

Stockport Local Safeguarding Children Board

Serious Case Review Executive Summary

AA aged 11

AbA aged 8

HA aged 6

SERIOUS CASE REVIEW EXECUTIVE SUMMARY **A CHILDREN**

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1 INTRODUCTION

Summary of Events Leading to Serious Case Review

- 1.1 On 20 August 2006, and following contact from neighbours, the Police were called to the family home in Stockport. The bodies of AA, AbA, HA, and that of their mother were found. They had been killed by blows to the head with a blunt instrument.
- 1.2 On 31 August 2006 RA, the father, was arrested on suspicion of murder. He was subsequently charged, tried and convicted of the murder of the children and their mother.
- 1.3 On 6 October 2006 the Stockport Local Safeguarding Board Initial Serious Case Review Panel was convened and agreed that the grounds for a Serious Case Review were established and recommended this to the Director of Stockport Children and Young People's Directorate. The Director endorsed this recommendation.
- 1.4 Whilst it was unclear as to the actual date on which the family had moved to Stockport, it was evident that this had been a relatively recent event, and thus it was agreed that membership of the Serious Case Review Panel should include agency representatives from Manchester.

2 TERMS OF REFERENCE

- 2.1 The purpose of serious case reviews carried out under the guidance of Working Together to Safeguard Children is to :-
 - establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
 - identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
 - as a consequence, improve inter-agency working and better safeguard and promote the welfare of children
- 2.2 In addition to this, the Stockport Local Safeguarding Board Initial Serious Case Review Panel proposed the following terms of reference which were confirmed at the first meeting of the Serious Case Review Panel:
 - Could the circumstances have been anticipated?
 - Cross border working when families move area
 - Were assessments timely, responsive and appropriate?

- 2.3 In addition to confirming the terms of reference, the Serious Case Review Panel agreed to seek a contribution from an independent person who would be able to make a contribution on cultural factors which might assist in identifying lessons to be learned from the case.
- 2.4 It was also agreed that the Review would consider information concerning events following on from the beginning of the marital relationship in 1993.

3 FAMILY DETAILS

3.1 The family comprised of:

- Mother UR
- Father RA
- Son AA (aged 11)
- Son AbA (aged 8)
- Daughter HA (aged 6)

4 MEMBERSHIP OF THE SERIOUS CASE REVIEW PANEL

- Policy Officer Housing Manchester City Council
- Independent Chair of the Panel - author of the overview report
- Designated Doctor for Child Protection Stockport
- Team Manager Quality Assurance and Performance Management Unit, Manchester City Council
- Litigation Manager, Stockport
- District Manager School Attendance Improvement Service, Manchester City Council
- Designated Doctor for Child Protection Manchester
- Principal Education Welfare Officer Stockport MBC
- Service Manager Safeguarding Children Unit Stockport MBC
- Designated Nurse for Child Protection Stockport
- Detective Chief Inspector Greater Manchester Police
- Designated Nurse for Child Protection Manchester
- LSCB Administrator, Stockport MBC

5 CONTRIBUTORS WHO PROVIDED MANAGEMENT REVIEW REPORTS TO THE SERIOUS CASE REVIEW PANEL

- North West Ambulance Service
- University Hospital of South Manchester
- Manchester PCT
- Central Manchester & Manchester Children's University Hospitals
- Greater Manchester Police
- School Attendance Improvement Service – Manchester
- Stockport Education Welfare Service

- Manchester City Council – Diversity & Inclusion Team
- Children’s Services Manchester
- GP
- Manchester PCT
- Stockport PCT
- Housing Services, Manchester City Council

6 SUMMARY OF HISTORY OF FAMILY

- 6.1 The first contact between the family and public services came with the birth of AA in November 1994. UR had married RA in Pakistan in 1993.
- 6.2 RA lived with his parents in England. UR joined RA in England around four months after the marriage. When she arrived she spoke English as a second language.
- 6.3 AA presented emotional and behavioural concerns at home and at school. These were the basis for referrals for support within school and from the Health Visiting and School Nursing Service to the Community Paediatrician and Child Mental Health Service.
- 6.4 AbA and HA did not present the same concerns and experienced good health.
- 6.5 UR experienced a number of significant events impacting on her physical and mental health.
- 6.6 It is evident that UR was a young mother who was subject to verbal and occasional physical abuse from her husband and his family, and who appeared isolated and lonely.
- 6.7 UR was admitted to hospital in April 2003 following an overdose. This might have been linked to her husband’s belief that she was involved in a relationship outside the marriage.
- 6.8 There is evidence of concern from the GP about the impact of mother’s mental health on the children, and in particular mother’s concern about AA’s behaviour.
- 6.9 The A children attended their first primary school between 2001 and 2004. They all accessed nursery provision at the school and progressed into main school. Whilst at school the attendance of all 3 children was very good. Both parents were said to be supportive of their children’s education.
- 6.10 On 30.04.04 UR presented as homeless with her 3 children. She explained that whilst attending her fathers’ funeral in Pakistan, her husband sold their house and all their possessions. She could not

locate her husband at that time, and had no choice but to present as homeless.

- 6.11 The family were then placed in Homeless Families accommodation until 04.05.04. The children were re-admitted to school.
- 6.12 UR appeared to build good relationships with her housing support workers and disclosed that her husband had been violent towards her but not the children (though one of the children had been very upset by the violence).
- 6.13 There was concern about AA's behaviour within school. Behaviour management support was implemented following a period of exclusion. The school solicited additional support via an external service and the school's Special Educational Needs Co-ordinator in an attempt to modify AA's behaviour and to promote social and academic performance.
- 6.14 There were no concerns expressed about AbA or HA whilst in attendance at school.
- 6.15 The first contact the Social Services department had with UR was in May 2004 after she had returned from Pakistan. She sought financial assistance, as she reported that her husband had sold the family home and contents whilst she was away. The social worker at the time offered financial assistance and also assisted UR in trying to secure payments from the Benefits Agency and clothes from a charity. This support in arranging finances continued throughout May 2004.
- 6.16 In August 2004, the family GP made a referral to Social Services expressing concern about UR, in that she was being treated for anxiety and depression.
- 6.17 On 1st November 2004 transfer to a new school was sought by UR following a change of address. The children were granted immediate admission to commence the following day. Appropriate plans were put in place to meet the needs of AA and attendance of all the children continued to be good throughout their time at the new school.
- 6.18 The social worker visited UR on 4 November 2004. The social worker was sufficiently concerned about UR's health and state of mind to make an immediate call to request that the nurse at homeless families accommodation visit UR to assess her health. In addition, she made a referral to an Asian Women's outreach project. UR said that her husband had apologised for selling the house and contents and was seeking reconciliation. She also stated that 'everyone' was pressuring her into reconciliation.
- 6.19 In January 2005 UR also disclosed rape by someone she knew to her accommodation provider.

- 6.20 On 14.02.05 the family were permanently rehoused. UR was noted to have had several ongoing medical conditions including depression and panic attacks.
- 6.21 During May 2005 UR's husband and other family members were applying pressure on UR for her to reconcile with her husband, but the children were reported as happy and well cared for, and their new home was well maintained.
- 6.22 In concluding work with the family in May 2005, the social worker recorded no concerns about UR's care of the children. UR was adamant at that time that she would not be reconciling with her husband. The case was closed on 3rd May 2005.
- 6.23 In November 2005 UR ceased to engage with the housing support worker and the case was closed in February 2006.
- 6.24 On the basis of surveillance at a Stockport address in February 2006, officers from the DWP formed the view that the family were residing at that property. Additionally they had evidence that UR had a fifty per cent interest in the property. On 12th April 2006 UR was interviewed, under caution, and denied that the family were living in Stockport.
- 6.25 On 09.06.06 UR informed school staff that, due to the distance being travelled from Stockport, the children would be transferring school. The children ceased attendance at school at the end of that day.
- 6.26 Prior to the discovery of the murder and subsequent investigation little of significance was known by the police about UR, RA and the family.
- 6.27 The police had received reports about disputes within the relationship of UR and RA related to her alleged extra-marital relationship, and in June 2006 UR made an allegation of rape against the individual involved in that relationship which was treated as a crime.

7 SINGLE AGENCY ANALYSIS

7.1 Health

- 7.1.1 During the period under review the children were seen by several health visitors and school nurses, who, on an individual basis, provided a good service, showing sensitivity to their needs, and ensuring adequate support to assist their functioning as a family unit.
- 7.1.2 There were a number of areas of evident good practice, including the supportive visits to UR by health visitors; the diligence and persistence of the school nurse in obtaining child mental health involvement for AA;

the well rounded referral by the GP to Children's social care services; the GP's advocacy of the family's housing needs; and the child psychologist's support to UR and AA, particularly maintaining a good dialogue with the school nurse when AA was not brought to appointments.

- 7.1.3 With hindsight, there are a number of areas, in relation to support for UR, which may have benefited from a different approach. These relate to her mental health needs and the response to the evident impact of domestic abuse on her and the children, and, in particular, on AA.
- 7.1.4 UR spoke English as a second language, having arrived in the UK one year prior to the birth of AA. She was assessed by her first health visitor as having a reasonable understanding and command of English. On one occasion a link interpreter was used to aid assessment of her needs and she was clearly appreciative of this. It may be that her language and cultural needs could have been further met with a greater use of local ethnic support services to reduce her isolation and increase her understanding of services available to her.
- 7.1.5 UR throughout has been described as lonely, isolated and at times suicidal, with one hospital admission following an overdose. Whilst she received supportive involvement from health professionals this was not extended to referral to adult community mental health services.
- 7.1.6 Written information particularly in relation to UR regarding her mental health, family circumstances and disclosures of domestic abuse remained at different times with the health visitor, GP, school nurse and child psychologist.
- 7.1.7 There is evidence of good communication between practitioners but no clear written information or chronology was available at the point of transfer between health visitors and school nurses.
- 7.1.8 Whilst UR received support from these professionals no one person had an overview of this information and no-one instigated multi-agency planning mechanisms under Children in Need policy and procedures.
- 7.1.9 AA's presentation of aggressive behavioural problems were not linked to his exposure to domestic abuse by health professionals although UR suggested that as an explanation. Whilst acknowledging that homelessness and marital breakdown were more immediate issues for professional involvement and concern, the historic domestic abuse could have been more fully explored as part of his assessment.
- 7.1.10 There were no child protection issues raised throughout the period under review. There was concern about AA's repeated non-attendance at the Child and Adolescent Mental Health Unit. This was viewed as a potential child protection issue, and considered as such, with appropriate action taken.

7.1.11 UR's disclosure of domestic abuse at the hands of her husband and extended family is recorded on a number of occasions by different practitioners. Although these incidents are recorded, there is no evidence they were acted upon, or supported offered to UR.

7.1.12 There is no written evidence that the disclosure made by UR with respect to domestic abuse occurring within the family was shared with the school nurse when health visiting records were transferred or when UR disclosed the same in interview with the child psychologist.

In relation to the latter, information sharing may not have occurred as RA was not part of the family unit at the time and so did not pose a threat. That being so, he continued to be involved with the family prior to their being re-united.

7.1.13 In 2004 GP notes mention of husband's "morbid jealousy" and two alleged rapes by known assailants. It is not recorded whether the children witnessed these events. These instances were noted and UR was advised what to do but no further action was taken, particularly in regard to potential risk to the children.

7.1.14 Overall, the GP's records provide good detail about the family and, in particular, UR. This is particularly helpful given the number of moves the family experienced. It does, however bring with it capacity issues for GP's to familiarise themselves with the records of all members of the family. This understanding is critical if links are to be made between domestic abuse and child behaviour problems as in this case.

7.1.15 There was little evidence of information sharing with respect to the incidents when all three children presented to the Accident and Emergency Department. This was despite concerns being raised about delayed presentation of injuries and non attendance of follow up appointments.

7.1.16 Both UR and RA attended hospital accident and emergency department on a number of occasions. Whilst they received appropriate treatment in their own right no consideration was given to communicating with appropriate health colleagues to consider the impact on their role as parents.

7.1.17 After AbA's visit to hospital 3 on 5th June 2006 an A&E slip was sent to Stockport PCT, where it was received on the 9th June and forwarded to School Health Records Department, as the family had given a Stockport address and school. This was the point where Stockport should have requested the records from Manchester, although they would not have known that Manchester was the previous responsible authority, but this could have been discovered via education. Stockport does not have a computerised system for school health records.

- 7.1.18 It has to be noted that, whilst this administrative transfer of health records did not take place, as would have been expected, there was a procedure in place where the designated/named nurse for safeguarding children would communicate with each other in cases where either considered there to be a risk where families were moving to another area. However no such concerns arose in this case.
- 7.1.19 On 6th July 2006, Stockport School Health received a phone call from Manchester Child Health stating that the children were in the area, however when the telephone call was received it was not connected with the accident notification. The accident notification was never received by the school nurse and was still with the administration department when the children died. It is thought that the notification was due to be sent after the school holidays.
- 7.1.20 When a child starts in a Stockport school, it is expected that the school requests all education records and notifies the School Health department. There is no evidence to suggest this happened.
- 7.1.21 The A and E notification from Hospital 3 was not processed properly, resulting in the school nurse not being aware of the children's admission to School 3.
- 7.1.22 Attempts to trace the family after they had moved from the Manchester area complied with current policy and procedures.
- 7.1.23 During the course of the review recommendations were agreed by Stockport NHS PCT which would avoid a recurrence of the flaws in the administrative system which occurred at Stockport School Health on receipt of the A and E notification.

7.2 Housing

- 7.2.1 When UR returned from Pakistan in April 2004, she was homeless. From that point on she received a good service from both housing services and accommodation providers, with a prompt and sensitive assessment of the family's needs and of their eligibility for provision of temporary accommodation, which itself was of good quality.
- 7.2.2 Once re-housed support services provided frequent visits, and there is evidence of a good supportive relationship between support workers and UR.
- 7.2.3 Whilst, in the main the welfare and safeguarding needs of the family were met, it is evident that there were a number of occasions, when significant information could have been shared, and when greater clarity about procedures and processes, may have provided the opportunity for different approaches and outcomes.

7.2.4 There was a lack of clarity about how to deal with the concerns raised in the GP's letter in September 2004. This led to information not being shared appropriately.

7.2.5 There is no evidence of the Homeless Families Assessment Officer being informed of UR's disclosure of being raped which was made to her accommodation provider in January 2005, following on from her expressing anxiety about the threat of rape in the previous November. This led to no action being taken.

Given that the incident in January involved someone UR knew, there does not appear to have been consideration given to the safeguarding needs of the children. This could have led to a Section 47 investigation with consequent sharing of information and the opportunity for a re-evaluation of the level of need and services required.

7.2.6 Additionally, UR could have been offered re-housing in another area; a referral to a rape crisis centre; and encouragement to contact the Police.

7.2.7 Domestic abuse was disclosed both to a homeless accommodation keyworker and a Homeless Families Support Worker. This information was not shared with the community support officer enabling UR to inform the community support officer that she was reconciling with her husband without this giving cause for concern.

7.2.8 Information was not shared relating to the claim that the family were not residing at their last address in Manchester. The community support officer was aware that an informant had suggested that the family was residing with the children's father in Stockport.

7.2.9 The additional information on domestic abuse which came to the attention of the housing support team was not shared with the Homeless Families Social Work Team, which was also not advised of father's resumption of contact with the children in April 2005. This meant that when social work involvement ceased on 3rd May 2005, the decision to do so had not taken account of those factors.

It also has to be said that the decision to cease social work involvement was taken without consultation with housing support services or any other agency.

7.2.10 Since 2005 Housing staff have been trained in the impact of domestic abuse on children and current practice would have led to both of these referrals being made.

7.3 Social Care

- 7.3.1 In relation to social work involvement with the family it is important to understand that this was provided by the Homeless Families Social Work Team, which operated on a multi-agency basis. A member of the team attends twice-weekly, multi-agency meetings to consider any 'new' families which have entered Homeless Families Accommodation. In 2004 partner agencies attending the meetings included midwifery, health visiting and an education worker. Funding for the education worker was apparently withdrawn sometime in 2004, so it is not known if there was an education representative at any meeting that may have considered the A family.
- 7.3.2 At these multi-agency meetings, if it is decided that the lead agency is to be children's services, in cases where there are significant concerns to warrant commencing child protection or case planning processes, then a social worker from the team is allocated. The social worker would then follow Manchester's Children's Services policy and procedures..
- 7.3.3 It is not possible to determine whether the A family was presented at such a meeting.
- 7.3.4 The first referral for the family was made on 5th May 2004, by the Job Centre, and was in relation to the need for financial assistance. Financial payments under Section 17 of the Children Act 1989 were made on 5th May, 7th May, 13th May, 19th May and 27th May. The family GP made a referral expressing concern on 17th August 2004.
- 7.3.5 Manchester's case planning processes are in line with the National Assessment Framework. In addition it has procedures in relation to requests for financial assistance. These two processes would dictate that an initial assessment could have been commenced on 5th May 2004, and should have done so on 13th May (the time of the third Section 17 payment), and a conclusion reached within seven working days as to further action. This did not happen.
- 7.3.6 It seems that although the case was open from May 2004, the initial assessment did not commence until November 2004, in response to the referral from the GP on 17th August.
- 7.3.7 The initial assessment was concluded on 3rd May 2005. It identified the most pressing concerns for the family as UR's physical and mental health, along with the family's finances. There was no decision to draw up a case plan for work with the family or to undertake a core assessment as Manchester's procedures dictate for allocated family support cases. Given the concerns about UR's health, this would seem to have been appropriate, and would have obtained a multi-agency approach to supporting the family.

- 7.3.8 Whilst the initial assessment took account of environmental factors and of the family's cultural identity, it did not address the individual needs of the children. The children were seen during the course of the initial assessment in 2004/5, but not on their own. Apparently, this was because there were not considered to be child protection concerns to warrant it. There is nothing recorded that reflects any wishes or feelings the children themselves may have expressed, these being mediated through the view their mother had of them.
- 7.3.9 Significantly the initial assessment did not take account of information and opinion held by any other agency, resulting in significant gaps in, and denying the opportunity of, a proper assessment of need and evaluation of risk in this case.
- 7.3.10 The lack of a Section 17 Children Act 1989 family support case plan is also critically important because it would have ensured a multi- agency, more focussed approach to meeting the family's needs , and would have prevented what could be seen as 'drift' and inactivity between November 2004 and May 2005. It would also have facilitated the opportunity to share information about the nature and level of domestic abuse within the family.

None of the other agencies raised concerns with Children's Social Care despite there being sufficient evidence that criteria for a referral was met by individual agencies. These referrals were not made; neither were any level 2 case planning meetings convened. Either process would have facilitated multi-agency information sharing, and a more informed evaluation of needs and risks.

- 7.3.11 The social care assessment was not timely or sufficiently responsive but this was viewed as an individual practice issue. It is evident from supervision records that the lack of Team Manager oversight and scrutiny had compounded the issue.
- 7.3.12 During the period of involvement 2004/5, there was no information held within the social work service that would suggest the children's needs should have been viewed within a Section 47 Children Act 1989 child protection framework. The social worker noted the possible removal of the children by father as a potential child protection concern, though there was no apparent evidential basis for this. There is nothing recorded to suggest that UR or the social worker felt he was a risk to the children.
- 7.3.13 Since 2004, Manchester's Children and Families Division has undergone a significant reorganisation. The Homeless Families Social Work Team operates in much the same way as it did in 2004, in that it still holds multi-agency meetings and assigns lead agencies. The District social work teams now operate separate Duty and Assessment Teams, Locality Teams and Permanence Teams. This has resulted in much more focused initial work with families, and adherence to

timescales and procedures for Initial Assessments has improved. In family support cases such as these, the Core Assessment has to have been completed and a case planning meeting organised.

7.3.14 The referral received by the Emergency Duty Service on 12th May 2006 was deemed to be malicious and no further action was taken by the social work team. Given that the police had visited the property and reported no concerns; that there had been no historical child protection concerns; and no referrals or involvement for twelve months this seems to have been appropriate.

7.3.15 There is nothing to suggest that the family were informed that the Children and Families Department held this referral and information about them. A letter could have been sent to UR, explaining the referral, and also asking her to contact the department should she need advice or support. The fact that somebody saw fit to make a malicious referral suggests that UR as perhaps having problems with somebody, and may have benefited from some advice. That option was not put to her at the time.

7.4 Education

7.4.1 Whilst there is evidence of good working relationships between the key professionals, and between the schools, school nurse and UR it is noteworthy that there is a lack of recording on the school record in relation to family circumstances, and their impact on AA in particular. It is unclear to what extent those working most closely with AA, were aware of the history of domestic abuse within the family.

7.4.2 The absence of documentary evidence on the school record is also apparent in relation to:

- Notification of AA's 7 day fixed term exclusion for physical assault on another pupil. Evidence of communication between school and the LA concerning the exclusion is missing from the pupils file. Notification to parents is also missing from the pupils file.
- Additional support was offered to AA from the Diversity and Inclusion Service shortly after the exclusion. Again there is no information concerning this on file. This is concerning since AA seemed to engage well with a programme of activity which had been based on a responsive, timely and accurate assessment of his emotional and behavioural needs.
- Additional in school support continued after AA transferred to school 2. It is understood that an initial meeting was held where it was decided that AA would be placed on 'school action'. There are no records of this meeting or any subsequent meetings, or any indication that parents were invited. Overall, the lack of involvement of parents and the missed

opportunity to involve other agencies through evoking the Children in Need procedures meant that important information sharing did not take place. As a result the wider safeguarding issues were missed.

- 7.4.3 The school records had transferred properly from school 1 to school 2, but not from school 2 to school 3. When UR informed staff at school 2 on 09.06.06 that the children would be transferring school, details of the new school were not given and there is no indication that such information was requested. Deletion from roll took immediate effect without knowledge of the school that the children would be attending. Such action is contrary to the LA / DfES advice to schools.

7.5 Greater Manchester Police

- 7.5.1 Although the police had little knowledge of the adults involved, prior to the murder of the children, they did have significant information about UR's extra-marital relationship.
- 7.5.2 When in June 2006, UR reported being raped by the man with whom she had been having an affair, the allegation was viewed as being consensual, based on UR's expectation that he would marry her.

The allegation of rape was not taken seriously by officers and as a result the investigation that followed was flawed. Existing policies & procedures in relation to the investigation of this type of offence were not followed by individual officers and as a result only minimal enquiries were made.

- 7.5.3 Greater Manchester Police currently has robust policies and procedures in relation to serious sexual assault (Operation Nightingale) and continue to drive towards improved performance across the force through Operation Talon.
- 7.5.4 It is also of concern that references made in other reports to police involvement do not appear to be held or cannot be found in police records (e.g. police records do not reflect referrals about domestic abuse - Housing 16/6/05).
- 7.5.5 Recent policy and procedural change on behalf of GMP includes a 'zero' tolerance approach to domestic abuse so that action can be taken without the complainant making a formal complaint.

8 MULTI-AGENCY ANALYSIS

- 8.1.1 UR received positive support, to differing degrees from individual agencies, and was provided with information and access to appropriate support groups. She was given the telephone number of a Pakistani

Women's Support Group in April 2003, and similar advice was subsequently given by Housing support workers.

- 8.1.2 The service provided to the family seems, for the most part, to have been sensitive to their racial, cultural, linguistic and religious identity.
- 8.1.3 Whilst AA's needs were well articulated by the school nurse; well assessed by the child psychologist; and to an extent, well met by the Diversity and Inclusion Service, the focus of agency involvement with the family was with mother, and there was a lack of focus on the children, and there was little meaningful engagement with the father
- 8.1.4 There is evidence of timely, responsive and accurate assessments by individual professionals. Importantly there is also evidence that, at various stages in the family's involvement with services, and at critical incidents, the opportunity to share information on a multi-agency basis and thereby provide a more informed evaluation of needs and risks, with the potential to offer further family support was missed.
- 8.1.5 In relation to assessment of need and evaluation of risk the agencies' awareness of the impact of domestic abuse does not seem to have been sufficiently keen to raise necessary concerns about the welfare and safeguarding needs of the children.
- 8.1.6 There were no obvious risk indicators to suggest that the lives of the children and their mother were to be ended in such a violent way. Whilst there was reference to father's 'morbid jealousy', and evidence of domestic abuse, there was no evidence, or pattern of, abuse, or neglect, of the children. Father had no criminal record and he seems to have determined a tragic course of events when he became aware of his wife's continuing affair in early July 2006.
- 8.1.7 Certainly, these circumstances could not have been anticipated by the agencies involved with the family, and, even with the benefit of hindsight it does not appear that any different decisions or actions would have altered the tragic outcome to events in July 2006.

9 CONCLUSIONS

- 9.1 A number of lessons have been derived from the reports provided to the Serious Case Review Panel and from its deliberations on how services were involved with a family, within which the lives of the mother and children were ended so violently and tragically.
- 9.2 The seriousness of domestic abuse and particularly its impact on children requires higher regard. This could be afforded by further embedding the operation of Section 17 Children in Need Case Planning

processes to the same level as that of Section 47 Safeguarding processes. A multi-agency training strategy is needed to underpin this.

- 9.3 Professionals' understanding of the impact of domestic abuse on the mental health of the children and their mother was lacking and further training opportunities are required to address this issue.
- 9.4 Whilst professionals understandably focussed on the difficulties facing the mother in this situation, this seems to have deflected attention from attending to the needs of the children and the importance of obtaining the wishes and feelings of children in family support work needs to be reiterated.
- 9.5 The standard of record keeping, and understanding around sharing information was shown to vary considerably across and within agencies. This is a critical issue in situations of domestic abuse when information needs to be passed on speedily and professionally if resources are to be made available urgently. This is particularly important when, (as in this case), families have frequent changes of accommodation with consequent changes in service providers.

10 RECOMMENDATIONS TO LOCAL CHILDREN'S SAFEGUARDING BOARDS – STOCKPORT AND MANCHESTER

- 10.1.1 Manchester LSCB to ensure full implementation and audit of the Integrated Domestic Abuse and the Impact on Children policy.
- 10.1.2 Stockport LSCB to develop an Integrated Domestic Abuse policy linked to the Child in Need model of multi-agency intervention.
- 10.1.3 The Chairs of the Manchester and Stockport LSCB to initiate discussions with the Department of Work and Pensions in order that protocols can be drawn up for the exchange of information in cases where there are evident concerns about the welfare and safeguarding needs of children. It is noted that this may require a national policy.
- 10.1.4 To develop an integrated multi-agency standard of what information should be held on children's records and who it should be shared with and to ensure that individual agency training on recording practice is monitored for effectiveness by audit reports to the LSCB.
- 10.1.5 To ensure that member organisations of the safeguarding boards have policy and procedures in place to facilitate the sharing of information wherever there are safeguarding concerns about children of adults who are employed by that organisation, and that staff are aware of this policy.

10.2 Health

Manchester & Stockport Primary Care Trusts

10.2.1 The PCT to implement a domestic abuse policy that includes appropriate training, routine inquiry and information sharing.

10.2.2 The PCT to devise and implement mechanisms to strengthen links between GPs and schools, through the school nurse service.

Manchester PCT

10.2.3 To review Manchester PCT current policy and procedures relating to transfer of records to other authorities including the use of reference addresses.

10.2.4 To undertake a review of the Manchester PCT transfer of care/records policy between health visitors and school nurses to include the use of significant event chronologies so that at the point of transfer staff have access to all the relevant details.

Stockport PCT

10.2.5 Stockport PCT to improve the effectiveness of the notification to school nurses of visits to A and E by school aged children.

10.2.6 Stockport PCT to introduce computerised systems into the school health administrative section and integrate information systems between school health and child health for 0 to 16 year olds.

GPs Manchester & Stockport

10.2.7 To revise the GP registration process to include psychological as well as physical matters so that a holistic family view and needs of adults as parents are considered.

10.2.8 Primary Care Trust to devise a risk assessment tool for families where a parent is victim of domestic abuse and sexual assault for use in primary care.

Central Manchester & Manchester Children's University Hospital Trust

10.2.9 Central Manchester and Manchester Children's University Hospitals NHS Trust must ensure that when injuries to children are identified, there is written evidence of information sharing with appropriate agencies involved in the care of the child and family.

10.2.10 When domestic abuse is disclosed with staff there is written evidence that this information has been shared with other agencies who may be involved with children who are being cared for by that adult.

Manchester NHS Trusts

10.2.11 The Chief Executives of the Manchester Trusts to ensure that a procedural pathway is developed so that an appropriate child-centred response is developed for children who do not attend appointments.

10.3 Housing

10.3.1 Housing Support Workers should develop auditable systems to ensure that all relevant information is collated at the point that they become involved in supporting a family.

10.3.2 When Housing Support commences contact should be made with the tenancy manager (and any other known agency) to provide reciprocal ongoing information sharing. Additionally when support comes to an end the relevant tenancy manager (and any other known agency) should be informed of this and made aware of any ongoing issues/concerns.

10.3.3 To reinforce and recirculate policy and procedures relating to domestic abuse. This should make clear the need for detailed information to be recorded in relation to domestic abuse incidents, along with any impact on children, and action taken as a result.

10.3.4 Work with Supporting People commissioners to ensure that staff within commissioned services are made aware of their responsibilities in recognising and responding to safeguarding issues.

10.4 Social Care

10.4.1 The Assessment Framework and case planning processes should be reinforced and non compliance addressed in individual cases via formal supervision.

10.4.2 The Emergency Duty Service should undertake a review of the Recording Policy within the service in order to ensure that it complies with the department's recording policy.

10.4.3 The District Managers with their duty teams should review how they inform families of information received in cases where no further action is taken, in order that this complies with Data Protection Legislation.

10.4.4 The District Managers with their duty teams and Homeless Families Social Work Team should review the content and implementation process of the procedure regarding financial support and subsequent initial assessment initiation and confirm the policy that three referrals will require an initial assessment.

10.5 Education

- 10.5.1 To ensure that all schools are fully aware and comply with DfES guidance which relates to deletion of pupils from the school roll and the transferring of pupils records to another establishment.
- 10.5.2 To put in place measures to ensure that recording procedures and processes are monitored for compliance, quality and accuracy.
- 10.5.3 To ensure that any assessment process concerning a child's behaviour includes the consideration of domestic abuse and that this is explored with relevant agencies.

10.6 Greater Manchester Police

- 10.6.1 Ensure front line officers do follow policies and procedures in relation to sexual assault allegations.
- 10.6.2 Officers to identify themselves clearly when passing on or providing information when communicating with other agencies. This to include provision of the FWIN number where applicable.
- 10.6.3 Within their current review of safeguarding procedures to consider extending the range of incident investigations which require an attending police officer to obtain details to be forwarded on to the domestic abuse team.

REFERENCES

1. WORKING TOGETHER TO SAFEGUARD CHILDREN 2006

2. COMMON ASSESSMENT FRAMEWORK FOR CHILDREN AND YOUNG PEOPLE 2003 (DfES)

3 THE EDUCATION (PUPIL INFORMATION) (ENGLAND) REGULATIONS 2005

4 MANCHESTER CITY COUNCIL MULTI-AGENCY CASE PLANNING PROCESSES FOR VULNERABLE CHILDREN AND CHILDREN IN NEED

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