this time, it has been recorded that she was living with her grandmother and mother, for example.

Introducing Child 3

2.11. Child 3 was born by caesarean section on 28th September 2018. Contributions to the Rapid Review observe that Child 3's Mother cared for the baby well in hospital. Child 3 was bottle-fed. Mother and baby were discharged from hospital on 30th September and the case transferred to Community Midwives in Wigan. Hospital records noted that she had help and support at home.

2.12. **Commentary:** once again, it is unclear how the judgement about good support was reached. It may have relied on self-report, here by Child 3's Mother and sometimes also members of her extended family, rather than being triangulated with information that might have been available from other agencies. With the number of births per year, it would be unreasonable to expect triangulation of information in every case. However, in this case, Child 3's Mother had been offered and declined involvement in the Family Nurse Partnership programme. Assessments of need and of risk are clearly dependent on information available and accessible at the time.

2.13. Community Midwives saw mother and baby on five occasions before discharging from midwifery care on 9th November. Advice was given regarding safe sleeping, not smoking around Child 3, and not leaving her or dogs unattended. A Moses Basket was advised as Child 3 had been sleeping in a baby recliner seat. On discharge Child 3 was observed to be alert, pink and well. She was on a lactose free formula and awaiting paediatric review.

2.14. The Health Visitor's first contact was on 10th October. She observed warm interactions, with Child 3's Mother speaking fondly about her baby. There were no parenting concerns and no low mood was detected. Child 3 was very responsive to her Mother. The birth Father was in contact. Basic health advice was given. A second contact occurred on 9th November. Child 3 was clean and appropriately dressed. Lots of emotional warmth and stimulation were observed. No parenting concerns were identified.

2.15. GP Surgery records have noted that Child 3 had looked well when seen but was referred to Paediatrics around 24th October and again on 1st November for constipation. She was brought by her Mother for the first appointment but then a pattern developed of Child 3 not being brought. As a result Child 3 was discharged[8]. A baby check for 13th November was apparently cancelled. Child 3 was not brought for immunisations on 10th December 2018 but was brought on 20th December for her first routine immunisations. GP records for 3rd January comment that Child 3 was still prone to constipation and follow-up with Paediatrics was chased. On 4th January 2019 Child 3 was taken to an A&E

[8] Reported in the WWL NHS Foundation Trust submission for the Rapid Review.

Department in another Greater Manchester local authority area with bronchitis. Her Mother became very upset when blood was taken from the baby's heel. Later she was observed cuddling her child[9]. On 17th January Child 3's second immunisations were cancelled by her Mother as Child 3 was still unwell.

2.16. **Commentary:** it is now clear that the pattern of missed appointments was raised with Child 3's mother by the Health Visitor. This was good practice. However, this intervention did not completely break the cycle.

2.17. Child 3's Mother attended A&E on 31st October via Ambulance with a PV bleed/passing clots. Records indicate that she had consulted her GP the day before with post-natal bleeding and discharge. At hospital this was treated as endometriosis and she was discharged home. She consulted her GP for anxiety on 27th November 2018 and again on 10th January 2019 when the anxiety is specifically linked to her housing situation and living conditions, regarding which she requested a letter for the Housing Department.

2.18. **Commentary:** the timeframe for the Rapid Review covered April 2018 to 17th October 2019, when Child 3 died. What is noteworthy is the limited amount of information available to the Rapid Review for the period between April 2018 and January 2019. Only two submissions, from GMP and from Bolton NHS Foundation Trust, contain reflections on how practice might have been improved. It is questionable whether the level of support was sufficient for a teenage mother with a history of adverse experiences. Her anxiety about her living situation is a marker here.

Introducing an Adult Male

2.19. The combined chronology first mentions this Adult Male in the life of Child 3's Mother in February 2019. For that reason, some background information is relevant first.

2.20. He has a background of adverse childhood experiences and behavioural difficulties, which brought him to the attention of various services. A diagnosis of learning disability had been recorded, with ADHD also suspected. He was referred to mental health services but did not attend appointments, possibly because contact details were incorrect. In April 2019 he was referred to secondary mental health for anxiety. Health records contain references to suicidal thoughts and hearing voices inciting violence. He did not attend a review in May 2019. Health records contain at this time a diagnosis of ADHD with psychotic symptoms.

2.21. He has an extensive criminal history involving assaults, theft, hate crime and public disorder. Up to June 2019, 16 incidents have been recorded of him perpetrating domestic violence and he was the subject of a restraining order with respect to the mother of a former partner.

2.22. In July 2018 GMP had intelligence that he was involved in the supply of Class A drugs. In the same month he was arrested for section 18 wounding of a baby[10]. In September 2018 he was arrested and charged with criminal damage of a window of his

[9] Bolton NHS Foundation Trust.

[10] The baby had been shaken and was placed by Wigan Children's Social Care with the child's father.

former partner's mother's home. In December 2018 he was referred to Addaction but failed to present for assessment[11]. On 16th January 2019 he was found guilty of criminal damage and aggravated vehicle taking. A Community Order was made with rehabilitation, which initially required him to attend appointments and complete unpaid work. He was disqualified from driving.

2.23. **Commentary:** this background information was known to some but not all of the agencies involved with Child 3 at the point when it is first recorded that the Adult Male entered her life and that of her Mother. Information-sharing is a key component of best practice in children's safeguarding. A strategy meeting would have been the appropriate mechanism to ensure that all the practitioners and services involved were fully cognisant of the risks arising from his involvement.

Growing Concerns

2.24. On 1st February 2019 a Health Visitor referred her to Start Well on account of her difficult housing situation. She was living with her grandparents. She reportedly also accepted that she needed support with her emotional health, and with budgeting, financial management, and accessing community resources and education. The Health Visitor has commented that the referral was made in order to ensure that the additional support that she felt Child 3's Mother needed was offered, and also to enable the Health Visitor to focus on the emotional and physical wellbeing of mother and baby. The Health Visitor referral followed a home visit on 31st January when Child 3's Mother had been very upset about her home circumstances. The Health Visitor, with consent, also referred Child 3's Mother for counselling and signposted her back to the GP because prescribed medication had caused her to have "weird feelings."

2.25. The submission from the NHS Foundation Trust responsible for Health Visiting commented for the purposes of the Rapid Review that there were three Early Help meetings with Start Well but that Child 3's Mother did not engage fully, with the result that her housing situation and finances were not addressed. The same submission notes liaison between the Health Visitor and Start Well, and between the GP Surgery and Children's Social Care. Start Well withdrew because of non-engagement in August 2019.

2.26. **Commentary:** the reported liaison for information-sharing is good practice. Withdrawing involvement without a whole system meeting to discuss the implications of non-engagement, and without assertive outreach, is questionable.

2.27. Health Visitor records first mention Child 3's Mother having a relationship with this Adult Male in February 2019. On 7th February the combined chronology records that a Social Worker was concerned that Child 3's Mother was in a relationship with the Adult Male. The Social Worker was supporting an ex-partner of the Adult Male and, because of the history, was concerned about the potential for harm to Child 3. Checks were completed. Child 3's Mother said that the Adult Male was a family friend, that she was not in a relationship with him, and that Child 3 did not have contact with him. Children's Social Care was apparently satisfied with this account and took no further action. The Health Visitor was informed that Children's Social Care had closed the case on 8th February.

[11] In August a fire had occurred at the home of his sister and mother but no suspect could be identified.

2.28. **Commentary:** the Health Visitor was rightly concerned about the potential risks to Child 3, given that the Adult Male was under investigation for non-accidental injuries to a baby. The Social Worker does not appear to have triangulated the information provided by Child 3's Mother with other intelligence that might have been available. This was a missed opportunity and might suggest the influence of the rule of optimism. No multi-agency meeting was convened. The Children's Social Care and Start Well analysis for the Rapid Review concluded that checks at this point were insufficiently robust and the family history was not considered. The vulnerability of Child 3's Mother and the extent of the risk posed by the Adult Male were not explored. No strategy meeting was convened. It is hard to disagree with this analysis. Indeed, this critical analysis remains pertinent throughout the remainder of the case.

2.29. Health Visitor records for 18th February contain correspondence from Start Well confirming the focus for Early Help, namely support to pursue housing options and to assist with budgeting and finances, making links with community groups, and building confidence and self-esteem to help Child 3's Mother manage stress.

2.30. GP records note that Child 3 was seen for conjunctivitis on 25th February. Child 3 had also been seen in A&E on 22nd February when an examination had been normal. On 27th February the Health Visitor on a routine visit observed lots of emotional warmth and stimulation. However, Child 3's Mother had again been upset about her housing situation and the lack of space she had for herself and her child. The birth Father was said to not be contributing financially and this seemed to have caused some animosity. Child 3's Mother requested a voucher for the food bank. The Health Visitor's records contain reference to discussion about the Adult Male and also about domestic abuse, with Child 3's Mother denying any fear of the birth Father or the Adult Male.

2.31. On 1st March, the Community Rehabilitation Company (CRC) breached the Adult Male but the Court allowed previous orders to continue. CRC was aware by this date that the Adult Male was under investigation by GMP concerning allegations of abuse of a child.

2.32. On the same day, the Health Visitor completed an application form for the Young Persons Accommodation Panel. Child 3 and her Mother were living in an overcrowded house, residing in a box room with a travel cot. By this time Child 3's Mother was known to be pregnant. GP records note that Child 3 had oral thrush on 4th March.

2.33. Start Well and the Health Visitor did have a conversation on 7th and 12th March to discuss early help and plan the interventions needed. On 11th March a Start Well Officer and an observing manager visited to build a relationship with Child 3's Mother and to discuss the offer of support. This was the first contact between Start Well and Child 3's Mother following the referral from the Health Visitor at the beginning of February. It was agreed to make an application for a mother and baby unit. During the visit Child 3's Mother informed them that she was pregnant and that the father was either Child 3's Father or another male with whom she had slept once. Her low mood was observed. The Health Visitor was to be contacted to arrange an Early Help review. Four messages were left for the Health Visitor between 14th March and 4th April. Health Visitor records also contain reference to four calls to Start Well that were not returned between 27th March and 29th April. This caused a delay in holding an Early Help meeting. During this time the Health Visitor had made a referral to Children's Social Care and was attempting to inform Start Well of this without success until 29th April.

2.34. On 21st March the combined chronology states that Child 3's Mother disclosed to the Health Visitor that she was two months pregnant. This was during an opportunistic meeting in the street. She did not disclose the identity of the father. On the same day Child 3 was reviewed by a paediatric team[12] because of constipation. It was recorded that her weight gain had slowed and a plan was devised involving medication, blood tests and monitoring by the Health Visitor, to be reviewed in a couple of months. Lactulose was to be stopped. It was recorded that Child 3 was living with her Mother, grandmother and other family members. The following day, Child 3's Mother was seen by Community Midwives and referred to Bolton Hospital for maternity care. Child 3's Mother informed the Hospital of Children Social Care's involvement. A Start Well Worker was named as support. On 23rd March GP records note that Child 3 had been seen in an Accident & Emergency Department of a Hospital outside Wigan for a swelling to her right foot. Nothing abnormal was detected. Following assessment she was discharged. There is no evidence that the Health Visitor received any correspondence from the Hospital regarding this attendance. It was also never mentioned by Child 3's Mother to the Health Visitor. GP records contain an entry on 29th March regarding the new pregnancy and a comment that nothing adverse was being reported by a Social Worker.

2.35. **Commentary:** the confirmation of the pregnancy does not appear to have triggered a review of what the Health Visitor was told in early February by Child 3's Mother concerning her involvement with the Adult Male. This may have been because Child 3's Mother only disclosed to the Health Visitor that the Adult Male was indeed the father of the unborn child once she had miscarried, although she was asked directly about paternity beforehand, at which point she had stated that it could have been Child 3's Father or the result of a one-night stand. An assumption appears to have been made that the wider family was a circle of support and protection. The accommodation situation had been recognised as unsuitable and two options appear to have been pursued, namely referral to a Young Person's Accommodation Panel and application to a Mother and Baby Unit. Several agencies are involved but no multi-agency meeting had been convened to share information, assess risk and agree a coordinated plan. Services were working in silos.

2.36. Around 26th March the Health Visitor referred Child 3 and her Mother to Children's Social Care as it appeared that family relationships were breaking down and they had nowhere to live. On the following day the referral was closed as it did not apparently meet the social care threshold. As the lead professional for Early Help the Health Visitor liaised with Start Well and the Mother and Baby accommodation between March and May[13]. CAMHS was contacted by a Housing Service supporting young mothers for information. This was provided. A Start Well Worker visited on 9th April. Child 3's Mother was seen at her mother's home. Child 3 was clean and well dressed. It was acknowledged that the Adult Male was the father of the unborn child but that he would not be allowed to see the baby when born or Child 3. It is recorded that Child 3's Mother had seen a Midwife[14] and that a scan was planned for 17th April.

[12] At an NHS Trust within the Greater Manchester area but outside Wigan.

[13] By 22nd March Child 3's Mother had visited a Mother and Baby Unit and a formal referral was made.

[14] This occurred on 16th April at which Child 3's Mother disclosed that the Adult Male was the father of the unborn child, information which the Mother only told the Health Visitor after she had miscarried.

2.37. **Commentary:** the lengthy delay between the Health Visitor's referral to Start Well and the beginning of the latter's involvement displays a lack of urgency in meeting the need for additional support that had been identified. The usual timescale for following-up a referral would be two days. However, the Health Visitor did continue to offer Early Help within the remit of her role and responsibility. It is also unclear why Start Well did not refer the case to Children's Social Care on learning of the paternity of the unborn child.

2.38. On 4th April GP records note that Child 3 was seen for a cough and wheezing. On 11th April a Community Midwife completed an application for admission to a Mother and Baby Unit[15]. On 15th April Child 3 was not brought to an outpatient paediatric clinic. On 16th April Child 3's Mother contacted a Community Midwife. She acknowledged that the Adult Male was the father of the unborn child but stated that they were not currently in a relationship and that he was not allowed to see Child 3. The Community Midwife reported this conversation to Children's Social Care and was advised to submit a referral, which was done. A Social Worker confirmed that, at a finding of fact hearing, the Adult Male was considered a risk and one of a pool of people who could have injured a 4 month old.

2.39. **Commentary:** the finding of fact hearing took place on 4th March 2019 in the Family Court. The Crown Prosecution Service had previously concluded that it would be difficult to prove beyond all reasonable doubt when and by whom that baby was injured. Investigations into this case were still on-going when Child 3 died. Nonetheless, the acknowledgement that an Adult Male, under investigation for possibly injuring a baby, was in a relationship with Child 3's Mother, with possible access to Child 3, did not prompt a strategy meeting or initial child protection case conference. Reliance was placed on Child 3's Mother's reassurances and on the support from Start Well.

2.40. **Commentary:** the documentation collected from agencies for the Rapid Review records that the threshold was not met for Children's Social Care when the Health Visitor referred the case on 26th March. Considering the events recorded for 26th March, the reflective analysis from Children's Social Care and Start Well for the Rapid Review is critical of the absence of checks and management scrutiny, and of the lack of professional curiosity regarding Child 3's Mother's living situation. It also notes that there was evidence that, for whatever reason, Child 3's Mother was not being truthful. The referral from the Community Midwife did prompt allocation of the case to a Social Worker. The documentation collected for the Rapid Review records that an Advanced Practitioner directed that an assessment should commence and a strategy meeting be requested. No strategy meeting was convened. Yet, as the analysis from Children's Social Care and Start Well for the Rapid Review acknowledges, days were passing with no knowledge of where Child 3 was living. Risks were not recognised or assessed. Child 3's Mother was not being tested on what she was saying about her relationship with the Adult Male. A Social Work response from Children's Social Care was delayed.

2.41. Child 3's Mother experienced a miscarriage around 18th April[16]. She continued to reassure the Health Visitor that the Adult Male was not allowed contact with Child 3. She was not at the family home when a Start Well worker called on 25th April. On 29th

[15] 24 hour supported accommodation for single women under 25 with a child under 5.

[16] She was seen in an A&E Department on 23rd and 24th April, with a scan planned for 29th April. She did not attend this appointment. However, on 7th May she did attend for an ultrasound scan that confirmed the miscarriage. She was discharged.

April the Health Visitor contacted Start Well and an Early Help review was set for 13th May. This followed a home visit when the Health Visitor had no concerns about Child 3's Mother's parenting. The Health Visitor clearly recorded that there was to be no contact between Child 3 and the Adult Male. Start Well were to support Child 3's Mother to attend a Mother and Baby Unit on 2nd May. It is recorded that Child 3's Mother was "gutted" about her miscarriage and stressed about her living situation.

2.42. However, with Start Well and Children's Social Care, when staff visited on 1st May, she stated that she was aware of the allegations against the Adult Male but did not believe them. She was advised of the risks to Child 3 of the relationship with the Adult Male, being told explicitly by a Social Worker that Child 3 would become subject to child protection procedures if there was evidence of a relationship between them[17]. There is a record of the Community Midwife attempting to make contact with the Social Worker but there was no response to a left message. Health Visitor records contain three attempts to speak to the Social Worker between 29th April and 3rd May but there was no response to the messages that were left. Contact was eventually made on 17th May when the Health Visitor understood that a child protection plan would be initiated if it was confirmed that the Adult Male was in a relationship with Child 3's Mother.

2.43. **Commentary:** the documentation submitted for the Rapid Review notes that the Social Worker asked Child 3's Mother to reflect on what she had been told would be the statutory response if she maintained a relationship with the Adult Male, and to then respond. It is questionable whether, given the concerns about the risk to young children from the Adult Male, this was a safe approach to adopt. The critical analysis from Children's Social Care and Start Well for the Rapid Review observes that leaving Child 3's Mother to reflect was inappropriate.

2.44. **Commentary:** the critical analysis from Children's Social Care for the Rapid Review observes that there was a delay in allocating a Social Worker to the case, between 17th April and 1st May. This was outside expected timescales. The direction for a strategy meeting was not progressed and there was no management follow-up. There does not appear to have been a thorough risk assessment that encompassed the risk of homelessness, the impact of the miscarriage, the risks posed by the Adult Male, and Child 3's Mother's living arrangements.

2.45. **Commentary:** the Health Visitor shared information with a Mother and Baby Unit on 2nd May and Start Well on 3rd May, for "safeguarding purposes". This was good practice. An understanding given to the Health Visitor by a Social Worker that a child protection plan would be initiated if a relationship was confirmed between Child 3's Mother and the Adult Male was not followed through, reflecting the inconsistent messaging about (the consequences of) that relationship.

2.46. On 1st May the Adult Male's GP referred him to mental health services for a review of his mood and risk profile. He did not engage with mental health services and was discharged back to his GP on 29th May.

2.47. On 9th May Child 3 was not brought to an appointment with a Paediatrician for weight and bowel monitoring, and blood tests. There were also outstanding immunisations, which the Health Visitor followed up on 16th May. Child 3 had been

[17] Recorded by a Community Midwife in the combined chronology for 17th May.

observed pulling her hair at either side of her head, causing it to thin. Nonetheless, the Health Visitor had also continuously documented warmth and affection between mother and child. The Health Visitor discussed with Child 3's Mother age appropriate development and stimulation. On 13th May the planned Early Help review did not take place as Child 3's Mother was at a hospital. On 15th May an outpatient paediatric appointment was not kept. On 16th May Child 3 was not brought for her second routine immunisation. Around 17th May the Health Visitor discussed concerns with Start Well about a relative who was living with the maternal great grandmother, and how this was contributing to Child 3 and her Mother not living there. Child 3's Mother had given this as a reason for not wanting to live there in late March and it had been part of the referral to Children's Social Care at that time. The Health Visitor was also worried that Child 3's Mother was blaming the Adult Male's ex-partner for the injuries to the other child. The Health Visitor was also reporting concerns about Child 3's slow weight gain. Following advice on more responsive feeding, adequate weight gain was recorded. The Health Visitor referred her concerns again.

2.48. On 18th May an anonymous referral out of hours from a friend was received, reporting concerns about Child 3 and her routine. Child 3 was sleeping in a pram rather than a cot, and with her mother was staying at her maternal grandmother's home that had no heating. On 20th May a Start Well Officer and the Health Visitor undertook a joint visit for the planned review. No concerns were identified regarding Child 3's health and wellbeing. Start Well was to access a full-size cot and to explore how Child 3's Mother might access teaching assistant training. The Health Visitor was to follow-up on counselling to support Child 3's Mother's emotional wellbeing and information on groups at a Family Centre. She stated that she had ended her relationship with the Adult Male but as a result was being harassed and threatened. The Start Well worker emailed this information to a Social Worker. The Health Visitor shared safeguarding information with the counselling service alongside enquiry about when an appointment would be offered.

2.49. **Commentary:** information-sharing between practitioners and joint visits are good practice. The Health Visitor's referrals of concerns was good practice. However, additional risk factors were now emerging, namely Child 3 not being brought to appointments and a disclosure by Child 3's Mother of the Adult Male's coercive and controlling behaviour. An anonymous referral had highlighted again risks associated with Child 3's living situation. Child 3's Mother was also downplaying concerns about the allegations against the Adult Male. Nonetheless, no strategy meeting was convened, nor does there appear to have been any consideration of how to use legal options to seek to protect Child 3's Mother from domestic abuse. The mention of harassment could have been explored further and appropriate tools such as a DASH completed. It appears to have been assumed that, because Child 3's Mother's relationship with the Adult Male had been stated to have ended, no assessment was required concerning how Child 3 would be kept safe[18]. With her consent the Health Visitor had made a referral for counselling in February and she continued regularly to chase up an appointment. The delay in offering an appointment was unfortunate since Child 3's Mother's openness to the idea of support for her own emotional health and wellbeing was lost.

2.50. **Commentary:** additional reflections have been provided by Start Well relating to this joint visit. It occurred on the same day that a Social Worker was trying to contact Child 3's Mother regarding the anonymous referral. This is given as an example of the lack of

[18] Start Well response to a question asked by this reviewer.

coordination and communication. It also appears that the Early Help review documentation was not uploaded, meaning that there was no shared plan going forward.

2.51. On 21st May Child 3 and her Mother were accepted for a place at a Mother and Baby Unit. The aim of this provision is to prepare residents for a move into their own property. Key worker support is available. Start Well reported that Child 3's Mother was pleased. **Commentary:** it has, however, taken several months to make progress regarding accommodation. This is one example where it would have been best practice to consider Child 3's lived experience.

Continuing Concerns

2.52. On 28th May Child 3 was seen in paediatric clinic for blood tests. Nursing staff were concerned at how Child 3's Mother handled the situation and these concerns were escalated to Children's Social Care. The allocated Social Worker was not available but a Staff Nurse was informed that the Adult Male was a risk to children. However, the combined chronology indicates that a Social Worker subsequently made contact with Start Well and was told by a worker there that Child 3's Mother had not been witnessed to be abrupt with her child. This has been confirmed by additional information provided by Start Well, to the effect that the Start Well worker had conveyed that there were no concerns regarding Child 3's health or interaction with her Mother. There were concerns about Child 3's Mother's low mood and the need for counselling to help her manage her emotions[19]. There is, however, no evidence that Child 3's Mother kept a counselling appointment on 4th June.

2.53. **Commentary:** Additional reflective analysis provided by Start Well observes that the advice given to Children's Social Care was based on just three contacts with Child 3 and her Mother. The same analysis comments that there is a lack of clarity in the recorded notes about how much contact the Adult Male had with Child 3 and an absence of a shared understanding of what might be an acceptable level of contact, if any. Additionally, as commented upon by the Health Visitor, Start Well did not direct the Social Worker to speak to the Health Visitor; nor did the Social Worker contact the Health Visitor.

2.54. Also on 28th May the Social Worker spoke with Child 3's Mother by telephone. Apparently she confirmed that she did not want a relationship with the Adult Male and had been advised by the Health Visitor to contact GMP if worried. The Social Worker informed Child 3's Mother that her case would be closed. This was approved by the Team manager three days later. Child 3's Mother contacted Start Well distraught about the referral to Children's Social Care. No record has been provided that the Health Visitor was contacted by Start Well with this information although this had been planned.

2.55. **Commentary:** case closure is an inexplicable decision. Analysis for the Rapid Review from Children's Social Care is unequivocal. Case closure was inappropriate. The concerns referred by the Health Visitor (and indeed the Community Midwife) had not been adequately explored. There had been no detailed risk assessment of the relationship

[19] The Social Worker should have contacted the Health Visitor for information about Child 3 but appears not to have done so.

between Child 3's Mother and the Adult Male, of wider family relationships and family history, of the impact of the miscarriage, an unstable living arrangement and Child 3's Mother's emotional health and physical wellbeing. Decision-making was outside expected timescales. There had been no coordination meeting of professionals, no strategy meeting as had been directed, and there was no apparent plan to keep Child 3 safe. Thresholds had been misapplied. A Section 47 Children Act 1989 investigation and strategy meeting through to Initial Child Protection Conference would have been the appropriate pathway to follow.

2.56. **Commentary:** it appears that Start Well workers had only seen Child 3's Mother on three occasions. This raises the question of what "early help" was being offered, not least because Children's Social Care decision-making appears to have been influenced by their apparent involvement.

2.57. On 17th June GP records note that Child 3 was seen with a rash. The same day a Start Well Officer supported Child 3's Mother to move into a Mother and Baby Unit. During the move Child 3 was cared for by one of her mother's sisters. In a telephone contact three days later, Child 3's Mother stated that she was unhappy at a Mother and Baby Unit, did not know anyone, felt she was being watched and disliked the curfew. When advised that, if she left, she would be intentionally homeless, she became angry and hung up. The Health Visitor was informed on 21st June.

2.58. **Commentary:** Children's Social Care analysis for the Rapid Review criticises the lack of professional curiosity shown regarding the reasons for Child 3's Mother being unhappy at a Mother and Baby Unit. However, Health Visitor and Start Well records do contain reference to why Child 3's Mother was unhappy there, namely that she felt isolated due to having to be back in the accommodation at 20:00 and did not want to sit and stare at 4 walls. The Health Visitor explained that this was reasonable for a bedtime routine for Child 3. Child 3's Mother was advised that her child needed a routine, a helpful pointer to the need to consider Child 3's lived experience and perspective. It is also possible that Child 3's Mother had been unsettled by a sister being offered a property with her boyfriend that week, triggering again her wish for her own property. It was during this time when the Health Visitor made another referral to Children's Social Care to request more intervention. Thus, equally questionable at this point is whether sufficient and effective "early help" was being offered, adequate wrap-around intervention to support this transition. Indeed, the Health Visitor's referrals to Start Well and to Children's Social Care are evidence of a recognition that further support was felt necessary.

2.59. On 24th June Child 3's Mother left a Mother and Baby Unit and stayed with her mother. This generated concerns about the possible exposure of Child 3 to risks at this address. The Health Visitor received information raising concerns that Child 3 had not been taken to 2 GP appointments, and had unhealed sores by her ears/hairline. The Health Visitor referred these concerns to Children's Social Care. GP records contain a reference to the Health Visitor being concerned about Child 3's Mother's low mood. Health Visitor records note that Child 3's Mother had missed her counselling appointment earlier in the month and that it was felt that emotional support would be beneficial. An Early Help meeting took place with the Health Visitor, Child 3 and her Mother, Start Well Officer, and maternal great grandmother. Child 3 presented with a rash, scratches on her face and sores on her ears. Child 3's Mother stated that Child 3 was purposely pulling her hair out and had taken her to the walk in centre. She

requested to be supported into her own home and became distressed when she would not get her own way. She did not want to stay with members of her extended family. She stated that she had no clothes or food for Child 3 and left the meeting. The Health Visitor notified the GP of her concern about Child 3's Mother's low mood. The Health Visitor recorded that Child 3's Mother was tearful and frustrated about her housing situation. Nonetheless, warm interactions between mother and child were also observed and recorded. Safe sleeping advice was given as Child 3 and her Mother were sharing a bed. Play and stimulation for Child 3 were discussed.

2.60. On 25th June Child 3 was not taken to a GP appointment arranged by the Health Visitor to treat the sores around her ears. GP records contain an entry that a message was left for the Health Visitor regarding this missed appointment. A Start Well Officer spoke with the Health Visitor about concerns around Child 3's presentation, including the possibility that the hair pulling could be linked to neglect. The Health Visitor had by then spoken with staff in Children's Social Care, to be told that there was no role for Children's Social Care unless Child 3 was left alone with her maternal grandmother. The Health Visitor contacted Wigan Family Welfare to get access to counselling and mental health support for Child 3's Mother. The Mother and Baby Unit offered a slower integration to support her to live there.

2.61. On 27th June Child 3's Mother was advised that the blood tests would need to be repeated for Child 3. A Start Well Officer tried unsuccessfully to contact Child 3's Mother by telephone to enquire about her and Child 3. The Start Well Officer discussed with a Manager possible help from another worker in relation to stimulation support for Child 3 and her Mother. The Start Well Officer had not been able to contact Child 3's Mother by the following day. Also on 27th June the Health Visitor outlined her concerns again to Children's Social Care and Start Well. She outlined increasing developmental and health concerns for Child 3, slow weight gain and constipation, with Child 3 not being taken to appointments, pulling her hair causing thinning, and scabs to ears. Her Mother was unsure how this happened. She had attended a walk-in centre in Leigh on 19th June after noticing swelling and was given antibiotics. 4 scratch marks seen were consistent with her explanation. She was referred to the GP for further assessment on 24th June. Rash was present to torso and arms. There were also concerns regarding living arrangements.

2.62. **Commentary:** the Health Visitor continued to raise concerns, which is good practice. There is evidence of good communication between the GP and Health Visitor. However, these were repetitive and arguably escalating concerns, with little by way of a changed approach from Children's Social Care. Further escalation of concerns would have been appropriate. The "Early Help" meeting between some of the professionals involved and family members was good practice but not all services with a contribution to make were present and it is difficult to discern a protection plan that addressed all the risks and needs that had been identified.

2.63. The Children's Social Care and Start Well information contribution to the Rapid Review records that in supervision on 28th June concern was noted that a Social Worker had been unable to contact Child 3's Mother. The case was to be reallocated for assessment with a direction to focus on the family's living arrangements. The same contribution records that on 2nd July a visit took place and the case closed as "reports were accepted."

2.64. **Commentary:** it is unclear what is meant by "reports accepted" and the decision to close the case is inexplicable given the risks that had been identified and the decision to reallocate for assessment. There was no discussion with the Health Visitor prior to the case closure decision. This was poor practice.

Parallel Events

2.65. As already noted, the Adult Male was first recorded to be in contact with Child 3's Mother in February 2019. He was already the subject of a restraining order to protect an adult female from conduct amounting to harassment or causing fear of violence. He remained under that restraining order for the duration of the period under review here. He was charged as a result of a breach of that order on 13th April 2019.

2.66. GMP were also aware in April of threatening behaviour towards another adult female who did not provide a statement and therefore the charge of assault was dropped. There was a domestic disturbance involving the Adult Male in May 2019, which GMP reported to Children's Social Care and Health. A neighbour reported concerns about drug dealing in later June, with children known to be present. GMP reported this to Children's Social Care, Health and Probation[20].

2.67. The investigation of the Section 18 wounding of a young child was ongoing throughout this time. Legal Services within GMP applied to the Family Court on 6th August 2019 for evidence, including a finding of fact[21]. This was preceded by a lengthy process that included needing consent from all parties for the application for disclosure, which began on 7th June. Documentation was released by the Family Court on 10th September 2019 and, in relation to the finding of fact, 16th October. GMP received this two days later and sent it to the CPS for review.

2.68. The Community Rehabilitation Company (CRC) was informed by Children's Social Care of the allegations of abuse of a young child that had possibly been perpetrated by the Adult Male. Thereafter there were only occasional subsequent updates received by the first Senior Case Manager in CRC, and Officers only saw the Adult Male twice.

2.69. **Commentary:** by June 2019 GMP were aware of a relationship between the Adult Male and Child 3's Mother as a result of his electronic tag. The GMP contribution to the Rapid Review comments that this information was not cascaded to partner agencies appropriately.

2.70. **Commentary:** there is some information-sharing between agencies but, mindful of the preceding chronology, this was clearly partial. The delay in disclosing Family Court documents to GMP to assist with their investigation of the Adult Male is unfortunate. The pattern of behaviour in which he was engaging does not appear to have been factored into assessments of the risks that he presented to women or young children.

[20] When GMP report such incidents, recording by Health and Social Care practitioners would be made on a relevant child/parent's file and not routinely cross-referenced to other families with whom, in this case, the Adult Male was involved. A holistic picture, therefore, is not easily obtained.

[21] The Rapid Review report gives the date when the initial request was made as the 17th April. GMP's own chronology also gives the date of 17th April when the Officer in Charge submitted a request via GMP Legal Services for a finding of fact from the Family Court.

Case Unfolds

2.71. On 1st July a Start Well Officer and the Health Visitor applied for welfare priority for a property for Child 3's Mother as she was on the waiting list. On 3rd July the Health Visitor liaised with Children's Social Care and was informed that there was no role for Children's Social Care unless Child 3 was left unsupervised in the care of her grandmother.

2.72. **Commentary:** this seems a surprising position to have adopted given the history of concerns.

2.73. On 4th July a different Start Well Officer, allocated to offer additional support, spoke with Child 3's Mother who said where she was staying. A visit was attempted the following day but was unsuccessful. On 8th July, during supervision, a Start Well Worker raised concerns regarding Child 3's Mother sofa surfing. The Manager advised contacting Children's Social Care. The Officer later contacted Child 3's Mother to ask why she had failed to meet the worker three days previously. She stated that she did not like all the questions. She confirmed that Child 3 was living with her between her maternal grandmother and maternal great grandmother.

2.74. Health Visitor records also contain this information. Additionally, there is a reference that Child 3 was not to be left in the sole care of her maternal grandmother, and another that Child 3's Mother was now declining to access counselling, having missed two appointments. On 13th July Children's Social Care closed down their involvement on the basis that Child 3's Mother was to engage with Start Well and prioritise Child 3's health by taking her for medical treatment.

2.75. **Commentary:** it was a Social Worker who advised the Health Visitor that Child 3's grandmother was not to be left in sole charge of the child but there is no indication of what would follow if this was observed.

2.76. **Commentary:** there is no evidence that the Start Well Officer contacted Children's Social Care as advised. There is no evidence that Child 3's Mother's reaction to attempted contact was factored into a risk assessment and care plan. Children's Social Care should have known that Child 3 was not being taken for appointments and that her Mother was expressing reluctance to engage with Start Well, as the Health Visitor had informed the Social Worker of this. The closure decision is questionable.

2.77. **Commentary:** the Children's Social Care analysis for the Rapid Review observes, correctly, that case closure was inappropriate. There had been no apparent consideration of a professionals' meeting and/or strategy meeting, as a result of which no holistic or multi-agency accumulative view had been formed. A strategy meeting was necessary. Put another way, involvement was episodic rather than based on a cumulative understanding of the case chronology, with agencies and services working along parallel tracks with little cross-over.

2.78. **Commentary:** additional analysis provided by Start Well indicates that both Child 3's Mother and Start Well were now under the impression that a Social Worker was now leading the case. This merely adds to the inter-agency failure to confirm leadership responsibility for this case since, elsewhere, the operational assumption seems to have been that this role fell to the Health Visitor.

2.79. **Commentary:** Health Visitor records contain an entry for 8th July that Child 3's Mother had been exploring private rented accommodation but would need a guarantor. This possibility does not appear to have been pursued.

2.80. On 11th July Child 3 was not brought to an appointment with a Paediatrician for weight and bowel monitoring. There were also outstanding immunisations. On 12th July she was not brought for her second routine immunisations. This was repeated on 24th July. As a result of the pattern of not being brought, Child 3 was discharged by the paediatric clinic. The Health Visitor was informed of these developments by the GP surgery.

2.81. GMP recorded three notifications in July and August 2019 that the Adult Male had breached his curfew. He was also arrested in July for assault and burglary. He was also reported as being a victim of domestic violence from an adult female whom he had reportedly harassed previously.

2.82. **Commentary:** the combined chronology records again that Child 3 had been observed pulling her hair at either side of her head, causing it to thin. However, the Health Visitor had continuously observed and documented warmth and affection between Child 3 and her Mother. This might be evidence of the operation of the Rule of Optimism, of being unduly reassured by some observations to the exclusion of assessment of risks arising from her living situation and involvement with the Adult Male. Risk assessment should have included information from GMP regarding the Adult Male's non-compliance with Court orders and further offending, if that information had been shared with other agencies.

2.83. **Commentary:** the pattern of Child 3 not being brought to appointments should have been the focus of a multi-agency risk assessment rather than, as in the case of the paediatric clinic, discharge and case closure. Such an assessment might have prompted further attempts to engage Child 3's Mother.

2.84. Start Well had contact with Child 3's mother on 23rd July regarding housing and welfare benefit issues. Start Well agreed to contact Housing. Child 3 was seen appropriately dressed, smiling and responsive. Telephone contact was made with Housing.

2.85. **Commentary:** Start Well, in additional information provided for this review, has provided detail of a management oversight on record for 19th August. It is quoted in full because it summarises key shortfalls in this case. It is recorded that: "There is no episode coordinator on the system and the lead professional is not actually the lead professional. There is no plan and no reviews on the system so direction of involvement is unclear." Despite these pertinent observations, no action seems to have been taken to remedy the shortfalls. The Independent Reviewer has been told that the Health Visitor's assessment has been sent in and uploaded onto the case recording system but that no plan or review has been uploaded, even though Early Help reviews did take place.

Increasing Concerns and Uncertainties

2.86. On 20th August 2019 Child 3 was taken to the GP surgery suffering from acute conjunctivitis. It was observed that Child 3 had a very flat nose bridge. A Practice Nurse advised that she should be taken to A&E.

2.87. **Commentary:** the Practice Nurse should have sent a referral to Children's Social Care. There is no Hospital record that the Practice Nurse spoke to staff there. Noteworthy too is that Child 3 was taken to an Emergency Department in an NHS Trust in the Greater Manchester area but outside Wigan.

2.88. At an A&E Department she presented with multiple facial bruises and injury to her nasal bridge. A child protection medical was completed, which identified seven injuries. The examining Paediatrician stated:

"Although these injuries could be consistent with the explanations given, and with injuries associated with normal childhood play, it is important that social workers continue to closely monitor this case. In view of the fact that there are background concerns regarding mum's previous partner, there have been concerns raised regarding non-attendance at paediatric outpatient follow up appointments and that [Child 3] has not had her up to date immunisations. It would be beneficial if the social worker team, in conjunction with the GP/Health Visitor can arrange for [Child 3] to have her immunisations and to help the family to attend these and any future outpatient appointments at Wigan Hospital."

The report also reiterates information provided by Children's Social Care that Child 3's Mother had had a year-long relationship with the Adult Male and there was an ongoing investigation regarding him inflicting a serious injury to a child. On the day of the medical the Health Visitor also spoke to a Safeguarding Nurse and shared information again about the Adult Male.

2.89. Staff at the A&E Department notified Children's Social Care of their concerns. Child 3's Mother could not explain some of the marks on Child 3's face; others she attributed to Child 3 banging her head on the pram and bumping her nose while crawling or falling. Child 3 was taken from the Hospital by her Mother despite recommendations to stay and there being outstanding elements of the medical to complete. She was told to return the following day for medical photographs to be taken.

2.90. **Commentary:** GP records note that concerns were discussed with the paediatric team[22] and that a Social Worker informed the team of the missed paediatric outpatient appointments and the presence of the Adult Male. What is recorded in the GP notes illustrates an absence of risk assessment and safety planning. There are entries to the effect that the GP was unaware of any safeguarding concerns regarding Child 3, that Child 3 was "subject to early help social work involvement" and that a Social Worker would need to closely monitor the case. Child 3's Mother had been advised to have no contact with the Adult Male but there was no recognition of what she had reported previously when she had attempted to end the relationship, namely harassment. The possibility of coercive and controlling behaviour by the Adult Male does not seem to have featured in the work being undertaken by any practitioner in this case.

2.91. Also on 20th August, according to the combined chronology, an email was sent from a Start Well Worker to the Health Visitor outlining concerns about Child 3's Mother's engagement and for advice on any further required actions, without which the case would be closed. She had declined to attend groups at a Family Centre. The Health Visitor advised Start Well to inform the Social Worker in Children's Social Care about

[22] See 2.86 – Hospital records have no note of this.

non-engagement. Contact was received from the CRC that the Adult Male had attended an appointment with Child 3's Mother, confirming they had been in a relationship for one year and that they planned to live together. CRC shared concerns for Child 3 and her Mother due to the Adult Male being investigated in respect of serious harm to another very young child and having breached a restraining order in respect of his ex-partner. CRC confirmed a significant family history of abuse.

2.92. **Commentary:** it appears that neither GMP nor CRC considered the use of Claire's Law. The Independent Reviewer has since been informed that Start Well is now using Claire's Law when necessary for the purposes of safeguarding.

2.93. Directed by an Advanced Practitioner, an immediate visit was required from Children's Social Care as well as a strategy meeting to take place. As staff from Children's Social Care were unable to contact Child 3's Mother, GMP were requested to undertake a welfare check.

2.94. The combined chronology records GMP having received information from the Community Rehabilitation Company that Child 3's Mother and the Adult Male had presented as a couple. An Officer from GMP subsequently spoke with Child 3's Mother and she denied being in a relationship. She maintained that Child 3 had attended A&E as a result of a fall. GMP, having assessed risk as medium, sent referrals to Children's Social Care and Health.

2.95. A written report from the Hospital was not received until 9th September. However, it is important to emphasise that information was shared at the time of the medical between the GP and Paediatric staff, and between a Social Worker and Paediatric staff.

2.96. **Commentary:** the GP practice should have referred the case to Children's Social Care for a child protection medical to be arranged. The Paediatrician should have referred the case also immediately due to the injuries and possible doubt about some of the explanations that were offered for some of the harm observed. It has been suggested to the Independent Reviewer that discussion between a Paediatrician and a Duty Social Worker constituted a referral, which was followed up with a letter subsequently. It is possible, however, that Children's Social Care recorded a discussion rather than a referral. No agency requested a strategy meeting and no coordinated plan was devised in response to the risk posed to Child 3 as a result of uncertainties about the relationship between her Mother and the Adult Male. A section 47 Children Act 1989 investigation was not commenced and there was no initial child protection case conference.

2.97. On 21st August Child 3 was taken back to the Hospital for medical photographs following intervention by GMP and a telephone conversation her Mother had with the Health Visitor in which she confirmed her relationship with the Adult Male but denied that he saw Child 3. Start Well received an email from the Health Visitor regarding Child 3's hospital assessment, with a request that Start Well should share information about Child 3's Mother's non-engagement with Children's Social Care. The following day it is recorded that GMP were told by Children's Social Care that Child 3 was not to have any contact with the Adult Male until investigations about previous allegations of child abuse had been concluded.

2.98. Also on 22nd August a Social Worker completed a visit. Child 3's Mother stated that the relationship with the Adult Male was not serious, that they did see each other but

Child 3 did not have contact with him. Maternal great grandmother was looking after Child 3 when they did see each other. Health Visitor concerns that Child 3 was taken out a lot with limited routines were disputed by her Mother. Maternal great grandmother confirmed that Child 3 did not see the Adult Male. The Social Worker spoke to the Health Visitor who reported that Child 3 was not at her maternal great grandmother's very often. Child 3's Mother was staying with friends but would not say who they were. She had stopped engaging with Start Well and had accrued debt. The Health Visitor has been recorded as saying that Child 3's Mother was vulnerable and required enhanced support. The Social Worker attempted to contact the Adult Male but to no avail. It is recorded that Child 3's Mother, maternal great grandmother and the Community Rehabilitation Company would reiterate to the Adult Male that he could not see Child 3[23].

2.99. On 27th August a Start Well Worker contacted Children's Social Care, as recommended six days earlier by the Health Visitor. The delay was the result of the staff member being on annual leave. The request was actioned immediately on their return to work. There was a sharing of information. It appears that no evidence had been found of Child 3 being left alone with the Adult Male. By 27th August it appears from the combined chronology that Children's Social Care were considering closing the case, the rationale being that Child 3's Mother was compliant with advice that Child 3 should not see the Adult Male. Efforts by Children's Social Care to contact the Adult Male were unsuccessful, with the result that Child 3's Mother and extended family, and the Senior Case Manager at the Community Rehabilitation Company were to tell him that he should not see Child 3[24]. It was also the case that the Start Well Worker was considering case closure. Around 30th August the Health Visitor was informed that Start Well was indeed ending its involvement with Child 3's Mother following discussion with a Manager who had agreed to speak to a family centre regarding whether the case could be transferred there. It appears, however, that the Health Visitor was not told by Children's Social Care of their case closure. As a result, when Children's Social Care received on 9th September the written report of the examination on 20th August, no action was taken. By 17th September, the Health Visitor knew that both Children's Social Care and Start Well had ended their involvement, the rationales at that time being given as the case not meeting Children's Social Care thresholds, the involvement of Start Well and, for Start Well, the Mother's non-engagement.

2.100. **Commentary:** no practitioner or agency challenged the closure decisions. No strategy meeting had been convened, as had been directed by an Advanced Practitioner. Too much reliance was placed on the reassurances provided by the family concerning the involvement of the Adult Male with Child 3. The delay in Children's Social Care receiving the Hospital's written report on the medical examination on 20th August is unfortunate and demonstrates a lack of urgency. When it did arrive, it was not given due regard because of a prior decision to close the case. The same can be said of the response to the Health Visitor's expressed concerns, another referral having been sent on 30th August as a result of Start Well's parallel decision to close down their involvement due to Child 3's Mother's non-engagement. These closure decisions, as observed in the Rapid Review, were highly questionable. No professional meeting or strategy meeting had been held, the latter having been ordered in both April and August 2019. No manager challenged the closure decisions. That relating to Children's Social

[23] This may have been what the Social Worker intended should happen but CRC has no record that it was expected to speak to the Adult Male in this way.
[24] See note 20.

Care appears to have been based on one home visit and not on the accumulation of concerns of risk of harm, including an inconsistent picture of key relationships. There do not appear to have been any unannounced visits and no challenge or concerned curiosity expressed towards the adults involved.

2.101. **Commentary:** the Start Well Manager did not speak with the Family Centre until 3rd October, a significant delay demonstrating a lack of timeliness and urgency. Further reflection from Start Well provided for this review rightly questions how the closure decision could have been arrived at.

2.102. Information provided for the Rapid Review by the Offender Manager, Community Rehabilitation Company, who was working with the Adult Male, recorded that he was breached in August and resentenced to another Community Order for this original offence in September. He also received another Community Sentence at the end of August for aggravated vehicle taking.

In Parallel

2.103. At the pre-sentence report stage the Community Rehabilitation Company had been advised by the National Probation Service that the Adult Male was in a relationship with a young woman who had a child. At the beginning of September the Offender Manager sought information about the status of the investigation into the Adult Male's possible involvement in allegations of abuse of a child. No further update appears to have been available and the Offender Manager received no information from Children's Social Care about his contact with Child 3 or relationship with her Mother. At his first meeting with the Offender Manager on 9th September, however, he denied being in any relationship.

The Final Weeks – More of the Same

2.104. GP records note for 6th September that Child 3's eye complaint had not settled. On 10th September a safeguarding alert was added to the GP's records. Health Visitor records for 10th and 17th September contain notes of conversations with an Advanced Practice Nurse to the effect that different accounts had been given of the injuries observed on 20th August, with the Nurse suggesting a meeting to develop a robust plan. On 17th September the Health Visitor and the Safeguarding Nurse at the Hospital where Child 3 was examined on 20th August were told that the injuries that had been observed then were to be reviewed. This was the same date that Children's Social Care and Start Well closed down their involvement, leaving the Health Visitor as the only practitioner with continuity of involvement. **Commentary:** neither the Health Visitor nor the Advanced Nurse Practitioner appear to have received further updates from the Hospital.

2.105. On 19th September Child 3 was not taken for her second routine immunisations. Health Visitor records contain an entry of a suggestion for a meeting with Start Well. **Commentary:** this was a repeating pattern, despite the Health Visitor discussing the missed immunisations with Child 3's mother at Early Help meetings on 20th May and 24th June, and immunisation forming part of the Early Help action plans.

2.106. On 30th September the Adult Male informed his Community Rehabilitation Company Offender Manager that he had moved to his sister's address. His sister was contacted and confirmed this. She denied that anyone else was living there. **Commentary:** it does not appear that the Offender Manager notified Children's Social Care.

2.107. On 4th October the Hospital sent a letter, written by a Consultant Community Paediatrician, to Children's Social Care following a peer review[25] of the injuries examined on 20th August. It was received by the GP on 10th October and by Children's Social Care. The review meeting was concerned at the number of bruises/injuries on Child 3's face: "concerns raised about the number of bruises/injuries on [Child 3's] face, albeit with histories given to explain them, combined with concerns about missed out patient appointments & lack of immunisations." There were four areas of injuries on her face all with different explanations. "Following these reviews, we would strongly recommend that social care organise a meeting to review progress with provision of appropriate support and monitoring of [Child 3], to ensure that her needs are being met and that any persisting safeguarding issues are being addressed."

2.108. **Commentary:** there is no evidence that the letter, which did not arrive until 11th October, was preceded with verbal communication of the re-analysis of the injuries and the renewed concern and recommendations. This is a significant omission although it should be noted that there is no formal process for circulating the outcomes of a peer review, which is primarily constructed as a learning opportunity for Paediatric and other Hospital staff.

2.109. On 4th October the combined chronology records that Start Well decided to transfer the case to a Family Centre to engage Child 3 and her Mother in sessions. **Commentary:** it is unclear what prompted this decision. This appears to be another example of the failure to articulate and record the rationale underpinning decisions, and the failure to use an effective chronology to inform risk assessment and management.

2.110. By 7th October the Health Visitor had information that Child 3's Mother was staying with the Adult Male's sister, with the Adult Male having contact with Child 3 as both he and Child 3 were also living there, and a referral was sent to Children's Social Care. Child 3's Mother knew that the referral was being sent, and had agreed with this. Child 3 was recorded as pulling her hair out and at risk. Child 3's Mother informed the Health Visitor that Children's Social Care had told her that the Adult Male was allowed contact with Child 3 as long as she supervised it. This resulted in the Health Visitor making a referral to Children's Social Care, whereupon it was confirmed by the Duty Social Worker that this was the case and encouraged a referral. The Health Visitor's contact with Children's Social Care included concerns about Child 3's 9-12 month review being outstanding, missed paediatric appointments, outstanding immunisations, Child 3 pulling her hair out and instability around living conditions. The Social Worker spoke to Child 3's Mother who confirmed that she was allowing supervised contact.

2.111. **Commentary:** so the messaging has changed from the Adult Male not being allowed any contact with Child 3 to one where her Mother could supervise this. This change was not based on any risk assessment. GMP were still acting in the belief that no contact was to be allowed. The messaging became even more convoluted. The combined chronology for 8th October records that a Social Worker contacted Child 3's Mother who said she had been supervising contact between Child 3 and the Adult Male. She acknowledged the relationship and wanted to move in with him. She was advised not to allow any contact between Child 3 and the Adult Male pending further assessment, to which she apparently agreed. Again, on 11th October a Social Worker visited Child 3's Mother at

[25] Peer review is a meeting held every two months for the purposes of learning. Cases are not automatically placed on a list for discussion.

the Adult Male's sister's address and advised no contact with the Adult Male when Child 3 and her Mother were seen. It is recorded by Children's Social Care that a risk assessment of the Adult Male was to be completed.

2.112. **Commentary:** it is unclear whether this visit was prompted by receipt of the letter from the Hospital, sent on 4th October. Child 3's Mother said she had been told it was fine for the Adult Male to have contact with Child 3. She was told there must be no contact, which she agreed to. She was staying at the Adult Male's sister's home who was clear she did not think that he posed a risk to children. She disclosed her own children had been removed from her care. Child 3's Mother was asked about her lack of engagement with Start Well and missed appointments. She was advised that Children's Social Care would support her with re-housing. She denied that Child 3 was continuing to pull her own hair out.

2.113. **Commentary:** there is potentially an issue of disguised compliance here, namely it would be expected that Child 3's Mother would agree with what the Social Worker was requiring. There is also evidence of minimisation of concerns.

2.114. On 8th October the Adult Male was seen by a Community Rehabilitation Company Senior Case Manager. He stated that there were no children in the property where he was living. A further appointment was given for a week later, with the stated intention to arrange a home visit at that time. **Commentary:** this information was not shared with other agencies. So, whilst Child 3's Mother was now acknowledging the relationship with the Adult Male, he appears not to have disclosed the full extent of his contact with Child 3 and her Mother.

2.115. Also on 8th October a new Start Well Family Centre Worker telephoned the Health Visitor. This is the first involvement by Start Well since the closure decision in later August. The worker had been unable to contact Child 3's Mother. Concern was noted about the outcome of the August medical and that Child 3 and her Mother were living with the Adult Male's sister and that he appeared to have supervised access to Child 3. The Health Visitor had referred the case again to Children's Social Care.

2.116. On 10th October Housing Options spoke to Child 3's Mother about her living situation. She had been staying between her mother and grandmother's addresses but was asked to leave two weeks ago. Since then she had been living with her partner's sister but had been given two more weeks. She was wanting accommodation for her and her baby only. An appointment was made for 18th October.

2.117. On 11th October there is a final entry from Start Well, a management overview on record to the effect that there were no contact numbers or address for Child 3 and her Mother.

2.118. On 14th October the Health Visitor weighed Child 3. This was satisfactory. This was the last time that the Health Visitor saw Child 3 who was in the care of her maternal great grandmother. A telephone conversation took place on the same day between the Health Visitor and Children's Social Care/Start Well. Discussion related to outstanding health checks and Child 3's Mother's plans to stay with relatives/friends in Bury whilst Child 3 remained with her maternal great grandmother for the week. It was agreed that health checks would be completed the following Monday. The Health Visitor raised previous concerns. It was agreed that information would be shared following the

completion of a health assessment. The combined chronology records that it was agreed that the child and family assessment timescales would be extended. Children's Social Care records include an entry on file of management oversight, to the effect that the Social Worker was to undertake a risk assessment of the Adult Male, the deadline for which was extended.

2.119. **Commentary:** it is unclear who agreed to this extension and why. However, it appears that case management oversight was resting with a Social Worker and an assessment planned. It is clear, however, that despite Child 3 being known to be in the presence of the Adult Male, no practitioner or manager had escalated concerns and no strategy meeting or interim child protection case conference had been held. No risk assessment was completed of the Adult Male. Notwithstanding observations of warmth and affection between mother and child, the Rapid Review documentation observes the absence of any parenting assessment of Child 3's Mother, of any risk assessment of the harm posed by the Adult Male, and of any assessment of the child in this family context. The Graded Care Profile was not used and there was no assessment of the emotional distress being exhibited by Child 3.

16th October 2019

2.120. On 16th October North West Ambulance Service were called to the address of the Adult Male's sister by Child 3's Mother. The initial story was that Child 3 had fallen downstairs but was later seen floppy and white, having been placed in her pram. There were discrepancies between the account given by Child 3's Mother and the Adult Male's sister who was also in the house. Paramedics are recorded in the combined chronology as finding the injuries inconsistent with the accounts being given. Child 3 was taken to a local Hospital, subsequently being transferred to Manchester Children's Hospital.

2.121. GMP Officers took statements at the Hospital. The Adult Male's sister changed her account and stated that the Adult Male had been left alone with Child 3. He was initially arrested on suspicion of a Section 18 assault.

2.122. On 17th October Child 3 passed away as a result of her injuries. The Adult Male was arrested on suspicion of murder. Child 3's Mother was arrested on suspicion of causing or allowing the death of a child and perverting the course of justice. The following day the results of a post mortem showed findings indicative of severe head impact of the type usually seen in a road traffic accident or a multiple storey fall from height. Findings were totally incompatible with a minor domestic fall or accident. On 19th October the Adult Male and Child 3's Mother were charged with the offences for which they had been arrested.

2.123. In parallel, on 18th October the finding of fact was obtained from the Family Court relating to the allegations of child abuse against the Adult Male in respect of another young child. The finding of fact was sent to the Crown Prosecution Service. GMP's investigation of those allegations remained ongoing at the time the injuries to Child 3 were reported. GMP referred the handling of that case to the Independent Office of Police Conduct.

3. Thematic Analysis

Direct work with Child 3 and her mother

3.1. Child 3's Mother was young and she had experienced instability and adverse events during her childhood. There does not appear to have been any consideration given to focused work to support her to plan for Child 3's birth, other than the offer of involvement in the Family Nurse Partnership programme, which she declined. Prior to Child 3's birth, therefore, there was no assessment of her parenting skills or attention to where she would live with her baby. Put another way, no early help offer is evident. Children's Social Care and Start Well have no recorded contacts with Child 3's Mother in the period before Child 3's birth. Indeed, the first social work contact was in February 2019 when there were concerns that Child 3's Mother was in a relationship with the Adult Male. Start Well have no record of any involvement with Child 3's mother before February 2019. Staff then appear to have attempted to engage Child 3's Mother at the request of the Health Visitor but attempts at engagement appear to have been reactive rather than persistent. As a result her needs, including her housing situation, were never comprehensively addressed.

3.2. As a result of action by the midwifery team, involvement in the Family Nurse Partnership was offered to Child 3's mother on 6th February 2018, with an introductory visit taking place on 1st March. This was followed up one week later but Child 3's mother declined a further home visit. In telephone contact on 16th March, she declined involvement due to the programme's intensity. At the learning event it was noted that Bolton had a pathway to follow when parents declined this form of Early Help; the pathway did not exist in Wigan. Child 3's Mother has told the Independent Reviewer that she did not feel that she needed the programme at the time. Looking back, however, she has reflected that support from Early Help would have been better earlier. **Commentary:** there are lessons here about being clear what is being offered, and why, and about being respectfully persistent in offering support.

3.3. Further opportunities to consider Early Help arose in November 2018 and January 2019 when Child 3's Mother was expressing anxiety, especially about her housing situation. In November 2018 she reported feeling down. Discussion took place around the support available if she felt she wanted it, including the Wigan Family Welfare Counselling Service. She also spoke of feeling well supported by her family.

3.4. This was reviewed at the next contact on 31st January. An Edinburgh Postnatal Depression scale questionnaire score of 18 indicated that depression was likely. In addition to ongoing Health Visitor support, about which Child 3's Mother was very positive in her responses to the Independent Reviewer, a referral to counselling was made and also to Start Well. The Health Visitor also signposted her to the GP for a medication review. However, there were significant delays in Child 3's Mother being offered a counselling appointment, meaning that to some degree at least her mental health needs were not met. Child 3's Mother has told the Independent Reviewer that, by the time an appointment was offered, she did not feel that she needed it.

3.5. The initial special circumstances concerns raised by the midwifery team should, under service arrangements then in operation, have prompted allocation of a Health Visitor to offer antenatal visits. This did not happen, possibly due to lack of capacity within the team. At the learning event it was clarified that Start Well would receive referrals for

expectant mothers with a view to offering early help. It was stated that such referrals are now happening. It was also observed that the Family Nurse Partnership programme has been replaced. A new team, the precise referral criteria for which are being worked out, will be working with "vulnerable families", including teenage parents. This team might fill a gap that was observed at the learning event, namely when parents rejected an enhanced ante-natal service.

3.6. **Recommendation One:** As the Early Help offer is being reconfigured, Wigan Safeguarding Partnership should commission and scrutinise audits of the effectiveness of the new service.

3.7. **Recommendation Two:** Wigan Safeguarding Partnership in partnership with Wigan Safeguarding Adults Board should convene a multi-agency summit. The purpose should be to establish whether there is sufficient recognition of the potential impact of adverse childhood experiences and whether a whole family approach is sufficiently embedded in practice. This should cover but is not restricted to the Early Help offer, and should also include an emphasis on professional curiosity and a trauma-informed approach.

3.8. By the time Child 3 was born, her Mother's relationship with the baby's Father had ended. There is no record of any service considering whether he could be part of a circle of support and safety for Child 3. There is no record of his opinion having been sought about the welfare of his child. Health Visitor records include notes of conversations with Child 3's Mother to the effect that he was having contact with Child 3 but that she did not feel confident in leaving him alone with the baby.

3.9. Child 3's Father has confirmed that he did engage with Child 3, seeing her most Saturdays. He also contributed financially and sent texts to Child 3's Mother. He said that he would have gone more frequently but was working. He did not always see Child 3's Mother when he visited. He felt welcomed and comfortable when seeing Child 3 at her great grandparents' home but felt less comfortable in the environment of Child 3's grandmother. He confirmed that he had seen Child 3 the day before she died. He talked about having fed her and made bottles for her. He said that he knew what to do, having grown up with nieces and nephews. **Commentary:** there are echoes here of Child 3's Mother being told that she should not leave Child 3 alone in the company of her mother.

3.10. Child 3's Father confirmed that no-one in the wider family had raised concerns with him. However, he said that Child 3's great grandmother had not wanted the Adult Male in her home. He recalled one brief telephone call that he had received, around March 2019, saying that the Adult Male was around Child 3. He was not sure of the identity of the person who called. No second call was made. He spoke to the Adult Male subsequently, telling him to "leave Child 3 out of it." He did not have any knowledge about the Adult Male's background. He also confirmed that he had seen marks on Child 3's face but had accepted the explanation, that she had fallen over, as it seemed understandable, based on his experience and knowledge of young children.

3.11. Child 3's Father said that he had "tried to be the best Father" and had "put effort" into being a parent. However, he had felt left out, not considered, and found it difficult to understand why no-one had contacted him. "I could have done something but I was not given the opportunity." He felt that he was not seen as a parent. In summary, he wanted to remind practitioners to "put themselves in the child's shoes", and to consider the role of birth fathers. "Both parents are important." He hoped that his contribution

would help "to save another child's life" as the "system had failed." **Commentary:** the Independent Reviewer understands that Child 3's birth was registered jointly by both her Mother and Father. Child 3's Father had parental responsibility.

3.12. Continuing the theme of "thinking family", assumptions were made that Child 3's Mother's wider family were a protective circle of support[26]. At the learning event it was clearly stated that the grandparents with whom Child 3's Mother was living offered a warm and nurturing environment where Child 3 appears to have thrived. Child 3's Father also expressed warmth towards Child 3's Mother's grandparents (Child 3's great grandparents), seeing them as "the best." The room in which Child 3 and her Mother were living, however, was small. Subsequently, concerns were expressed should Child 3 be left alone with her grandmother. Nonetheless, there was no thorough (risk) (signs of safety) assessment, including family history. This would have been appropriate, for example, when it was clear that Child 3 and her Mother living with other family members was not sustainable. No risk assessment was undertaken when Child 3's Mother went to live with the Adult Male's sister, even when he had given the same address to CRC as his place of residence. A more formalised signs of safety approach would have offered one model for thinking family and for risk assessment. This does not appear to have been in use at the time, giving an appearance that visits, contacts, assessments and plans lacked focus and specified desired outcomes.

3.13. **Recommendation Three:** The outcome of the adoption of specific practice and operating models for focused assessment and intervention as standard practice by Children's Social Care should be scrutinised by Wigan Safeguarding Partnership.

3.14. There was an optimistic over-reliance on Child 3's Mother's self-reports, for example when she was discharged home with her new-born baby in relation to the availability of support, and when she sought to reassure practitioners in February 2019 that she was not in a relationship with the Adult Male. Insufficient checks were performed; cumulative history was not brought together. Reassurances provided by other family members were also accepted at face value. There is no evidence that disguised compliance was considered.

3.15. Throughout Child 3's life there were shortfalls regarding risk assessment, for example when she was at risk of homelessness and there were emergent concerns about her relationship with the Adult Male[27]. Risk assessment would have been appropriate when she disclosed her second pregnancy and when she revealed that she had ended her relationship with the Adult Male but was being harassed. It has been acknowledged by Children's Social Care that coercive and controlling behaviour was not considered either at this point or subsequently. When Child 3's Mother was stating that she did not believe what practitioners were sharing with her regarding the concerns about the Adult Male, the implications for safety planning should have been risk assessed. Similarly, the implications for safety planning should have been considered when Child 3's Mother stated in July 2019 that she did not like all the questions being asked of her.

3.16. Child 3's Mother has told the Independent Reviewer that, had any practitioner said that they did not believe what she was saying, this would have made her think. She also reflected that "vulnerable mums like me don't always listen." She felt that it would have

[26] Section 2.35.
[27] Section 2.39.

been necessary to explain things clearly so that she understood. As Child 3's Mother pointed out, it is always necessary to consider that people may be wary of social services. She has accepted that she was indeed wary because of her childhood experiences as a child, and a fear that Child 3 would be taken away. **Commentary:** these observations shared by Child 3's Mother reinforce the importance of professional curiosity, especially about the impact of past events on present behaviour and presentation.

3.17. On the theme of coercive and controlling behaviour, the Health Visitor did consider the possibility of domestic abuse and did challenge Child 3's Mother when she did not believe what was being reported about the Adult Male. It has also been suggested that not all practitioners with knowledge of the Adult Male recognised the potential for coercion and control in his relationships. Use of Claire's Law does not appear to have been considered.

3.18. Child 3's Mother has told the Independent Reviewer that she does not know why she was not told that the Adult Male was being investigated for possibly hurting a child. She feels that she should have been told this. Child 3's Mother has also stated that she did not always feel scared of the Adult Male but that he could behave threateningly towards her and Child 3's Father, especially if there were any signs that she might return to him. She described one incident when the Adult Male punched her; another when he threatened her with social services if she left him. It reminded her of what she had witnessed as a child, so she tried to shield Child 3 from this. Crucially, she has disclosed that the Adult Male did not want her to attend an appointment on 18th October and in the run-up to that date had been saying "you're not going."

3.19. **Recommendation Four:** Coercion and controlling behaviour should be addressed in multi-agency training offered through the Wigan Safeguarding Partnership and Wigan Safeguarding Adults Board as a contribution to a "think family" approach to practice, including legal rules to protect victims from domestic abuse, and should be recorded as having been discussed in safeguarding supervision.

3.20. Risk assessment is a core component of safety planning. As commentary on the chronology highlights, Child 3's Mother received unclear and/or inconsistent messages from the practitioners involved regarding the implications for her care of Child 3 of her relationship with the Adult Male. This may partly have been the result in delays in receiving from the Family Court a finding of fact with respect to the risks presented by the Adult Male. However, had all the available information been shared across the different agencies involved, and had those agencies met together, a uniform approach would have emerged. Equally, it is hard to fathom how Social Workers could be certain that Child 3 would be safe when leaving her Mother to reflect on the concerns expressed about the Adult Male. Finally, in the final weeks before Child 3's death, when it was clear that Child 3's Mother was allowing contact between Child 3 and the Adult Male, a risk assessment of him was planned but not undertaken.

3.21. Child 3's Mother has stated that the messages from social services were "unclear and inconsistent." "I thought he could be near her with my supervision or any adult supervision. When (a social worker) came I even said to my nan, are you listening to this and I made him say it again, that the contact can be supervised by an adult, including me."

3.22. Child 3's Mother has also commented on risk assessment, as follows: "First visit was (a *social worker*); she explained I would be child in need and known to social care for 6 weeks while there is a risk assessment. Why do an assessment with someone who should not be near kids? Someone should've said straight to me, if you want to be with him, Child 3 will be in care. That would've been my choice to make then. I may have listened. I still don't understand what assessments I have had."

3.23. There were three social work assessments completed by Children's Social Care on 31st May, 13th July and 2nd September. Judging by what has been recorded, none were adequate. In the first there is no recognition of the Adult Male's power in the relationship with Child 3's Mother. Faith is placed in the maternal grandparents to protect Child 3 in the event that her Mother did not prioritise the child's needs over her relationship with the Adult Male. Sections of the template relating to authorisation by the Manager once the assessment findings had been shared remain incomplete. In the second assessment there is no analysis of the actual relationship between Child 3's Mother and the Adult Male; it seems to have been accepted that this relationship was not serious, as if that somehow reduced the risks. There is no in-depth consideration of Child 3's Mother's engagement with Start Well. Yet, reliance is placed on Start Well assisting with needs relating to housing and finances. There is no reference to Child 3's Mother having missed an appointment with respect to her mental health. There is no entry in the section of the template concerned with discussion of assessment findings. There are no Manager comments.

3.24. In the third assessment, there is evidence of copying and pasting from previous work. There are no Manager comments. The referral history is given but without critical analysis of it in relation to this referral for assessment; for example, Child 3's Mother had not engaged with Start Well. It has been suggested that the three assessments represent a "start again" approach rather than each building and re-assessing a cumulative picture. It has also been suggested that the approach to assessment was insufficiently assertive and professionally curious.

3.25. **Recommendation Five:** Children's Social Care should conduct routine audits of social work assessments and managerial oversight of decision-making, with reports scrutinised by Wigan Safeguarding Partnership.

3.26. Closely connected with safety planning and with risk assessment is the lived experience of Child 3. From December 2018 onwards a pattern emerged of Child 3 not being brought to appointments. The Health Visitor did follow-up missed immunisations but encouragement alone did not break the pattern. Further practical support was needed to ensure that Child 3 was seen. There was evidence of behaviours indicative of emotional distress, such as Child 3 pulling out her hair. There were some concerns reported about Child 3's Mother's attitude towards her, although there were also positive reports about emotional warmth towards Child 3 by her Mother. It is possible that too much weight was given to the positive parenting behaviours that were seen, reflective of over-optimism. The Health Visitor has reflected on how much child friendly interaction Child 3 was given and whether she had to "fit in with an adult day." Panel members in discussion with the Independent Reviewer have observed that Child 3's lived experience was not routinely referenced in assessments.

3.27. At various points a lack of urgency is apparent, for example delays in allocating a Social Worker between the Health Visitor's referral on 26th March and 17th April, in Start

Well responding to a referral in early February from the Health Visitor, and in addressing her housing situation. Other than expressed concerns by the Health Visitor periodically throughout Child 3's life, and concern from Hospital staff as a result of their reflections on their observations in a medical in August 2019, it is difficult to discern any practitioner viewing the world from Child 3's position. The Health Visitor has suggested that other practitioners and services may have been reassured that she was visiting routinely and that Child 3's Mother was engaging well with her.

3.28. Throughout the case, from the time Child 3 was born, there was a lack of professional curiosity and of robust assessments leading to planned and focused work by Start Well and Children's Social Care. There were three referrals to Children's Social Care from the Health Visitor, in March, June and October 2019. The recorded decision on the first referral was that the threshold for statutory intervention was not met, with a recommendation that involvement with Start Well continued. There was already evidence that reliance could not be placed on the effectiveness of this plan. Child and family assessments in May, June/July and August/September resulted in no further action decisions, again relying on Child 3's Mother's involvement with Start Well and compliance with (mixed) messaging about contact between the Adult Male and her child. No-one in Start Well or Children's Social Care appears to have thought through the implications of Child 3's Mother not engaging with Start Well. It is possible to conclude, therefore, that practice in this case is emblematic of the findings in OFSTED inspection reports.

3.29. Child 3's Mother has also commented on the issue of engagement. She has suggested that Start Well did not engage with her, especially after she left the mother and baby home. **Commentary:** this reinforces the observations made earlier in this section of the report about assertive outreach and the importance of there being a clear and structured Early Help plan of work.

The team around the child

3.30. There are examples of liaison between practitioners involved. For example, Midwives shared concerns with Children's Social Care when Child 3's Mother was first pregnant. At various points Community Midwives and the Health Visitor referred Child 3 and her Mother to Start Well and to Children's Social Care. The GP Surgery also contacted Children's Social Care. The National Probation Service shared information with Children's Social Care in August about the Adult Male. There were also some instances of joint visiting.

3.31. There were, however, missed opportunities to share information. GMP did not cascade information to other agencies about their involvement with and knowledge of the Adult Male. GMP records indicated that the Adult Male was deemed to be a risk to younger children. Information held by different agencies regarding the Adult Male, for example with respect to his mental health, was not known to all the agencies involved, resulting in a partial picture of the risks he posed. The Health Visitor was not informed of the outcome of the review by the Hospital of the findings of the child protection medical that was undertaken in August 2019.

3.32. When information was shared, it was not routinely triangulated with what else was known, for example when the Health Visitor referred concerns to Children's Social Care and/or Start Well. At times the significance of shared information was not fully assessed,

for example when the Paediatrician reported to Children's Social Care on the child protection medical and when the Hospital sent a further evaluation of the findings of the medical in October 2019 to Children's Social Care. There were some delays also in receipt of this information in writing in August and October respectively. The Health Visitor, for example, received a report on the August examination on 4th September. At the learning event those attending reflected that improvements were needed in how concerns were communicated, for example by the Hospital where Child 3 was examined. Bolton, the Independent Reviewer understands, has established a secure email system so that child protection medical examination reports can be sent electronically to avoid delay in receipt by Children's Social Care. Such a system has not yet been set up in Wigan. There was also significant delay in the Family Court providing a finding of fact regarding the adult male's involvement in other cases of abuse/neglect involving children.

3.33. At no point in this case did all those practitioners and operational managers involved with Child 3, her Mother and the Adult Male meet. CRC and Children's Social Care held one discussion in February 2019 about the allegations relating to the Adult Male but there was no further follow-through, possibly because the CRC responsible officer changed. CRC did not undertake further safeguarding checks with other agencies, and neither GMP nor Children's Social Care updated CRC on their involvement with or concerns regarding the Adult Male.

3.34. There were Early Help meetings in May, June and July, which included the family, but not everyone with a contribution to make was present because the focus was on Early Help and not the overall situation. No strategy meeting or initial child protection conference was held. As a result there was a failure to share all available information and assessments, and to agree an overall strategy. A strategy meeting that was advised by a Manager in Children's Social Care as being required did not take place. At the learning event it was suggested that this might have been because the decision was reversed as part of step-down of the case to Early Help. If so, no record to that effect has been seen.

3.35. There were other missed opportunities to bring services and practitioners together, even before the direction for a strategy meeting was given. GMP have questioned why a pre-birth conference was not held, given Child 3's Mother's adverse childhood experiences, to explore the need for Early Help. From February 2019, as concerns mounted about the Adult Male's involvement, including when he was named as the Father of the unborn child (later miscarried) and subsequently when Child 3's Mother was saying that separation from him was proving difficult, multi-agency meetings would have been appropriate. The GP Surgery and the Paediatrician could have formally referred Child 3 for a strategy meeting or case conference in August 2019.

3.36. At the learning event the view was expressed that the absence of professionals meeting together was a key shortcoming in this case. One reason is that not everyone involved appears to have known that any service or practitioner could have called and convened a professionals' meeting. This is one illustration of an absence of a shared understanding of policies and procedures. Reservations were expressed at the learning event concerning whether this position had changed. The Health Visitor has stated that she has called professionals' or strategy meetings since the Child 3 case but has been met with defensiveness and some resistance. She has also stated that, when offering to help other practitioners and services to engage with Child 3's Mother, and when raising

her concerns, she did not feel listened to. With each change of worker, the Health Visitor felt that she had to "start again."

3.37. **Recommendation Six:** Wigan Safeguarding Partnership should undertake audit work routinely to ensure that strategy meetings and professionals' meetings are convened. Audit work should capture the experience of different practitioners in convening and contributing to multi-agency and multi-disciplinary case discussions.

3.38. Another point of potential misunderstanding of policies and procedures revolves around the paediatric examination in August. The advice given to Child 3's Mother was to take her child to hospital. At the point that advice was given the situation does not appear to have been viewed as triggering the Section 47, Children Act 1989 pathway, with an immediate request to Children's Social Care for a child protection medical. Consequently, on arrival at the hospital a paediatric medical examination was completed but this was not formally designated as a Section 47 examination. The examination took place at the same time that Children's Social Care had received information from the National Probation Service that the Adult Male had been accompanied to a meeting by Child 3 and her Mother. The absence of Section 47 enquiries and a strategy meeting meant that none of this information was clearly brought together. Nor was there an opportunity, therefore, to interrogate what Child 3's Mother was saying to the different practitioners and services involved, for example at the GP surgery and then at the hospital about Child 3's presentation. Nor was there any opportunity to observe the inconsistent messages that had been given to Child 3's Mother about her contact with the Adult Male, with an opportunity lost to agree and restate the risk management plan in this respect.

3.39. The "grey picture" given as the outcome of the August medical and again in October when the examination was peer reviewed, should have prompted a strategy meeting to collate information and coordinate a way forward. Paediatric medicals will not always reach a judgement that what has been observed is conclusively evidence of abuse. At the learning event it was suggested that engaging Children's Social Care remained a challenge, especially if "trigger words" were not used. It was suggested that services might have different understandings of "thresholds not met."

3.40. There was an assumption or expectation that the Health Visitor was the lead professional but there was no multi-agency meeting at which this was agreed. Had this been formally recognised and agreed, it would have given her authority to escalate concerns and to call for a strategy meeting. As it was, services and practitioners were working largely in isolation, in silos, although there was liaison between practitioners as the combined chronology has recorded. Silo working was exacerbated by practitioners using different IT systems to record information, something that has begun to change subsequently to some degree. Further review of who may have access to which modules on different recording systems would be helpful in the spirit of promoting multi-agency working to safeguard children.

3.41. On the subject of recording, there were occasions when Child 3 was seen with her Mother and a friend, for example in June 2019 with sores to her ears. Recording should specify who was present on such occasions, especially given the context of this case involving the Adult Male.

3.42. Although some practitioners were diligent in sharing information and referring concerns, there is no evidence of any escalation of concerns about decision-making between services and practitioners/managers involved. Thus, neither GMP nor the Health Visitor challenged Children's Social Care regarding the failure to convene a strategy meeting or case conference. It has been suggested that, for health practitioners at least, local escalation processes at the time were unclear. No-one appears to have escalated challenge to decisions by Start Well and/or Children's Social Care to close down their involvement with Child 3 and her Mother, although the Health Visitor did question Children's Social Care's closure decision and did request a copy of the child and family assessment to help her understand the decision. No-one appears to have suggested that the repetitive concerns should prompt a review of the approach being taken to the case. As a result, the case demonstrates a "start again" approach.

3.43. In cases involving risk and repetitive concerns, closure decisions should not be made without multi-agency discussion to reappraise the risks, to ensure safety of the child, and to consider the implications for other practitioners and services if one organisation does, indeed, withdraw. In all cases where concerns have been referred, it is good practice for assessors to close the loop by discussing their emergent findings and conclusions. This did not happen.

3.44. **Recommendation Seven:** Wigan Safeguarding Partnership should convene a summit to review the threshold document and how different services understand and use it. Using this case as an illustration, policies and procedures surrounding the threshold document should be reviewed, especially the approach to re-referrals, the convening of multi-agency meetings and the importance of escalation.

Organisations around the team

3.45. There are examples of shortfalls in supervision and management oversight in Children's Social Care and in Start Well. For example, Children's Social Care cannot account for why a required strategy meeting did not take place. There are no records that would indicate why a pre-birth assessment was not conducted and why no Children Act 1989 section 47 investigation took place. Recording of decision-making, and the reasons for decisions, is a core requirement of best children's safeguarding practice, as well as being a requirement of administrative law.

3.46. There was a lack of management oversight in CRC with respect to the Adult Male's poor compliance with Court orders. Health Visitor supervision prioritised child protection cases at the time but this approach has now been revised so that any case where there are concerns can be raised in supervision. It has been suggested that, at the time of this case, it was unclear how support and supervision were provided to Health Visitors for cases of concern. However, the Health Visitor had discussed this case with her Manager both to ensure support for her approach and as the first step of escalation.

3.47. There are only two references in the combined chronology to supervision records. Around the end of June 2019 a supervision record in Children's Social Care noted the requirement for an assessment. Shortly thereafter the case was closed following minimal contact with Child 3's Mother. In July a Start Well supervision record noted that Children's Social Care were to be contacted about concerns. It appears that this action was not completed. These are two examples where management oversight would have been expected but from February 2019 onwards there is an absence of regular checks

and Manager scrutiny in both Children's Social Care and Start Well. The most glaring example is the failure to challenge why no strategy meeting had been convened when one had been directed. Subsequent information provided by Start Well and by Children's Social Care includes detail of management oversight on file, one for Children's Social Care and two for Start Well[28]. Given the repetitive concerns, this level of oversight is inadequate.

3.48. As the earlier commentary on the chronology in this report identifies, management decisions that authorised case closure were inappropriate and inexplicable given the repetitive and escalating concerns being raised, especially by the Health Visitor. It is unclear whether supervisors and managers in Children's Social Care and Start Well considered the outcome of the child protection medical in August 2019 and the report in October that contained further reflections on the findings of that examination. It is possible that case closure decisions within Children's Social Care were based on an assumption that Start Well had fully engaged with Child 3's Mother and that she was compliant with a requirement to ensure that Child 3 did not have contact with the Adult Male. If so, these assumptions were not tested.

3.49. **Recommendation Eight:** All services with responsibilities for safeguarding children should provide Wigan Safeguarding Partnership with assurance that records indicate robust management and supervisory oversight.

3.50. As the combined chronology also reveals, there were delays in allocating the case to a Social Worker in March/April/May 2019 and examples where decision-making in Children's Social Care was outside expected timescales.

3.51. The Independent Reviewer has been told that, at the time of this case, social work practice in Children's Social Care was not robust and that there was no challenge or follow-up at every supervisory or management level of completed assessments. The Independent Reviewer has been told that referrals were looked at in isolation and that the history of a case was not pulled together. This was in a context of increasing workloads and lack of capacity, with people stepping in and out of cases, with the quality of work compromised by the quantity of work. It has been suggested that Children's Social Care was in "huge difficulty"; that changes, for example to the duty service or to managerial responsibilities, had destabilised provision. The portfolios that Managers were allocated were too large. There was over-reliance on agency staff, both Managers and Social Workers, in which financial pressures were implicated, and that practitioners were carrying too much work, with limited reflective space, supervision and management oversight. Doubt has been cast on whether the staff involved in the three Children's Social Care assessments had the time, experience, knowledge and skills required. It has been suggested that temporary staff would not necessarily have known the procedures to follow.

3.52. The picture that has been presented is one of loss of resilience, with permanent staff demoralised and leaving. Work was being moved through rather than robustly reviewed. Some of those interviewed have described the situation as a "horrific time", suggesting that changes made to the service were not thought-through or evidence-based, demonstrating a lack of connection with risks inherent in the work. This has been attributed in part to poor data reporting at the time, for example with respect to

[28] 8th July, 19th August and 27th September.

caseloads, unallocated work and the types of risk being presented at the "front door" of the service.

3.53. Part of this picture relates to the interface between Start Well and Children's Social Care. A picture that has been presented to the Independent Reviewer is one of a growing disconnect between Start Well and the rest of Children's Social Care, at least partly the result of changes in senior management responsibilities but also a failure to think through and appraise the interfaces and transitions (stepping up and stepping down) between Early Help, Children-in-Need work and child protection. It has been suggested that over-optimism permeated the organisational culture of Children's Social Care, mirroring the over-optimism in assessments of Child 3 case – "it has been alright so far; it will be alright now."

3.54. Separate management structures at the time for Start Well and Children's Social Care have been criticised on the basis that it should have been one service. Children's Social Care has been described as being "an island on its own" at the time, with very high thresholds that resulted in considerable difficulty in escalating cases into social care. Criticism has also been expressed regarding the absence of support for Managers and the fact that some (more senior) managers did not have a practice background.

3.55. The Independent Reviewer has been told that concerns about risks in the system were raised at the time, including staff being taken out of Start Well and into Children's Social Care, but change did not result at the time. The sense conveyed by those interviewed by the Independent Reviewer is that the system at the time did not feel safe.

3.56. The Independent Reviewer understands that an audit was completed of the step-down arrangements from Children's Social Care to Start Well after Child 3's death and that some decisions were found to have been premature, with the outcome that some Start Well cases were stepped up into child-in-need or child protection levels. As a result the Independent Reviewer understands that a new model of working has been introduced with cases remaining at a child-in-need level for longer. Management responsibilities have also changed.

3.57. Concerns expressed to the Independent Reviewer mirror those contained in OFSTED reports. Close monitoring of the outcome of the Children's Social Care action plan, as recommended earlier, by the Wigan Safeguarding Partnership will be necessary to ensure that systemic shortfalls are being corrected to provide a safer context within which Social Workers and other staff are working.

3.58. Concerns have also been expressed about the availability of support for staff after Child 3's death. The impact of Child 3's death continues to be keenly felt by staff involved at the time, not least because of a recognition that there were missed opportunities to act and that there are lessons to be learned.

Governance

3.59. Greater Manchester procedures are available online[29]. The procedures advise that Early Help should be offered as soon as problems emerge, the objective to ensure that services work together with targeted provision. Unlike for some of the other local

[29] https;//greatermanchesterscb.proceduresonline.com (accessed 16th February 2021)

authorities in the Greater Manchester region, no local Early Help strategy for Wigan appears in these procedures.

3.60. There are procedures for non-engagement and disguised compliance, which include provision for multi-agency meetings, which might have proven useful in this case. There is guidance on Early Help assessment but no website link to Wigan. There is guidance on thresholds but, again, no direct link to a thresholds document for Wigan.

3.61. The procedures advise that there should be a strategy discussion when there is reasonable cause to suspect that a child has, or is likely to suffer significant harm. The discussion is to be chaired by Children's Social Care. It is not made clear that any practitioner or service can request a strategy meeting. This is an omission.

3.62. Wigan Safeguarding Board also published procedures online[30]. There is a protocol for the resolution of disagreements, essentially an escalation procedure. This does not appear to have been considered in this case, suggestive that the protocol and procedure should be disseminated again, with teams having to evidence that time has been given to when it should be used.

3.63. Given expressed uncertainty about responsibility for requesting and convening strategy meetings, there is an argument for reviewing available guidance and then through, team meetings and a sequence of multi-agency training, ensuring that the procedures are embedded in practice.

3.64. There is guidance on thresholds, which identifies four levels. There are templates for Early Help assessment, initial action plans, reviews and case closure. Given the findings about Early Help in this case, it would also be timely to review how the threshold document is understood and being used. In particular, how do practitioners understand the interface between cases involving emerging needs or identified needs, those where there are multiple or complex needs requiring more targeted support, and those that are complex and serious? Recommendation Seven above seeks to address this point.

3.65. A further question concerning governance is how well sighted Wigan Safeguarding Board, and subsequently Wigan Safeguarding Partnership, were of the organisational context presented in OFSTED reports regarding Children's Social Care; further, what assurance it sought and received regarding standards of safeguarding practice within and between agencies. The Independent Reviewer asked several questions of the Independent Chair and the senior representatives of the three lead partners, namely Children's Social Care, CCG and GMP, for Wigan Safeguarding Board.

3.66. One question centred on what oversight was maintained on implementation and outcome of SCR recommendations. The response to the Independent Reviewer was that "SCRs were a standard agenda item on partnership agendas, with good debate, challenge and discussion about cases and learning. In 2019, some meetings were cancelled, attendance not always consistent from Children Social Care, moving into early 2020. Agendas focused on dealing with the critical issues of Covid-19 in the first half of 2020. The SCR subgroup did meet routinely during this period. We recognise that we have had recent feedback from our Independent Scrutineer and Ofsted visit in October 2020 that we need to evidence how partners have embedded the learning. This is an area of focus for us in the coming year." Separately, however, the Independent Reviewer

[30] https://www.wiganlscb.com (accessed 16th February 2021)

has been told that SCRs completed by Wigan Safeguarding Board had not been published, which raises questions about accountability, transparency and dissemination of learning.

3.67. A second question focused on audits through which assurance might be obtained that procedures and decision-making were robust. The Independent Reviewer was told that "there were some multi agency audits during 2019, one on complex safeguarding, and 'toxic trio' impacts on children and those adults open to Adult Social Care. In February 2019 a core group dip sample audit took place and a plan on a page action plan agreed. Early Help Assessments audit took place in February 2020. The partnership was not always sighted consistently on the quality of practice across individual agencies nor testing whether the partnership learning from Case Reviews was changing practice in frontline services. A Children Social Care diagnostic was discussed in depth by the partnership alongside the new Quality Assurance and Performance Framework that had been developed in early 2019 including audits, dip samples, data analysis and Practice Weeks. The Learning and Improvement group met routinely throughout this period."

3.68. Separately, the Independent Reviewer has been told that there was no effective performance management framework in place. This has been acknowledged. Thus, "records of meetings don't show that there was a routine dashboard of multi-agency performance information given to the board during 2019. In Oct 2019 Q1 Children Social Care data was shared and discussed. This meant that key indicators that were concerning or showing an emerging theme were not available for discussion, debate, or challenge. There was evidence of routine single agency data being available, including CCG data. The challenges with the IoPS[31] data base for GMP were also routinely discussed and challenged."

3.69. A third question asked about how well-sighted Wigan Safeguarding Board, and subsequently Wigan Safeguarding Partnership, were on the challenges being faced by Children's Social Care. The response to the Independent Reviewer was that "there are always challenges managing a complex service like Children Social Care, these were well understood by all partners. Focusing on 2019, the dialogue was always open, and relationships were strong between the three tripartite leaders. Concerns about the level of agency staff needed to cover sickness, vacancies and additional demand became noticeable during spring/summer 2019. This was unusual as Wigan had always had a permanent workforce and unlike other local authorities had rarely used agency social workers. … It is important to note that most of the agency requirements in 2019/20 came in the later stages of quarter 3 post - October 2019 - and predominantly the final quarter from January 2020. Discussions were being had between the partners in relation to increased capacity from the Police and Health into the MAST in 2019. In the absence of a performance dashboard, indeed asking the right questions, this may not have been known by the partnership."

3.70. Asked about what assurances were received in relation to the strategic and operational management response, the following reply was received. "Relationships were strong. On reflection, whilst it worked at the time, there is recognition the 'checks and balances' didn't always pick up on every issue. Serious issues were usually dealt with within the partnership and escalated where necessary – Children Social Care did not feel they needed (in summer 2019) to escalate any workforce issues (agency use) as this was an emerging issue- not systemic at the time. We were talking actively about the MAST

[31] The GMP data system.

arrangements. Escalation arrangements were in place and had effectively been used to challenge on CAMHS service delivery and in relation to IoPS and GMP capacity."

3.71. The Independent Reviewer also enquired about the oversight exercised by Wigan Safeguarding Board and subsequently Wigan Safeguarding Partnership regarding the OFSTED reports. In response, the Independent Reviewer was told that "the revised partnership arrangements were new in October 2019. We were still trying to introduce accountability and clear governance in the new arrangements. This is reflected in the minutes of meetings. Perhaps too much attention was set on the effectiveness of the governance and the transition to new arrangements at this time. It was only actively determined in Summer 2020 that an Independent Scrutineer was needed, and this was enacted by October 2020. In relation to the Ofsted Visit (March 2019) the partnership leaders were sighted on the reports/reviews and the action plans verbally spoken to at the meetings, including minutes (November 2019) that suggest a Partnership Engagement Group would be set up across the three partners to address the immediate learning from the Rapid Review. It is clear the meetings were established - there was no update to the Partnership Leaders on progress recorded. However, the Partnership Leaders had strong and effective relationships and a strong culture of picking up the phone and talking, challenging, and discussing issues, and this is what happened at the time. This became a period of significant senior management change in Social Care in the early months of 2020 with Director of Children's Services moving position and Practice Director leaving. Then Covid-19 started in Spring 2020." **Commentary:** a clearer performance management framework, considered at each meeting of the Board/Partnership, might have given more robust assurance that the practice and management concerns identified by OFSTED were being effectively addressed, or signalled the need for further action to mitigate risks. The role of the Independent Scrutineer will be significant going forward.

3.72. Finally, the Independent Reviewer asked how the Board/Partnership was informed about serious incidents and the action taken in response to notifications. In response it was stated that "there was a process for referring in cases. Records show a routine number of rapid reviews were convened and took place and the indeed the number was high compared to comparators. There was a good relationship between health and the partnership to ensure routine information was shared via the SUDC[32] process and serious incidents within Children Social Care. We do know however that in 2019 we did not notify on one reportable incident, linked to Child 3. In addition, we recognise that some reporting was slow from Children Social Care, so there was proactive chasing by the partnership to ensure notifications took place. There was no escalation into the partnership leaders that the process was not working effectively until Spring 2020. At this point the procedures were reviewed and improved. The partnership then took responsibility for all notifications. The new system included a procedure that any partner could refer in and the three tripartite leaders would agree on suitability."

3.73. In terms of assurances received and oversight of action planning following the death of Child 3, the Partnership responded as follows. "By March 2020, the meetings had become predominantly focused on our Covid-19 response. Staff were re-deployed from the partnership business team. Normal partnership business was suspended. The CSC action plan was not being monitored by the partnership. Covid-19 was causing significant delays in several work streams. However, the minutes from the November 2019 meeting show that a detailed discussion took place about the following areas:

[32] Sudden Unexplained Death in Childhood.

thematic areas of concern – responses to neglect, quality of planning, effectiveness of practice standards; support for staff involved in the case; use of resolution process for agencies and ensuring any practice concerns are escalated effectively, and robust review of all under 2s open to Start Well."

3.74. Some concerns have also been expressed to the Independent Reviewer in relation to the Rapid Review. There are two aspects here, namely firstly Operational Managers with responsibility for practice in Start Well and Children's Social Care not being allowed to compile or to contribute to the construction of a chronology, with some misrepresentation resulting, and secondly the submission of a combined chronology. Indeed, the Independent Reviewer felt it necessary to request two separate chronologies so that the involvement of each service was clear.

4. Parallel Processes

4.1. The agencies involved with Child 3, her Mother and/or the Adult Male completed internal reviews, some prior to and some coterminous with this review. These significantly reinforce the learning available and inform the recommendations arising from this review.

4.2. **Recommendation Nine:** All agencies should undertake a review of their approach to internal investigations as a result of learning from this case, reporting their conclusions and revised procedure to the Wigan Safeguarding Partnership. In particular, internal investigations must be timely, following a clearly laid-out process, with staff support offered. They must look at systems within which staff have been working and not simply focus on the practice of individuals.

4.3. North West Boroughs Healthcare NHS Foundation Trust

4.3.1. The Trust completed a concise investigation under the NHS Serious Incident Framework of the two referrals that it received in relation to the Adult Male.

4.3.2. **Commentary:** The Trust's investigation identifies several shortfalls relating to practice surrounding referrals. The referral was received on the same day that the GP had a consultation with the Adult Male. This is good practice. However, it was made on an older version, not then in use, of the referral form. Nor did the GP answer a question on the form concerning whether the Adult Male was residing with children.

4.3.3. The newer version of the referral form does not utilise the concept "urgent" but rather either "routine" or "emergency". There is no record to indicate whether the GP was contacted to discuss how to triage the referral using the new terminology. It was screened to be "routine", which the investigation rightly concludes was not proportionate to the highlighted risks.

4.3.4. The investigation is also critical of the fact that a multi-disciplinary team meeting process was not used to resolve the issue of whether the referral was routine or an emergency, which would have supported defensible decision-making. **Commentary:** what the investigation might have additionally explored is whether the two concepts then in use adequately capture the range of possible presentations. It is possible to envisage that a case might be regarded by a referrer as urgent because it was neither routine nor an immediate emergency. The terms in use are also somewhat ambiguous.

4.3.5. The referral was not triaged within 24 hours of receipt but rather only after 5 days. The investigation rightly points out that consideration should have been given to a home visit, or attempting contact via other family members, together with a discussion with the GP. That this opportunity was missed is seen as a result of time pressures and workload demands – the number of routine referrals and reduced capacity in the Assessment Team to respond. As a result a task-orientated approach was taken to referral management. **Commentary:** a safe system requires that close attention is paid to the workplace and the impact of workloads and resources on staff. Practitioners have a responsibility to highlight the impact of the workplace on their practice; managers have a responsibility to oversee and ensure that workplace arrangements enable best practice.

4.3.6. Since the episodes reported here, a new clinical model and referral process has been introduced. This includes 24-hour triage and MDT discussion and action planning in the event of non-engagement. **Recommendation Ten:** Wigan Safeguarding Partnership and Wigan Safeguarding Adults Board to receive an evaluation of the new adult mental health referral process.

4.4. Children's Social Care Investigation

4.4.1. There are eighteen findings and sixteen recommendations. These have been organised here in line with the systemic perspective outlined in section 1.8.

4.4.2. Domain of direct work with Child 3, her Mother and the Adult Male.

4.4.2.1. There was reliance on the Mother's self-reporting. Her understanding of what contact the Adult Male could have with Child 3 changed.

4.4.2.2. Previous staff involvement with family members influenced decision-making. For example, a Social Worker thought that the grandmother was a protective factor, which on one occasion resulted in no further action being taken. It is recommended that case history and accumulative information must be fully used to inform practice.

4.4.3. Domain of the work of the team around the child.

4.4.3.1. Information was not shared between Children's Social Care and Start Well. The two services operated separately, resulting in a lack of cohesion, impacting on judgements and decisions. It is recommended that Social Workers must share information with all the practitioners involved, and vice versa. **Commentary:** this position has now been rectified, with mutual access to records.

4.4.3.2. There was a "them and us" culture involving Children's Social Care and Start Well. It is recommended that cross-team working needs to improve.

4.4.3.3. Children's Social Care and Start Well staff did not have access to each other's electronic recording systems, perpetuating work in isolation. It is recommended that access to modules within the IT system be opened up.

4.4.3.4. Start Well Workers were not briefed about the Adult Male and the concerns that would arise if he had contact with Child 3. As a result, when he was seen with Child 3 and her Mother on the estate, this was not reported. **Commentary:** this conclusion is not supported by Health Visitor records. These records indicate that Start Well did know that the Adult Male posed a risk and was not allowed contact with Child 3. A conversation took place on 29th April between the Health Visitor and Start Well Worker informing her of this. During this conversation the Start Well Worker also informed the Health Visitor that Child 3's Mother had also informed her of the same information. This was again discussed at an Early Help meeting on 20th May at which Start Well were in attendance.

4.4.3.5. Not all discussions between staff involved were recorded.

4.4.3.6. When Start Well staff are not the lead professional for early help, they cannot complete (or add to) assessments, plans and reviews online. This resulted in delays in uploading information.

4.4.3.7. The Health Visitor was the lead professional. **Commentary:** this is clearly stated but where and by whom was this decided? When the lead professional is external, since there is no one record to which all practitioners can contribute online directly, there are delays in uploading information, with the consequence that information may be omitted from the case file and the danger that staff may hold only a partial view of the case. It is

recommended that the role of the lead professional be reviewed, especially when that practitioner is external to Children's Social Care.

4.4.3.8. Decisions of no further action are not recorded on the electronic record system, again the consequence being an incomplete picture. It is recommended that all key discussions and decisions should be recorded.

4.4.4. Domain of the organisations around the team

4.4.4.1. There were too many agency staff, who were not given any induction or training. It is recommended that the numbers of agency staff be reduced.

4.4.4.2. Cases were allocated immediately to agency staff without induction, training or log-in details for the electronic record systems, which prevented access to case history to inform decision-making. It is recommended that training be provided to all staff on the IT system and that the system itself be reviewed to ensure that it is fit for purpose.

4.4.4.3. The thresholds of need procedural document was not shared with agency staff. **Commentary:** it is, however, available electronically on the Wigan Safeguarding Board website.

4.4.4.4. Staff knowledge and competence concerning the electronic record system was variable.

4.4.4.5. The IT system was difficult to navigate to find information and details of the person who recorded it. Hence the recommendation for review to ensure it is fit for purpose.

4.4.4.6. No specific timeframes were set for cases, resulting in decisional and practice drift. Early Help reviews were meant to be conducted every four-six weeks by the lead professional but this was not written down to formalise the process. It is recommended that timeframes are required. **Commentary:** Health Visitor records, however, confirm that 3 Early Help meetings were held, with the one on 20th August postponed because of Child 3's medical examination in hospital. This would have been one opportunity to consider whether supervision and management oversight of practice and decision-making were adequate. This is a significant omission.

4.4.4.7. Very little support was offered to staff after Child 3's death. There was no offer of counselling and they were instructed not to discuss the case with each other. The investigation report comments that this is unacceptable. The report recommends the provision of support to promote staff wellbeing.

4.4.4.8. Development of a new culture features in the recommendations, one that promotes critical thinking and professional curiosity, models openness, and balances practice autonomy with management oversight.

4.4.5. Governance domain

4.4.5.1. Some staff had left by the time of the investigation. **Commentary:** it is unclear why staff who had left were not contacted, if necessary through the agency or professional regulatory body with which they were registered.

4.4.5.2. The delay in commissioning a formal review of the case is noted for its impact on staff and on their recall of their practice. It is recommended that the review process should commence without delay.

4.5. Children's Social Care Action Plan

4.5.1. The action plan, informed by the aforementioned investigation, contains twelve constituent elements. The domain of direct work with Child 3 and her Mother focuses on the child's lived experience. This includes managers providing timescales for

assessments and home visits, and supervision and scrutiny that clearly focuses and records this element of best practice for assessment and planning. Safety planning should use a signs of safety approach.

4.5.2. The domain of direct practice also includes developmental work on the use of history and accumulated information to inform decision-making. This is designed to ensure that the response to referrals recognises patterns in cases rather than being episodic. Chronologies are to be used, and their use audited. Recording should demonstrate that case history has been analysed. The action plan also recognises the need to improve critical thinking and professional curiosity, and to challenge over-optimism. Assessments should be checked to ensure that case history has informed decisions. Practitioners must not rely on adult self-reporting. On some occasions Child 3's other was seen in the presence of other family members who reinforced what she was reporting. The caution regarding not simply relying on self-reporting extends to not simply accepting what other family members state, especially when they are part of the same interview.

4.5.3. The domain of the team around the child is represented in the action plan by the need to ensure multi-agency information-sharing and the urgent need to establish a multi-agency front door. There is a whole section on the need to improve working professional relationships and multi-agency working, to develop a culture of teams working collaboratively together, and to promote acceptance of each other's professional roles. This priority includes development of a contact record and assessment checklist that clearly outline who should be consulted in order to achieve a multi-agency holistic assessment. Finally under this domain is a priority to review the role of the lead professional, especially when that professional is employed within a partner organisation, and to clarify timeframes for the involvement of Start Well in cases.

4.5.4. Several priorities fall into the domain of the organisation around the team. Firstly, management supervision and oversight must ensure that strategy meetings take place. Supervision policy and management capacity will be reviewed, with training provided on management supervision. Secondly, there is a focus on ensuring staff wellbeing, especially when a child dies. There is an acknowledgement that staff were not well supported when Child 3 died and the offer of support to staff is to be clarified.

4.5.5. Thirdly, the case file recording system is to be reviewed, to be followed by training. Managers are to record key decisions. Start Well and Children's Social Care will have access to each other's records. Fourthly, reliance on agency staff is to be reduced, with induction and training provided for all staff, including those recruited via employment agencies. An induction package will require development. Fifth, the focus on workforce strategy extends to including the development of a manager network and the establishment of whole service manager meetings. A new workforce model for locality and duty teams is to be developed.

4.5.6. A sixth priority is ensuring robust front door arrangements and the consistent application of thresholds. This includes a review of cases and of threshold documentation. Checklists for assessment are to be provided to facilitate critical thinking. Workshops to disseminate and promote the checklists are scheduled for November and December 2020. Finally, there is a clear priority to develop a culture of autonomy, openness and transparency, with an emphasis on support and safety,

partnership working and information-sharing. To that end leadership and culture change programmes are envisaged, with development work to improve relationships within the directorate. There will be a workforce strategy that includes the requirement of regular team and service meetings, and regular supervision. Good practice is to be recognised and rewarded. When staff leave, exit interviews are to be held and their outcomes analysed. Regular newsletters for staff will be circulated.

4.5.7. In the domain of governance it is recognised that there should be regular communication with the staff involved in Child 3's case concerning completion of the Child Safeguarding Practice Review.

4.5.8. **Commentary:** there is an implicit and at times explicit acknowledgement in the action plan of the need for change across three crucial domains when safeguarding children – direct practice, the team around the child and the organisations around the team. It is clear that what has long been recognised as requirements for good practice, such as clearly focused and understood information-sharing, multi-agency meetings (such as strategy meetings and case conferences), and management supervision and oversight were not securely embedded. These acknowledgements clearly resonate with the outcomes of OFSTED inspections. It is over one year since Child 3 died so the pace of transformation could be questioned. The Covid-19 pandemic, alongside the impact of turbulence and churn within the senior levels of Children's Social Care, will have impacted on pace. It is also an extensive agenda that will take time to deliver and then embed.

4.5.9. **Recommendation Eleven:** Wigan Safeguarding Partnership should routinely scrutinise the evidence for the impact and outcomes of Children's Social Care's action plan.

4.6. IOPC Report on GMP's Investigation

4.6.1. GMP referred their investigation of the Adult Male's suspected assault on another child and his contact with Child 3 to the IOPC. GMP had been informed on 30th July 2018 of an assault on a seven-month child, causing bleeding on the brain. The Adult Male was made subject to a bail condition that he was not to have any unsupervised contact with any child under the age of 16 unless directed and supervised by Social Services. The rationale is recorded as being "to prevent further offences." GMP were informed on 7th August 2018 that this bail condition may have been breached but this was not checked immediately as "no units were available." When GMP Officers visited the property on 14th August, the Adult Male was not present and the occupant stated that they were aware of the bail conditions and that he had not visited the address.

4.6.2. **Commentary:** there appears once again to be a reliance on self-reporting. The IOPC report observes that "[b]ail conditions are imposed in order to afford a level of safeguarding. Any potential breaches should be investigated, and all available information should be factored into decision making when conditions are reviewed." The available information included a violence flag on the Police National Computer and an extensive history of assaults, thefts and public order offences between February and June 2018. There was also an incidence of criminal damage on 30th September 2018, the victim being a member of the child's extended family. Investigation of bail breaches is identified as a point of learning for GMP.

4.6.3. The bail conditions were reviewed on 23rd October 2018. The Adult Male and the child's mother were both released under investigation. The bail conditions were removed, the rationale being that the Adult Male did not have contact with the child and that the relationship with the child's mother had ended. It does not appear that the possible breach of the bail condition earlier in August was factored into this decision.

4.6.4. **Commentary:** the IOPC report does not comment on whether, when and how Children's Social Care were informed of the removal of the bail conditions. The IOPC report does acknowledge that GMP did not share information about the Adult Male and the emerging risks relating to Child 3 with the GMP team investigating the assault on the other child. As the bail conditions had been lifted, no further review would have been undertaken without further information pertaining to that case becoming available. The rationale for the lifting of bail conditions, reviewed in line with new bail legislation, included (in addition to the reasons given in the section immediately above) that the child concerned had been safeguarded, with family court proceedings commenced.

4.6.5. On 25th June 2019 GMP Officers had seen the Adult Male in a property where Child 3's Mother was present. On this, and other occasions, the IOPC report notes that appropriate referrals were made to other agencies, including CRC and Children's Social Care. However, the report identifies that incidents were dealt with in isolation rather than being seen as part of a worrying pattern. The IOPC identifies as points of learning for GMP the sharing of information within GMP and with other agencies, and the importance of identifying patterns in order to ensure that risk assessments are robust.

4.6.6. The IOPC report also observes that there were missed opportunities to consider a joint GMP/Children's Social Care strategy meeting once information was emerging about the Adult Male's contact with Child 3 and her Mother. The report also observes that GMP would have expected Children's Social Care to have requested a strategy meeting, especially surrounding the events in August 2019, and to have updated GMP after their meetings with Child 3's Mother. The report also notes that Child 3's Father was not informed and that such a decision should have been made by GMP and Children's Social Care, with the latter taking the lead.

4.6.7. **Commentary:** whilst GMP may have had such expectations, it appears that there was no follow-up or no escalation of concerns. It is open to any service to formally request a strategy meeting and to escalate concerns when such a request is not then actioned by Children's Social Care. This does not appear to have happened and is a significant omission.

4.6.8. GMP's risk assessment, particularly relating to the child protection medical in August 2019, was medium. This assessment, the report suggests, was influenced by reassurance from Children's Social Care that there were no immediate concerns. The report observes that, whilst the risk assessment made by the attending officer was appropriate, it did not explore the Adult Male's possible involvement in the assault on the other child. The report suggests that the risk assessment should have been considered when triaged by a specialist officer to be raised to high, to take into account the Adult Male's history of offending, including of violence, the access he appeared to have to children, and the recent bruising seen on Child 3. Indeed, as the report states, there were 16 public protection incidents involving the Adult Male as perpetrator and 5 as victim. A restraining order was in place relating to a relative of the child whilst he was being investigated for a potential assault.

4.6.9. The one occasion when a GMP Officer saw Child 3 was in August 2019 for a safe and well visit. By that time GMP already held information of Child 3's Mother being the victim of public protection incidents. The Officer was reassured by Child 3's Mother and grandmother that the Adult Male had not been inside the home and had not had any contact with Child 3. The Officer liaised with Children's Social Care whilst at the house and believed that a Social Worker was dealing with the case. A referral was sent to Children's Social Care and Child 3's Mother advised that the Adult Male was not to have any unsupervised contact with Child 3. As a result the Officer concluded that there were no immediate concerns and therefore no grounds for a Police Protection Order, which is an emergency order requiring that a child would be likely to suffer significant harm.

4.6.10. **Commentary:** the IOPC report records that risk was assessed as medium and GMP involvement was closed. It should also be noted that there was no independent verification sought of the assurances provided by Child 3's Mother and grandmother. There does not appear to have been any recognition or consideration of coercive and controlling behaviour, or of disguised compliance.

4.6.11. The IOPC report also considers GMP's role in seeking from the Family Court a finding of fact relating to the injuries sustained by the 7-month old child. The first record of consideration of requesting documentation from the Family Court occurs on 4th March 2019 but there were substantial delays as a result of the Adult Male not engaging with the Family Court, the need to obtain consent from the parties involved to the release of information, and volume of work in legal services. Information provided for the IOPC review indicates that such delays are apparently normal. A point of learning, not just for GMP, is that risks arise from delays in the release of information by the Family Court to the CPS. CPS was only in a position to make a decision whether or not to charge the Adult Male with offences relating to the 7-month old child by 11th October 2019.

4.6.12. **Commentary:** crucially, as the IOPC report comments, in the finding of fact was a statement by the mother of the 7-month old child, to the effect that the Adult Male was unsuitable to care for a child due to his character and intolerance towards children. She did not disclose this during police interviews. The Children Act 1989 is clear that the paramount principle is to safeguard and promote the welfare of children. Once this information was known, it should have been disclosed so that appropriate agencies could assess its relevance and significance for risk assessments relating to any child with whom the Adult Male may have had contact.

4.6.13. **Recommendation Twelve:** GMP should provide assurance to the Wigan Safeguarding Partnership regarding how the findings of the IOPC investigation have been taken forward into their public protection practice with children and their families, and with other agencies involved in children's safeguarding.

4.7. Community Rehabilitation Company Independent Management Review

4.7.1. Cheshire and Greater Manchester CRC conducted a Serious Further Offence Review, of the practice of three officers who were involved with the Adult Male.

4.7.2. At the point of sentence for breach of a conditional discharge and for failing to stop, on 16th January 2019, resulting in a 12-month Community Order, including 60 hours

unpaid work, risk was assessed as low. The case was allocated, appropriately, to a Case Manager. On 25th January 2019 the case was transferred, again appropriately according to CRC policy, to a Senior Case Manager as a result of information received from Children's Social Care regarding the Adult Male's involvement in the investigation of an assault on a 7-month old child. On 19th March 2019 the case was transferred to a second Senior Case Manager.

4.7.3. **Commentary:** the CRC review notes the high caseload carried by the second Senior Case Manager (SCM2). As a result of this, SCM2 did not review the case at the point of transfer and was therefore not familiar with key risk concerns, including child safeguarding concerns. This had an impact on inter-agency communication, information-sharing and joint working. A key component of effective safeguarding practice is management responsibility to ensure that workloads are manageable. This does not appear to have been the case here. The Independent Reviewer has been told that the Officer was "overwhelmed with work."

4.7.4. Risk assessments were formally undertaken once by the first Senior Case Manager (SCM1) and twice by SCM2. A risk assessment was also completed by the writer of the first pre-sentence report. That writer concluded that risk was low. SCM1's risk assessment concluded that risk was medium, although information about domestic assaults had been shared by GMP, and information had been received from GMP and Children's Social Care regarding child safeguarding concerns. The Adult Male was also known for violence towards partners and family members.

4.7.5. **Commentary:** the review concludes that the assessment lacked some detail but did identify relevant risks. It is surely questionable whether risk was appropriately categorised given what was known about the Adult Male's offending history.

4.7.6. The CRC review observes that a formal review of low risk cases should occur every six months. This did not happen and was a lost opportunity to address child safeguarding concerns. The report is critical that SCM2 did not act on the Adult Male's change of address and did not review risks as a result of an escalation in his offending. There was no consultation with Children's Social Care and no checks were made regarding his sister and the children in her household. This was an omission in terms of standards of child safeguarding activity.

4.7.7. There were further offences in June 2019 involving breach of a restraining order, breach of a Community Order and aggravated vehicle taking. A second Community Order was made on 30th August 2019. SCM2 undertook a risk assessment on 6th September but did not complete a comprehensive review. Only a "holding" assessment was completed due to a perceived lack of information and the Officer's annual leave. This was outwith CRC policy. The assessment is described as poor. Child safeguarding checks were not completed.

4.7.8. **Commentary:** a key component of effective safeguarding practice is the completion and regular review of robust risk assessments. Management oversight is an important safeguard to ensure standards of practice and compliance with agency policy and procedures.

4.7.9. The CRC review focuses on effective management oversight of high risk cases. This is a formalised system within CRC. The report notes the absence of effective management

oversight in February when the Case Manager was notified of the Adult Male's involvement in a child protection investigation by GMP. This is observed to have been a lost opportunity. The formalised system was used on 6th September 2019 but it was cursory in nature. Not all the issues linked to children's safeguarding were explored and appropriate actions set. This too was a lost opportunity.

4.7.10. **Commentary:** the CRC review is critical of the deployment of effective management oversight but there is no analysis of why the formalised system was not used as CRC policy required.

4.7.11. The review is similarly appropriately critical of the quality and quantity of contact with the Adult Male and of home visits. It observes that the opportunities that home visits presented were not taken up. The Adult Male complied only poorly with the Community Order. He was seen by Officers on only six occasions; 16 appointments were missed. He only completed 24 hours of unpaid work. Enforcement activity was not robust. When he was seen, these occasions were not used effectively to address risk and safeguarding concerns. His assurances about relationships were taken at face value.

4.7.12. SCM2 took no action around 29th April 2019 when he missed an appointment and explained that this had been the result of his partner having a scan. Given the ongoing GMP enquiry about assault of a young child, this was a missed opportunity. No action was taken either around 17th July when, seeking advice about his curfew, he disclosed that he was now living with his sister and her children. It had been recorded that Children's Social Care had advised that he was not to have any unsupervised contact with children. An opportunity to clarify his bail conditions with GMP and to complete a home visit were missed. Actions expected with respect to risk and child safeguarding were not undertaken.

4.7.13. **Commentary:** once again, self-reports were taken at face value; information given by an individual was not triangulated with what else was known across the services involved. The IMR is candid in its critique but does not reflect on why the lost opportunities occurred.

4.7.14. On enforcement action, the review concludes that SCM1's actions were prompt, with breach paperwork lodged on 19th February, resulting in 20 hours being added to the unpaid work requirement one month later. SCM2 failed to take enforcement action until 3rd September.

4.7.15. The review also considers contact with other agencies. It records that CRC was notified by Children's Social Care about the investigation of the Adult Male with respect to injuries sustained by a 7-month old child. This led to the case being transferred to SCM1 in line with CRC policy. This was good practice regarding multi-agency working and safeguarding activity. On 14th February 2019 SCM1 and a Social Worker met to share risk assessments and formulate a joint plan. This was good practice.

4.7.16. Between 17th April and 22nd April 2019 SCM2 was advised by Children's Social Care that the Adult Male had failed to attend Court hearings relating to some care proceedings. SCM2 did not act on this information so, whilst the information being shared was good practice, it did not result in a coordinated inter-agency response.

4.7.17. In August 2019 the Adult Male advised a Court Report Writer that he was in a relationship with Child 3's Mother. This information was sent to SCM2, which was good practice, with concerns due to the ongoing GMP investigation. There was also a formal referral to Children's Social Care. SCM2 did not act on these concerns; no appropriate safeguarding action was taken; no inter-agency work was initiated.

4.7.18. In September 2019, an enhanced management oversight meeting was held. As a result SCM2 was to contact Children's Social Care and to ascertain progress with the investigation into the assault on the 7-month old child. There was no exploration of the position in respect of Child 3, amounting to a failure to work effectively with Children's Social Care.

4.7.19. Finally, the review focuses on the case flags and markers on the CRC recording system. It concludes that whilst some markers were correctly registered, for example regarding child protection, other opportunities to place flags on the system were missed.

4.7.20. **Commentary:** it will be recalled that GMP had a case flag of violence for the Adult Male on his nominal file and on the Police National Computer file. As a result of CRC's analysis of their involvement with the Adult Male, five actions have been taken. Guidance on case registrations and the use of flags has been issued. Guidance on case transfers, and on enforcement, has been issued also, with staff training on the latter. Staff development is also being offered on child safeguarding, including risk assessment in cases of spousal assault. Finally, a reminder has been issued that the effective management oversight system is to be used quarterly. Personalised development action plans have been created. No actions have been identified with respect to the workloads being carried by Case Managers and inter-agency working other than reinforcement that CRC Managers should keep workloads under regular review.

4.7.21. **Recommendation Thirteen:** Wigan Safeguarding Partnership should seek assurance from CRC (and from the National Probation Service going forward), based on audits of practice, that the learning from this internal investigation has resulted in practice improvement.

4.8. Bolton NHS Foundation Trust Review

4.8.1. A key episode in the chronology is the child protection medical that took place on 20th August 2019. Following the death of Child 3, the Hospital involved conducted a review of that episode.

4.8.2. Staff in A&E spoke to Children's Social Care in Wigan within an hour of the arrival of Child 3. Information was shared by the Social Worker about concerns about Child 3's Mother's partner and that he should not have contact with Child 3, that Atherton Probation Office had informed Children's Social Care earlier in the day about their contact with this Adult Male and also that Child 3 should not be discharged home without further discussion with the Duty Social Worker. **Commentary:** information-sharing and liaison between agencies and practitioners involved was good practice.

4.8.3. Child 3 attended the Children's Ward and was examined by a Paediatrician. This was a thorough and detailed medical examination carried out by an experienced Locum

Consultant acting down on the middle grade rota, thereby requiring joint decision making with the Consultant on call and Social Worker the same evening. This took place and is well documented in the notes. **Commentary:** detailed case recording is good practice.

4.8.4. Medical opinion was that injuries could be attributed to the explanations offered by Child 3's Mother and all were over bony prominences in a mobile child. The findings were discussed with the Consultant Paediatrician and Wigan Duty Social Worker. The request to return the following afternoon for medical photographs was due to the fact that this service is currently only available in office hours. Discharge home was agreed with the Social Worker who advised that Children's Social Care would be attending the family home to review.

4.8.5. The injuries assessed were not conclusively abusive injuries; therefore collaborative decision-making to send Child 3 home was taken with the Consultant on call and the Duty Social Worker. It has, however, been considered further by the Consultant Paediatricians that admission to the ward overnight would have allowed information gathering from other professionals in office hours – for example the Health Visitor and the CRC Senior Case Manager. "With hindsight it is speculative but possible that admitting Child 3 to the ward would have supported information gathering and sharing ……equally this may not have offered any change to the course of action taken". It is recommended that there should be a low threshold for admitting children under the age of 2 with bruising overnight unless there are no safeguarding concerns. A further recommendation is to request that a Strategy meeting takes place even if a child is not seen to reach the threshold of significant harm by the Duty Social Worker.

4.8.6. The delay in providing written information was also considered within the review and actions taken in relation to this. A continued expectation is that there is telephone or virtual contact with the Social Worker at the time of attendance, with written communication/reports to be provided to Social Workers within 5 working days. Cases discussed at Peer Review have also been considered with telephone contact to take place in addition to written reports if learning is identified from a particular attendance and if it is agreed that there is a requirement for Children's Social Care involvement and review. The Medical Secretaries have identified secure email addresses for Children's Social Care out of area so that written reports and letters can be sent out as soon as possible once completed. The only area unable to provide a suitable email address despite being requested to do so is Wigan. **Commentary:** the Independent Reviewer has been told (March 2021) that a suitable email address has now been provided.

4.8.7. The nature of the medical peer review that occurred subsequently is that Paediatricians and other staff discuss a number of children who have presented to hospital as a learning exercise. Child 3 was discussed alongside a number of other children – typically 8-10 are discussed at each meeting. This is not a formal review process but a learning exercise for medical staff. It is a retrospective review and is held to primarily ensure consistency of practice and to support and provide training to junior staff. The outcome of the discussion about Child 3 was that a letter would be sent recommending that Children's Social Care convene a meeting of agencies involved to ensure support and monitoring was in place.

4.8.8. Finally, the report observes that appropriate GP referral pathways were not followed by the Wigan GP surgery. Had the correct process for Section 47 (Children Act

1989) medicals been followed by the GP surgery, then Child 3 would have attended a Hospital in Wigan rather than in Bolton. The GP surgery should have informed Children's Social Care of the need for a child protection medical rather than advising Child 3's mother to take her to A&E.

4.8.9. **Recommendation Fourteen:** Wigan CCG should provide assurance to the Wigan Safeguarding Partnership that the learning from this case has been shared with GPs and all members of primary care teams and community health services, and that all staff have been reminded of the pathway for child protection medicals.

5. Concluding Discussion

5.1. Children's Social Care has recognised that there was insufficient focus on the quality of the work at the time of this case. Significant changes continue to take place to ensure culture change and practice improvement, for instance with respect to the composition and structure of the "front door", sign-off of social work assessments and decision-making by managers, and the adoption of a "Signs of Safety" method of working. This is being accompanied by significant financial investment in social work posts and support in key areas. Internal audits and external checks are underway or planned to provide a litmus test of what is being achieved. There is, therefore, recognition that the Department has experienced a turbulent time, which has meant that the pace of change thus far has not been ideal, and implementation of an active programme of work designed to harvest the learning from the shortfalls in this case.

5.2. The Wigan Safeguarding Partnership must scrutinise the outcome of Children's Social Care's action plan. However, its focus must also fall on the outcomes of service improvement and enhancement activity in Start Well and in CRC and the reconstituted National Probation Service, where management, supervision and practice shortfalls have been identified.

5.3. Across all four domains of practice and the management of practice, what has emerged is a picture of unsafe certainty or premature certainty[33]. There was a lack of curiosity and of authoritative doubt in direct work with Child 3's Mother and the Adult Male, for example, and in managerial oversight of that practice. A position of safe or safer uncertainty, characterised by respectful curiosity and not understanding or deciding too quickly, was not achieved. The closest those involved came to this position was when the Hospital reflected on the outcome of the paediatric examination conducted in August 2019.

5.4. Both Child 3's Mother and Father have told the Independent Reviewer that they feel they were failed. Child 3's Father has pointed out that there was no consistent relationship between a Social Worker and Child 3 and her Mother. He has reminded those involved that he should have been involved as Child 3's Father. He hopes that his involvement in this review will help to prevent further deaths. Child 3's Mother has observed that no-one ever asked her to sign anything like a contract or written agreement that clearly spelled out what she was and was not allowed to do; that, she thinks, would have made her realise how serious the situation was. She feels that, after the August paediatric examination, robust interviews should have been conducted, with "proper consequences" and clarity about the potential outcomes if a child is felt to be at risk. She has also said that Social Workers should be honest about their concerns and that parents should be told of the reasons when they are referred to Social Services.

5.5. The components of best child safeguarding practice are well known. It is tragic that lessons are having to be learned again about the centrality of quality (risk) assessments, attention to case chronology, and engagement with significant adults; of not overestimating the ability of parents to keep children safe and triangulating what

[33] Mason, B. (1993) 'Towards positions of safe uncertainty." *Human Systems*, 4, 3-4, 189-200.

parents report with what is observed and known to practitioners; of robust inter-agency collaboration and management support and oversight of practice. Leadership in children's safeguarding resides in everyone involved with the safeguarding of children, whatever their formal role and designation. That leadership is ultimately brought together here in Wigan's Safeguarding Partnership that, going forward, must consistently ensure that best child safeguarding practice is evident in how practitioners are working with children and their parents, and with each other, and how services are supporting that practice.

6. Recommendations

Recommendation One: As the Early Help offer is being reconfigured, Wigan Safeguarding Partnership should commission and scrutinise audits of the effectiveness of the new service (section 3.6).

Recommendation Two: Wigan Safeguarding Partnership in partnership with Wigan Safeguarding Adults Board should convene a multi-agency summit. The purpose should be to establish whether there is sufficient recognition of the potential impact of adverse childhood experiences and whether a whole family approach is sufficiently embedded in practice. This should cover but is not restricted to the Early Help offer, and should also include an emphasis on professional curiosity and a trauma-informed approach (section 3.7).

Recommendation Three: The outcome of the adoption of specific practice and operating models for focused assessment and intervention as standard practice by Children's Social Care should be scrutinised by Wigan Safeguarding Partnership (section 3.13).

Recommendation Four: Coercion and controlling behaviour should be addressed in multi-agency training offered through the Wigan Safeguarding Partnership and Wigan Safeguarding Adults Board as a contribution to a "think family" approach to practice, including legal rules to protect victims from domestic abuse, and should be recorded as having been discussed in safeguarding supervision (section 3.19).

Recommendation Five: Children's Social Care should conduct routine audits of social work assessments and managerial oversight of decision-making, with reports scrutinised by Wigan Safeguarding Partnership (section 3.25).

Recommendation Six: Wigan Safeguarding Partnership should undertake audit work routinely to ensure that strategy meetings and professionals' meetings are convened. Audit work should capture the experience of different practitioners in convening and contributing to multi-agency and multi-disciplinary case discussions (section 3.37).

Recommendation Seven: Wigan Safeguarding Partnership should convene a summit to review the threshold document and how different services understand and use it. Using this case as an illustration, policies and procedures surrounding the threshold document should be reviewed, especially the approach to re-referrals, the convening of multi-agency meetings and the importance of escalation (section 3.44).

Recommendation Eight: All services with responsibilities for safeguarding children should provide Wigan Safeguarding Partnership with assurance that records indicate robust management and supervisory oversight (section 3.49).

Recommendation Nine: All agencies should undertake a review of their approach to internal investigations as a result of learning from this case, reporting their conclusions and revised procedure to the Wigan Safeguarding Partnership. In particular, internal investigations must be timely, following a clearly laid-out process, with staff support offered. They must look at systems within which staff have been working and not simply focus on the practice of individuals (section 4.2).

Recommendation Ten: Wigan Safeguarding Partnership and Wigan Safeguarding Adults Board to receive an evaluation of the new adult mental health referral process (section 4.3.6).

Recommendation Eleven: Wigan Safeguarding Partnership should routinely scrutinise the evidence for the impact and outcomes of Children's Social Care's action plan (section 4.5.9).

Recommendation Twelve: GMP should provide assurance to the Wigan Safeguarding Partnership regarding how the findings of the IOPC investigation have been taken forward into their public protection practice with children and their families, and with other agencies involved in children's safeguarding (section 4.6.13).

Recommendation Thirteen: Wigan Safeguarding Partnership should seek assurance from CRC (and from the National Probation Service going forward), based on audits of practice, that the learning from this internal investigation has resulted in practice improvement (section 4.7.21).

Recommendation Fourteen: Wigan CCG should provide assurance to the Wigan Safeguarding Partnership that the learning from this case has been shared with GPs and all members of primary care teams and community health services, and that all staff have been reminded of the pathway for child protection medicals (section 4.8.9).