Stockport Safeguarding Children Board and Stockport Safeguarding Adults Board

Report of a Joint Review:

Serious Case Review and Safeguarding Adults Review

KW and KG: A Family

Joint Review Authors: Dr Paul Kingston and Emma Mortimer

February 2018

STRICTLY CONFIDENTIAL

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Condolences:

This Joint Review was initiated because of the sad death of KW at 39 years of age. The Overview Authors and Panel Members would like to express their sincere condolences to all those who knew her and were affected by her death, and especially to her two sons, her brother and sister and her father.

The family also lost KW's mother in 2017 and the Joint Review panel's sympathy is with the family.

Gratitude and thanks:

KW's youngest son, KG is subject of the (Children Act 2004) Serious Case Review. However he and KW's friend, Sue both contributed significantly towards this Joint Review and our grateful thanks are extended towards both.

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A note about terms used in this report:

The authors of the Joint Review have used the term, '*mental health problems*' to refer to KW's mental health needs. These were evident to those who knew her, but it is important to be clear that she had not received a formal diagnosis.

Additionally, the authors have used the term, *'substance use'* to refer to KW's alcohol use. While the Joint Review found evidence of excessive use and indicators of dependency, this was not diagnosed and it is not the place of this Joint Review to draw any such conclusions.

1. Introduction

1.1 KW and KG

1.1.2 KW

KW was born in Stockport on 25th July 1977. She was one of three children to her parents, both of whom were white British. She lived in Stockport all her life and for several years worked for the local authority as a Youth Worker. She had a partner who was parent to her two sons, but that relationship ended in approximately 2003 and KW referred to this being coercive and controlling.

In approximately 2011, according to her son, KG, she was made redundant from her Youth Worker post and shortly after had a fall that impacted considerably on her mobility; combined, these seemed to mark a turning point in her life.

This Review has heard KW described as being '*fun-loving'*, '*a real laugh'*, and '*kind*', '*desperately proud and loving of her sons'* and '*very proud and private'*. She had enjoyed her job as a Youth Worker, and her son, KG told the Review about the really positive impact she had on young people's lives.

KW had two sons, KG, now 18, (age 16 when she died) and his brother, who was three years older than him. She had experienced domestic abuse in the past and was a single parent since her relationship with the boys' father deteriorated. Her own parents were extremely supportive to her and lived locally, looking after her and her children for significant periods of time during the last four years of her life. They had their own health problems and her mother, and KG's grandmother, to whom he was close, died as well in 2017. KG has therefore experienced significant bereavement in addition to the trauma described in this report.

KW also had support from her sister and brother, although her acceptance of this varied. KG's contact with aunt and uncle in this time was largely positive and both spoke up with concerns for his welfare during the last two years of his mother's life.

KW used alcohol significantly in the last years of her life; the review heard that this may have been exacerbated by a wish to manage pain and anxiety she experienced as a result of her physical and mental health problems. However, it also masked her mental health problems and its impact on her wellbeing and that of her children.

KW was a person who had emotional attachments to possessions and to items that reminded her of her people and experiences. This caused her home to be very full of objects that she was reluctant to discard. Having been evicted in early 2014, she had been rehoused by Stockport Homes and signed a new tenancy in March 2014. Many of her possessions were moved there and the reported piles of objects were a feature in that property as well as the previous home. In addition to this, her home was described by practitioners and by her friend as being unfit to live in and a health risk.

KW died on 27th October 2016. She was 39. She had been diagnosed with cancer two years previously and had not attended health appointments for the previous six months. She had reportedly not left her bed for some months. She had undergone therapy for a significant time and had also experienced other conditions that were not diagnosed, but which undoubtedly caused her pain.

KW's youngest son, KG was her carer for few years prior to her death and in the last six months of her life; this role extended in the last few weeks of her life to conducting very personal care to support her and to maintain a level of cleanliness in the home. He achieved this role, together with managing KW's anxiety, responding to her occasionally psychotic presentation and her desire to keep agencies away from the family, while also attending school.

KW had a number of good friends, but especially, Sue, who she met on a ward at Stepping Hill Hospital. Sue supported KW for last months of her life and was present when she died. Sue, one of the few people she trusted, spoke with the reviewers and gave a helpful explanation of some of the challenges KW faced.

KW died at the age of 39. Her friend, Sue, told the review that she was '*ready to die because she knew her sons could now manage without her'*, but that her distrust of agencies had left her, '*easy to ignore; no-one took responsibility for what was happening'*.

1.1.3 KG

KG was born in Stockport in 2000. His brother was three years older than him and both attended the same local secondary school. Information about the boys' father is unclear, but KG advised the review that he had not seen him for some years because he lived away from Stockport. He had positive relationships with his maternal grandparents, with whom he had lived periodically as a teenager and remains close to his grandfather. Sadly, his grandmother died during the year that followed KW's death.

KG says that he has a number of online friends, whom he has met through the gaming community, but few 'real life' friends. He currently lives with foster carers with whom he has a positive relationship.

KG left school at sixteen with, despite his reported intelligence, few qualifications. This was just six months before his mother's death. He has had mental health problems, has self-harmed and expressed what he described at age 15 as 'dark thoughts'.

KG was met by Stockport Safeguarding Children Board staff and one of the Independent Review Authors on three occasions for this review. He presents as a bright, eloquent, polite and thoughtful young man. KG described how hard it was to support his mum through her last months of life and how he kept hoping and expecting someone to come to the house, understand the problem and sort out what was going on, but, '*it just didn't happen'*. KG explained that he was keen to participate in the review to ensure that is mother was understood, and not just seen through one perspective; he wanted to ensure '*people know she was wonderful …..despite the problems'.*

2. Methodology

2.1 Legal context

KW died on 27th October 2016. Staff in Stepping Hill Hospital Emergency Department were shocked by the level of neglect she had experienced and by her physical presentation. A criminal investigation was commenced, but ceased shortly afterwards when it became clear that she had self-neglected.

HM Coroner was notified of KW's death and an Inquest will be held in June 2018.

The circumstances of KW's death were agreed to meet the statutory criteria[1] for a Safeguarding Adults Review in May 2017 by the Stockport Safeguarding Adults Board (SSAB) Independent Chair.

The concerns about the KG's experience were additionally considered by Stockport Safeguarding Children Board (SSCB) to have met the criteria set out in statutory guidance Working Together 2015 for a Serious Case Review[2] and the Department for Education and Ofsted were informed of this decision on 17th May 2017.

2.2 Overall approach

2.2.1 Initial approach and development of a Joint Review

The Joint Independent Chair of the SSCB and SSAB was clear from the beginning of the review process, that it was important that KW and KG's experiences included consideration of the way agencies support families in Stockport. A joint review therefore began, with one element focused on KW and one on KG. It was intended that two reports would be written, one concerning each person's experience, with an additional report considering learning in respect of families. Two Review Panels were established, with separate representation from the agencies that had been involved with KG and KW. The two reviews were to be informed by:

- Agency chronologies of events, covering the period 01.01.2013 to 27.10.2016
- Agency Individual Management Reviews (IMRs)

At a Review Panel meeting held in September 2017, discussion took place around the emergent learning from both aspects of the review; that for a number of legal, structural and organisational reasons, agencies that supported KG and KW struggled to understand the whole family system. The Review Panel therefore recommended that the Review, while importantly understanding the individuals' perspectives, especially those of KG as a child, should reflect this emergent learning and be considered through one Joint Review that focused on:

- KW and KG's experiences as individuals and as a family;
- Reflection on the way in which agencies in Stockport had, or had not considered a whole family approach to supporting them;

[1] S44 Care Act 2014

[2] Regulation 5, Local Safeguarding Children Board Regulation's 2006

- Key practice episodes, informed by the agency chronologies and IMRs, analysing the way in which systems in Stockport enable practitioners to work together across adults and children's services to support people in KW and KG's circumstances;
- Practitioners' views through a joint adults and children services learning event;

It was also agreed that the Joint Review's learning should be presented in a Joint Review Overview Report that while robust, should also be high-level, accessible and focused.

This approach was agreed by the Independent Chair of the SSAB and the SSCB.

The Review Panel was very aware that KG has a brother who may have had similar experiences as a young person growing up with KW and that he, despite having become estranged from his mother and brother a year before KW's death, had a right to be aware of and if he wished, participate in this review. The SSCB Manager made significant efforts to contact him but he did not respond to that contact and so the Review reached the conclusion that he had decided not to take part. For that reason, information about his part in the events considered in this Joint Review is deliberately limited.

2.2.2 Practitioner Event

A Practitioner Event for all frontline practitioners involved in supporting KW and KG was held on 28th November 2017. The half-day session focused Key Practice Episodes, which have been used to illuminate some of the important learning. These form a significant part of the analysis of learning in this report and are highlighted in the Timeline of Key Events set out in Section 3 of this report.

The Practitioner Event was facilitated by one of the Joint Review independent authors with the support of the two Board Managers. The session began by hearing about KG and KW's friend, Sue's perspectives and a photograph of KW was shared to assist the focus on her as a person.

The event was attended by a significant number of practitioners from across all agencies involved in this Joint Review, all of whom demonstrated an impressive reflective and thoughtful commitment to understanding what had happened, considering the experience of this family in order to learn and improve.

Practitioners reflected on learning from this review using the six safeguarding adults principles set out in Care and Support Statutory Guidance (2016), adapting them for use as well in consideration of learning for children's services. These principles are as follows:

- **Empowerment**
  People being supported and encouraged to make their own decisions and informed consent.

- **Prevention**
  It is better to take action before harm occurs.

- **Proportionality**
  The least intrusive response appropriate to the risk presented.

- **Protection**
  Support and representation for those in greatest need.

- **Partnership**
  Local solutions through services working with people, families and communities.

- **Accountability**
  Accountability and transparency in practice.

2.2.3 Overview Report

This Overview Report of the Joint Review is set out in a way that:

- Provides a Summary of Key Events at Appendix 1 that enables the reader to have an understanding of what happened from the perspectives of KG, KW and themselves as a family*;
- Focuses on Key Practice Episodes;
- Considers system-wide learning.

Individual agency Management Reviews (IMRs) and their responses to the Terms Reference for the Review have been considered during the Joint Review Panel meetings and at the Reflective Practice Event. This report does not therefore explore those in separate and distinct detail, but uses the information and reposes in consideration of the Key Practice Events and the emergent learning themes.

* *This Summary of Key Events is detailed in order to give the reader an understanding of a complex situation that features two people's experiences and a large number of agencies.*

2.2.4 Hindsight and positive reflection

The primary purpose of this review is of learning lessons, it is therefore important that the Review is mindful of the application of hindsight; this comment in the Pemberton Domestic Homicide Review is applicable in any form of review, investigation or enquiry that has a scope over several years; "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice*."[3]

Similarly, it is helpful to reflect on the statements contained in the Report of the Mid- Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[4]

These principles have been borne in mind in the conduct of this Joint Review and in the writing of this Overview Report.

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[3] A domestic homicide review into the deaths of Julia and William Pemberton, Walker, M. McGlade, M Gamble, J. November 2008 http://www.thamesvalley.police.uk/aboutus/crprev-domabu/crprev-domabu-whatdomabu/crprev-domabu-whatdomabu-howtvp/crprev-domabu-whatdomabu-howtvp-pemberton.htm (accessed 18.02.2016)

[4] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf (accessed 24.03.2016)

This Joint Review has been conducted with the Independent Authors' knowledge that supporting families in circumstances such as those experienced by KW and KG is challenging and can be easily open to criticism. That is explicitly not the purpose of this Joint Review; while comments are made about practice and approaches, the Joint Review is focused on a reflective practice approach. The intention is to support agencies in Stockport to develop and improve how they work to minimise risk and harm when supporting people in these circumstances.

2.3 Understanding KW and KG's experiences

All of those taking part in this Joint Review have been keen to ensure that the voice of KW and KG are heart of the reflection and learning that has taken place. In order to achieve this, one of the Joint Review independent authors met with KG and also with KW's friend, Sue. Their contribution to this review has been invaluable and the authors are extremely grateful for the insight that their openness and honesty has provided.

KG was offered an advocate to enable him to express his views, but he declined this and asked instead that he be supported by the SSCB Board Manager, with whom he had developed a trusting relationship. KG met with the Business Manager and her colleague, Senior Adviser for Safeguarding in Education and subsequently with the Independent Author of the Serious Case Review.

KG was very able to express his views and feelings about his mum's experiences, but was less able to do so about his own feelings and history. It was not in his best interests to probe this to any great extent and therefore, for this reason, KG's voice in in relation to himself is largely absent from this review.

2.4 Agency Participation in the Joint Review

The following agencies participated in all aspects of this Joint Review:

- Greater Manchester Police
- North West Ambulance Service
- Werneth Secondary School
- Pennine Care NHS Foundation Trust
- Stockport NHS Foundation Trust
- Stockport Homes
- Stockport Education and Careers Advice Service
- Stockport Adult Social Care
- Stockport NHS Clinical Commissioning Group
- Stockport Children's Social Care and Early Help Services
- The Prevention Alliance
- NHS Primary Care – GP Surgery

A number of organisations submitted two Individual Management Reviews, on account of providing both adult and children's services to the family.

This Joint Review would like to acknowledge the significant effort and commitment made by all agencies in providing their reports and chronologies; the resource implications of reviews can be significant and the hard work in providing an IMR and chronology report is not under-estimated.

Thank you.

2.5 Terms of Reference for the Review

The following Terms of Reference were agreed by the Review Panel. These formed the framework for the agency IMRs and for the Review Panel discussions.

The time period for the Joint Review is from the 1st January 2013 to the 31st October 2016. This period covers the time from when KG was placed on a child protection plan and KW first engaged with Mental Health Services and concludes on the date of KW's death.

1. How did your agency seek evidence about the views, wishes and feelings of KW and KG to what extent was it considered in assessments, decision making and plans? Were there any barriers for professionals working in your service in understanding the voice of KW and KG?
2. To what extent was it possible to work in partnership with the family of KW and KG in order to adequately safeguard KW and/or KG? What were the opportunities and barriers from your perspective?
3. What services did your agency provide to KW and/or KG and/or family?
4. What specific assessment(s) did your service undertake with KW and/or KG and/or the family? What was the reason and purpose and what was the outcome?
5. Were there issues in relation to capacity or resources in your agency that impacted on the ability to provide appropriate services to KW and/or KG? This should include comment about the quality of supervisory or management oversight, training and workload.
6. Identify any lessons learnt and implemented during the review. This should be explicit if any shortfalls in meeting standards have been identified as well as any gaps in policy, protocols or professional understanding.
7. What action(s), in retrospect, might have led to better outcomes for KW and/or KG? Why were these not considered/not taken at the time from your perspective?
8. Even in the most difficult of circumstances there can be good practice. What would you identify as good practice in this case?

NB This must be more than simply complying with expected standards of professional practice or legal requirement.

2.6 Joint Review Principles

The Review was conducted in accordance with the following principles:

- Focus on people not process: The Joint Review is concerned with the experience of KW and KG and will focus on this at all points of the review;

- Positive reflection: the intention of the review is to learn together and improve services, not to blame any individual or specific agency and the review will highlight positive and innovative practice as well as that which could have been done differently;
- Impartiality: the review will be conducted fairly and impartially with evidence of balance and objectivity and will be aware of the risk of hindsight bias;

- Equality and Diversity: the approach will be underpinned by an understanding of the inequalities in society that place some groups and individuals at disadvantage and that such groups and individuals are often excluded from services, for example, with respect to their age, gender, physical and mental ability, race, religion, language, sexual orientation and socio-economic status;

- Thoroughness: the review process will be robust;

- Confidentiality: all information gathered throughout the process will be treated as confidential and will only be shared or disclosed when appropriate to do so.

3. Key Practice Episodes

This Joint Review considered three Key Practice Episodes. A Key Practice Episode is a period of time within a case with significance - in hindsight. The Joint Review has considered what happened during these episodes, considered the standard of practice at the time and sought to understand, from a systems perspective the influences on the decision-making by practitioners. This enables the Joint Review to identify the relevant learning for safeguarding adults, children and families in Stockport.

3.1 Key Practice Episode 1: 26th June 2013 – 5th July 2013

3.1.1 Why this episode is of significance:

This episode is early in the timeframe of this review and is important because it covers the period of time when:

- KW was visited at home by GP 1, who expressed concern about the poor home conditions and about her wellbeing, especially as she was not attending health appointments;
- KW experienced several falls and was admitted to Stepping Hill Hospital;
- Information was received about KG's caring role from two sources;
- KW's father visited the family home with FSW 1 and agreed it was unfit for living in by KG;
- KW refused care and self-discharged.

3.1.2 Brief summary of episode:

Concerns had been raised by KG's secondary school about his welfare in May 2013; in particular, they identified both boys as being:

- Pale;
- Unkempt;
- In poor clothing and seeming malnourished.

At the same time, KW had not attended clinic appointments and was reported as also having physical mobility problems and neurological concerns. It was also known that she was drinking a significant amount of alcohol.

At that time, Stockport organised children's services into two parts: one was the Early Help and Prevention Service and the other was Children's Social Care, which handled statutory social care duties. Subsequently Stockport restructured all services for children into one service called Stockport Family. In May 2013, the Early Help and Prevention Service (EHP) allocated a Family Support Worker, FSW 1, whose role was to coordinate the Common Assessment Framework, (CAF). The Common Assessment Framework (CAF) is the process to identify children who have additional needs, assess needs and strengths in the family and to provide them with a co-ordinated, multi-agency support plan to meet those needs.

The family had not been known to social care prior to 17th May 2013, when Werneth School referred their concerns about KG and his brother.

KW's GP Surgery was aware of the concerns held by the school about KG and his brother because the School Nurse, (School Nurse 1) had spoken with GP 1 prior to referring the concerns to the Stockport EHP. In addition, PN 1 had spoken with KW, who telephoned on 26th June 2013 for support with her mobility problems and to KW's father who had expressed his concerns about her inability to cope, together with reference to dual incontinence, reduced mobility with significant

pain and reduced oral intake. PN 1 also spoke with KG and his brother's school and left a message for the School Nurse. This conversation led PN 1 to initiate a home visit by GP 1 to gain a wider understanding of the situation.

The home visit took place the following day, which was, as the NHS CCG noted in its IMR, unusual for a patient who was aged just 35. This is illustrative of the level of concern identified by PN 1.

On 01.07.2014, KW contacted FSW 1 and asked for handrails to be fitted in the home as she was unable to use the stairs and so was reliant on KG to care for her. FSW 1 also spoke to PM 1 at Werneth School, who told her that KG had not been to school that week as he was caring for his mum.

On the same day, KW was taken to Stepping Hill Hospital by her parents after a fall at home. She was admitted for investigations.

While in hospital, KW was referred to the Adult Social Care Hospital Social Work Team. HSW 1 had liaised with Occupational Therapy and Physiotherapy services as part of the discharge planning process and had conversations with FSW 1 and so was very aware of the problems with the family home. KW decided on 05.07.2013 that she would self-discharge and would not be persuaded otherwise, despite her father's concerns about whether or not he and his wife could support her needs at their home as well as the boys and the clinical concerns about risk of falls. Little information was provided to the Joint Review about consideration of KG's wishes and feelings during this episode.

3.1.3 Evaluation of professional practice

The actions taken by PN 1 in this period feature throughout this period of this review; PN 1 felt a sense of professional and possibly personal responsibility and was concerned for the family's welfare. She therefore shared information in order to address concerns around risk and was persistent in trying to address those risks.

3.1.3.1 Learning: Achieving effective safeguarding through partnership working

Discussion took place at the Review Panel about whether or not the conversations with KW's father and with the school were appropriate, given the lack of consent from KW. The Review's conclusion is that while consent would be ideal, the difficulty in engaging with KW at all meant this ***sharing of information on a proportionate basis***, with the best interests of a child was positive and should be seen as **good practice**.

Similarly, the decision taken by GP 1 to visit KW at home, when little was known, diagnostically about her health needs was also good practice, and showed that the surgery made *decisions based on risk and concerns*, rather than on a home visit policy. This was **good practice**.

GP 1 was concerned by the poor state of the home and the living conditions. This prompted him to suggest that he refer for Adult Social Care Support. This was positive, but it was unfortunate that the focus was on KW, rather than additionally considering risks to children. In addition, KW's father had mentioned his serious concerns about her mental health problems on the telephone and also the surgery knew that she had minimised her alcohol intake when registering. It would have been good therefore for both of these to have been explored at the visit. The focus on this visit was on KW's physical concerns, rather than on her holistic needs.

The suggestion by GP 1 that a referral to Adult Social Care may assist her was responded to by KW saying that she was already receiving help. Given the poor state of the home, the concerns raised by her father, KW's apparently avoidant behaviour experienced by the school and presumably shared with the GP surgery, together with concerns that she may be minimising her alcohol use, it would have been good practice for GP 1 to explore this further. This may have been achieved by probing more detail from her, and potentially checking with Adult Social Care. However, the conclusion of the visit was that KW was left to contact the surgery if she needed.

Those present at the Practitioner Event noted a key issue that is highlighted in this review, but is a common development area across all practice areas around the country is that practitioners tend to focus on their own interaction with a person and on their area of practice, rather than ***thinking and linking more broadly and as a multi-agency safeguarding partnership***. ***This is an important learning point for this review.***

3.1.3.2 Learning: Considering risks and the rights of *all* individuals in a family: avoiding assumptions about children's responses

The conversations that FSW 1 undertook with both KW and PM 1, at Werneth School, provided significant information about KG's carer role. This information, coupled with the knowledge that Stockport EHP already held largely informed the decisions made on 08.07.2013 to undertake an initial social work assessment under S17 Children Act (1989).

While KW was in hospital, her sons were staying with their maternal grandparents. FSW 1 arranged to meet her father at the family home. When they did so, both agreed that neither KW nor the children could return there unless it was cleaned up and sorted out. KW's father offered to do so and stated that he and his wife would care for the children after KW came out of hospital. FSW 1 gained significant insight through this visit, and it was therefore an important decision to have made.

While in hospital, KW was referred to the Adult Social Care Hospital Social Work Team. HSW 1 made contact with FSW 1 and they shared information and knowledge about the family's circumstances. ***This was good practice.***

KW self-discharged on 05.07.2013, against advice and the expressed concerns of her father. The home situation was unsuitable and KW was going to move to her parents' home with her sons. There is little evidence of risk assessment in relation to this decision, nor of a conversation direct with KW about consideration of her parents' needs and those of her sons. The information provided suggests a collusion with KW, by all concerned, including her family, despite her wishes being in no-one's best interests and in fact being fairly unrealistic (she only stayed with her parents for approximately ten days, until it became untenable for all concerned).

KW refused all services, apart from some basic equipment, such as a perching stool and a bath board. There is no indication that any other services, (for example, the school or GP) were informed of KW's decision to leave hospital, nor of her decision to refuse care support from Adult Social Care and therefore the risks this posed to her children. Further, there were significant implications for other adults in her refusal of care services; she had care and support needs and, if these were not going to be provided by commissioned care providers, one of her family members would have to do so, or her needs would be neglected. This is a significant area of concern that may have been discussed to an extent, but which did not, it seems, initiate a response that was proportionate to the risk, partly because KW was considered to have mental capacity to make this decision, however

unwise it may have seemed and because focus was on her as an adult, not on her children and not on her parents. This is an important area of learning, not just in Stockport, but nationally.

The Department for Education notes in its Triennial Analysis of Serious Case Reviews 2011-2014[5] that a number of reviews highlighted situations where children had not been seen because assumptions were made about them. This Joint Review was clear that assumptions were made about KG in practitioners contact with him and KW; his mature and sensitive approach meant that he was seen as being able to cope and there being little impact on him. For example, on one occasion, where KW was displaying psychotic behaviour and was, '*covered in faeces'*, he was described by attending Police Officers as being '*independent'* and not distressed. However, KG described this event when met as part of the Joint Review process in traumatised terms. ***This is a significant learning point about not making assumptions about what a child is thinking or feeling, nor about the impact of the harm on them necessarily being seen in their responses.***

Where adults are considered, in the terms of the Mental Capacity Act (2005) to have capacity to make 'unwise' decisions, responsibility for supporting them to manage the associated risks and for mitigating the impact on other who have rights, such as children or carers is of utmost importance. ***This is an important learning point for this review.***

3.1.3.3 Learning: The importance of conducting honest and respectfully challenging conversations with people

It is important for practitioners to have ***honest and difficult conversations with adults that are focused on risk***, ***understanding and supporting their own rights but also the rights of others***. This is essential when children are involved and the adult's decisions potentially impact negatively on their welfare. It is important that frank and open conversations take place with the person about the choices they are making, especially when these decisions have implications and impact upon others, particularly children. There is a sense, from the information provided throughout the whole time period covered by the Joint Review, that KW presented as challenging and the potential of her disengaging was such that important conversations with which she did not agree were easier to avoid. This is natural, but is unhelpful on a long term basis and the avoidance of those discussion seen during this episode laid the foundations for the dynamics within and the way in which KW's relationships with agencies functioned.

Practitioners need to be supported to have clear and honest conversations with people about their own responsibilities; this is a vital part of working with people on an equal basis, where they are a part of the solution, have control and influence over their lives, are empowered and are not being 'done to'. ***This is an important learning point for this review.***

When KW was self-discharging on 05.07.2013, a number of practitioners were involved in trying to manage the physical and care-related risks to her and to address the home situation. The speed at which this needed to happen as a result of KW's decision and insistence on the timing of it, meant there was little time for joint planning as a partnership. There is no question that KW was leading the events on 05.07.13 and there was little opportunity to consider the needs of and risks to others.

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[5] Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014
Peter Sidebotham*, Marian Brandon**, Sue Bailey**, Pippa Belderson**, Jane Dodsworth**, Jo Garstang*, Elizabeth Harrison*, Ameeta Retzer* and Penny Sorensen** *University of Warwick
**University of East Anglia - DFE May 2016

3.1.3.4 Learning: Multi-agency risk assessment and management with people and across adults and children's services

HSW 1 met with KW on the ward and carried out a needs led Community Care Act assessment with KW. As part of her assessment, HSW 1 also spoke with KW's parents separately, seeking an understanding of KW's support needs and also her history and their own ability to provide support. This was good practice; talking with the whole adult family about what was needed. HSW 1 also liaised with FSW 1. FSW 1 advised that she had planned a home visited post-discharge with SSW 1 from Werneth School. This is ***good partnership working across adult and children's services*** and is to ***be commended***.

However, the practice could have been greatly enhanced had there been a cross-adult and children's services risk management meeting of Adult Social Care hospital staff, NHS staff, Werneth school pastoral staff and Children's EHP practitioners. This would have allowed for discussion that would ensure consistent understanding of the current situation, the range of different risks presented with the views of all the family members at the core of the discussion. It would have allowed for development of a realistic, strong partnership risk assessment and management plan, with contingency built in. This would have allowed KW's right to be supported but also consideration of the rights of others, including her children. This could have been talked through and owned by the family and the agencies involved. This plan could have therefore ensured that the risks to KG and his brother, as well as those to KW and her parents could have been explored with a clear understanding of legal duties and frameworks within which the different agencies worked, together with a clear and agreed plan for additionally involving relevant organisations such as Stockport Homes and Environmental Health services.

The benefits to this approach are that it:

- Enables people's voices to be heard – *all* of those involved (in this case, including KG and his brother's)
- Acknowledges and enables shared understanding of the rights of all those concerned;
- Develops a shared understanding of the lived experience of the adults and the children and their perspectives, informing the knowledge and assessment of risk across partnerships and within families
- Supports people to make informed decisions based on risk and the options available to manage that risk
- Helps people to have choice and control over their lives
- Builds upon someone's strengths and resources, the support of family and other informal networks.
- Helps people understand their responsibilities and the implications of their choices, including any risks
- Helps people to understand why other actions may be needed to keep other people safe, including children
- Provides opportunity for confirmation of the person's understanding of risks and of the advice being provided to them, together with any requirements for action for the person and from agencies
- Achieves better understanding of the impact of the plan on the family's quality of life.

The ***importance of developing a multi-agency, realistic risk management plan that is focused on the views, wishes and feelings of all family members, that understands the individuals' rights and***

clearly allocates roles and responsibilities with families, as well as agencies, is an ***important area of learning in this review***.

3.1.3.5 Learning: Understanding the needs of carers

KW's father expressed his concerns to HSW 1 about how he and his wife would cope with KW and her sons at home. There is no information to suggest that that they were offered a carers' assessment, that the concerns he raised were addressed nor that this informed any risk assessment. The importance of working with informal carers and offering carers' assessments is underlined here and may be an important lesson from this review; the fact that four years have passed since this time may well mean that use ***carers' assessments is embedded in Stockport***. However, this is ***a question to be considered by the SSAB***.

Information had been received from two sources, KW's GP and the school about KG's caring role. This issue is considered in greater detail later in this report.

The information provided by relevant agencies about this episode refers to KG and there is no doubt that FSW 1 was focusing on his needs as well as those of KW. However, a theme of agencies focusing greater attention on KW than on KG is present throughout this Joint Review. This is unsurprising in some ways; KW's needs and / or her resistance to services drew and absorbed practitioners' main energy and focus. However, this was at the detriment of their ability to really seek and understand the views of her children. KG, who was just age 13 at this time.

A Team around the Child (TAC) meeting was held on 17.07.2013 and School Nurse 1 took away an action to refer KG to Signpost Young Carers' Service. However, she struggled to gain consent from KW to do so. This matter is considered in more detail separately in this report, (see 3.2.3.3) but it is important to highlight the additional challenge experienced by KG in gaining support as a child carer.

KG was a child carer of KW for the whole period of this Joint Review. While his school in particular identified this as an issue, there was a lack of a joined or focused up approach to supporting him and understanding the impact of this role on his emotional well-being and on his day to day life. There is extensive research available about the experience of young people who are carers. ***This is an important area of learning for this Joint Review; both statutory boards are asked to consider the benefits of undertaking joint learning around this important area.***

3.1.3.6 Learning: Seeking the voice of the child

Agencies seemed to have little understanding of what KG wanted or hoped for during this episode and his views about what would be best for his future were not apparently sought. ***The voice of the child or young person must always be sought when practitioners are working with children at risk of, or experiencing harm.*** This episode was early in agencies' contact with this family, but there was already information held by Werneth School, by the EHP and by KW's GP Surgery about KG experiencing harm. Practitioners should be encouraged and supported, through supervision and guidance, as well as through training to ***always seek to understand the child or young person's world***; try to ***gain their trust and empower them to speak up and express their hopes and fears and to give their views*** on what should happen. This is an ***important learning point*** from this Joint Review that will have been highlighted before in Stockport, and also nationally; the challenge is less about providing practitioners with the knowledge that this is important, but more about enabling

them to have the capacity, encouragement and support to do so. ***The SSCB is therefore asked to consider how it can gain assurance that this happens effectively across its member agencies.***

3.2 Key Practice Episode 2: 21st May 2014 – 9th June 2014

3.2.1 Why this episode is of significance:

This episode is important because it covers the period of time when:

- KW's brother became more involved in the family's life and visited school with KG and spoke with PM 1 at Werneth School, with KG opening up about what was happening at home;
- KW was admitted to Stepping Hill Hospital and disclosed that she had been assaulted two weeks previously;
- KW accepted mental health services and RMNH 1 was allocated to support her when she returned home two days after her admission;
- KG and his brother moved to stay with their grandparents. This led to the child protection plan ending and stepping down to an s17 Team around the Child (TAC) plan led by the social worker.

3.2.2 Brief summary of episode:

On 13.10.2013, KG and his brother were made subject a Child Protection Plan due to neglect. This followed the school's persistence in raising concerns about KG and his brother's welfare and his concerning presentation.

KW did not attend any Core Group meetings or Review Child Protection Case Conferences and appears to communicate with SW 2 only when this is helpful to achieving a practical goal, such a welfare benefits. In March 2014, the family were evicted from their home and SW 2 supported KW in delaying this to allow the family to be re-housed by Stockport Homes. Shortly after this was achieved, KW refused to communicate with him further, stating that she would be challenging the decision for the boys to be on a Child Protection Plan. KG was fourteen and his brother, who left home some months previously was seventeen.

In May 2014, KW's brother began visiting the family more regularly, having been away from Stockport for a while. On 21.05.2014, he went to school, with KG and asked to meet with PM 1. In this meeting, KG opened up about what life was like at home. He described the following:

- KW doesn't eat;
- He tries to make her eat bread to soak up the whisky but she refuses;
- KW drinks litre bottles of whisky but is then doubly incontinent;
- KG is worried about her liver;
- He has been looking after KW on his own since his brother left;
- He is worried that if she falls and breaks her legs it will be his fault;
- He described an incident from the previous Sunday where KW's behaviour was what appeared to be paranoid.

As a result, KW's brother moved KG from the family home to stay with his parents, KG's grandparents.

SW 2 sought support from GM Police to undertake a welfare check, SW 2 informed the police that the child had disclosed that his mother was drinking heavily and that she was not allowing the SW

access to the property. However, at the time of the request, Police advised they had no available officers. Follow up calls were made to the out of hours social care duty team who had no knowledge of the request. The police therefore delayed the matter in order to make contact with SW 2, who later advised the police that the children had moved out of the property.

The following day, her brother visited her to discuss the matters raised by KG. However, he found her on a baby changing mat on the floor, squashed between two chairs, covered in vomit and faeces. Animal faeces were also present on the floor. KW was admitted to Stepping Hill Hospital, where she was treated for alcohol withdrawal and acute delirium resulting from dehydration. On admission, she gave an account of alleged assault / sexual abuse that she said had taken place two weeks earlier. She also stated that she had experienced vaginal bleeding. A safeguarding concern was raised by ward staff and was received by HSW TM 1. HSW TM reflected on the impact of KW's mental health problems and her withdrawal of alcohol on this disclosure. It is unclear if the sexual assault was also disclosed to HSW TM1. He recalls that he contacted the police in relation to this referral. There are no records of this contact on police systems.

On 23.05.2014, KW was discharged and referred, with consent to Pennine Care NHS Foundation Trust, from where she was allocated RMNH 1.

On 08.06.2014, KW was taken to Stepping Hill Hospital after she was found in the road.

On 09.06.2014, a Review Child Protection Meeting was held and chaired by SW 2. The meeting decided that the fact that the children had both moved to live with their grandparents meant risk had been significantly reduced and so their names should be removed from the Child Protection Plan and 'stepped down' to a s17 TAC plan led by the social worker.

3.2.3 Evaluation of Professional Practice

The concerns about the welfare of both KW and KG that are seen in Key Practice Episode 1 gained a greater level of significance in this second Key Practice Episode. KG's description of his concerns on 21.05.2015, make difficult reading as does her brother's description of her presentation the following day.

3.2.3.1 Learning: Self-neglect

A number of IMRs, in this Joint Review, referred to knowledge during this and the previous Key Practice Episode of KW's significant and harmful alcohol use and of her self-neglect, coupled with her undiagnosed mental health problems. These issues were acknowledged by agencies as leading to her sons being neglected and so they were placed on a Child Protection Plan on 13.10.2013 under the category of neglect.

During this practice episode and the previous few months, KW's self-neglect had led to a number of grave incidents and cumulative concerning situations:

- Her children were placed on a child protection plan the previous October;
- Just a few months before, she had to be rehoused due to her difficulty in managing financially in the previous family home;
- She had been missing health appointments;
- Stockport Homes staff had visited the home and expressed concern about the condition of the property;
- Her brother had found her laying on the floor in vomit and both human and animal excrement;

- Her relationship with her boyfriend had broken down;
- Her eldest son had left home after their relationship had seemingly become untenable;
- She alleged that she had been sexually assaulted in May 2014 (further details unknown);
- She was admitted to Stepping Hill Hospital on 21.05.2014 in an extremely poorly state;
- An anonymous caller advised Children's Social Care that she was a 'chronic alcoholic who spends all her money on alcohol' and relies on KG to get her up when she collapses;
- She was again admitted to Stepping Hill on 08.06.2014 with apparent psychosis.

In addition, KG described his mother as not eating, of drinking bottles of whiskey and subsequently being doubly incontinent. He inferred that she is having alcohol-related falls and indicated that she is experiencing paranoid psychotic episodes.

These incidents and concerns co-exist with the knowledge by agencies that she hoards items in her home, that it is highly cluttered, and her parents and FSW 1 had considered her previous home as being uninhabitable. However, it should also be noted that photographs provided by GM Police at the Review Panel meeting held on 31st January 2018 and photographs in the possession of Stockport Homes also show that KW's bedroom was the location in the house that was uninhabitable; the remainder was relatively clean and tidy. Her self-neglect fluctuated and was, it seems focused on her bedroom more as she spent more and more of her life in her bed.

Despite this, there is information known at the time that evidenced that KW's self-neglect was becoming much more fixed and damaging to herself and to her sons during this period.

Self-neglect is an extremely challenging area of health and social care work. This is exacerbated when the self-neglect involves alcohol that masks underlying mental health problems. KW's refusal of Adult Social Care involvement in her life meant that the agency that would usually lead and coordinate multi-agency consideration of a person's own risks in terms of self-neglect was absent. The consideration of what was happening therefore was largely being considered from health perspective (by GP 1 and GP2, PN 1 and RMNH 1), and through a child protection lens, (SW 2 and Werneth School SN 1 and PM 1).

Self-neglect can be viewed as presenting in two ways; the first being one where a person's situation deteriorates in response to an event, for example as may be the case for an older person whose spouse dies. The second is where a person's circumstances lead them to make an active or passive choice that may be exacerbated through substance misuse. This latter is the scenario that KW experienced and which is much harder to address, especially where the person has the capacity, under the Mental Capacity Act (2005) to make an 'unwise' decision.

Research published in 2015 by the Social Care Institute for Excellence[6] concludes that:

'*Service involvement was found to be more successful where it:*

- *was based on a relationship of trust built over time, at the individual's own pace*
- *worked to 'find' the whole person and to understand their life history rather than just the particular need that might fit into an organisation's specific role*

[6] Self-neglect policy and practice: key research messages
Suzy Braye, David Orr and Michael Preston-Shoot - www.scie.org.uk

- *took account of the individual's mental capacity to make self-care decisions*
- *was informed by an in-depth understanding of legal options*
- *was honest and open about risks and options*
- *made use of creative and flexible interventions*
- *drew on effective multi-agency working'.*

The Care Act 2014 Care and Support Statutory Guidance[7] lists self-neglect as a category of abuse or neglect that may prompt a safeguarding enquiry. Under section 42, local authorities must make whatever enquiries they think necessary where an adult has care and support needs, is experiencing or at risk of abuse or neglect, [including self-neglect] and is unable to protect themselves because of their needs.

As noted previously, KW rejected offers of support by Adult Social Care and the response from other agencies to her apparently determined self-neglect was uncoordinated. As a result there was no overall analysis of what was happening or planning to inform a shared strategic approach to minimizing harm and there was little on-going communication between agencies about her situation. As a result, agencies were acting individually and one practitioner commented at the Joint Review Practitioner Event that they felt '*isolated and lost'* when trying to intervene and work with KW. ***When working with people who self-neglect, multi-agency working is essential***. It provides an opportunity for increased collaboration, shared decision-making and provides potential for a more creative approach to engaging with the person. ***This is an important learning point from this Joint Review.***

The SCIE Research highlighted above refers to the need to '*find the whole person and their life history*'. When practitioners try understand why a person behaves as they do, they are far more likely to be able to develop approaches that will support a person to reduce the behaviour that is causing themselves harm. Understanding a person's history is vital in informing us about how to work with someone. However, what is known about KW before her contact with social care services in 2013 is limited and none of the agencies involved in providing support to KW or safeguarding her children knew very much about her former partner, the children's father, the circumstances of their separation or much about the domestic abuse to which she had referred on a few occasions. Even less was known about her hopes, her fears and her possible shame around the interventions that she was experiencing.

There is no question that she put a great deal of energy into resisting conversations that probed beyond her immediate presentation of trying to prevent any form of engagement. However, Stockport NHS FT noted in its IMR that an Assistant Practitioner in the Acute Medical Unit at Stepping Hill Hospital had spent considerable time with KW building a rapport and this had resulted in her accepting medical interventions she had previously refused. Therefore, there was a potential for getting alongside KW in a non-threatening way, talking to her about her history and engaging with her in a way that was supportive. ***Understanding a person's lived experience, their wishes and feelings and their history is vital*** in working with anyone in a way that is focused on their rights and on empowering them to reduce risk of self-harm. ***This is an important learning point for this Joint Review.***

When KW was admitted to Stepping Hill Hospital on 22.05.2014, she was bleeding from her vagina and stated that she had been sexually harmed. However, she either could not, or chose not to give more information about what had happened. Given KW's history of non-engagement and resistance to service intervention, she needed careful support to enable her to trust and if possible, open up about what had happened. Stockport NHS FT staff from the ward raised a safeguarding adults

[7] https://www.gov.uk/government/publications/care-act-statutory-guidance/

concern in relation to this matter, in line with the multi-agency safeguarding adult's policy and procedures. However, on receipt, a decision was made by Adult Social Care to take no further action in relation to the concern. This decision took place without discussion with KW and, it appears with assumptions being made about the validity of her allegation. Given the serious, criminal nature of the allegation and physical manifestation of that harm, this is a response that will not have encouraged KW's trust or engagement with services. Regardless of a person's mental health or substance use, all allegations of serious harm should be looked into and only dismissed if there is clear evidence that they are entirely untrue; and such decisions should be only taken with extreme caution and decision-making well-documented and explained.

The SCIE research also refers to use of the Mental Capacity Act (2005) to understand a person's understanding of their own risk. The IMR produced for this Joint Review refers to health agencies undertaking capacity assessments on several occasions. However, these were undertaken (and referred to later in this report) in relation, appropriately, to specific decisions in respect of medical intervention. However, Mental Capacity assessments were not considered in relation to the risks that KW's self-neglect were causing her personally. Her Mental Capacity seemed to fluctuate and therefore this needed greater consideration, particularly in relation to the presentation of her mental health condition and alcohol use. Research undertaken by University College, London[8] found that women with severe mental illness are up to five times more likely than the general population to be victims of sexual assault and therefore this risk should be considered when assessing such safeguarding concerns. In addition, while the Joint Review considered that practice had moved no considerably in adults safeguarding since this incident, it is ***important that practitioners are aware of the need to talk through risk and concerns with the person themselves when making decisions about concerns raised within the multi-agency safeguarding procedures.***

Self-neglect became an adult safeguarding responsibility when the Care Act 2014 came in effect in 2015. This Key Practice Episode pre-dates enactment of the Care Act. However, the way in which the Care Act and accompany guidance describes the best practice response to such risks and harm, fits with the risk management and engagement described above.

3.2.3.2 Learning: Child Neglect

The multi-agency safeguarding children partnership involved with KW, KG and his brother was clear that they had been neglected and harmed. That neglect stemmed from KW's self-neglect, mental health condition and her subsequent inability to meet their needs. Following the decision made on 13.10.2013 to place the children's names on a child protection plan, KW refused attend child protection meetings and her engagement with SW 2 was minimal. For illustration of this, of four home visits that SW 2 undertook between April 2014 and 21.05.2014, on only two occasions was he admitted beyond the doorstep, and then only to the living room, no further.

On 21.05.2014, KG had disclosed to PM 1 at Werneth, with his uncle's support the nature of his home environment. This was highly concerning and SW 1 and colleagues from the school focused on his needs and arranged for him to move to his grandparents' home. The information received on this day was highly concerning and Stockport Children's Social Care and Early Help Service has highlighted a missed opportunity in communicating with Adult Social Care, Adult Mental Health services and GP 1 about KW's health and social care needs and the potential impact of these on KG. It also highlighted that when information was received the following day about KW having been

[8] Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J, Howard, L. (2015). Domestic and sexual violence against patients with severe mental illness. *Psychological Medicine, 45*(4)

admitted to Stepping Hill Hospital with 'alcohol detox and PV bleeding', this should have served as an alarm that initiated a core group meeting where legal options in terms of KG's welfare were explored. KG's name being present on a Child Protection Plan should have led to a heightened sense of concern about his welfare that meant that the two incidents described here escalated thinking into the next level of response; legal discussion and planning.

Stockport Family (and formerly, Stockport children's social care and early help services) uses the Graded Care Profile This is a specific tool to use with parents when issues of neglect are prevalent as a way to collectively identify issues of concern, grade the level of concern, and seek agreement on actions to make changes. The GCP can be reviewed at a later date to measure progress. The Graded Care Profile can contribute to the social workers holistic social work assessment of need/parenting capacity/risk etc. approach to risk assessment.

S30 of statutory guidance, Working Together 2013 is clear, (para 30) in stating that: '*practitioners should be rigorous in assessing and monitoring children at risk of neglect to ensure they are adequately safeguarded over time. They should act decisively to protect the child by initiating care proceedings where existing interventions are insufficient*' and, (para 47):

'*Assessment is a dynamic and continuous process which should build upon the history of every individual case, responding to the impact of any previous services and analysing what further action might be needed*'.

The responses to the incidents of 21.05.2014 and 22.05.2014 were not in line with these requirements and while there was effective information sharing between adults and children's services at this point, and the needs of KG were paramount in considerations in terms of his safety after the disclosure on 21.05.14, the requirement to respond to changed circumstances and adapt the response to families did not take place. Convening a core group meeting to review the current plan and, as noted previously, consider legal duties and powers would have been good practice. It is essential that practitioners are alert to and recognise new or increased risks, being prepared to escalate plans and take safeguarding action at any point, if and when it becomes necessary.

It is unclear, however what the plan for working with the family was at this point. A positive outcome seemed to be when KW engaged with a practitioner, although this engagement was almost always on her terms and rarely related to the needs of KG or his brother. The one exception was when SW 2 had a challenging discussion with her on 12.05.2014 about her alcohol use. This was **good practice** and could have been enhanced had there been further discussions and related planning that built on this.

Although the two boys had been on a Child Protection Plan since 13.10.2013, over six months, the Joint Review gained no sense of what KG's views were at that point, nor of what the overall plan was for improving their day to day lived experience. It well-known that working with parents who have mental health problems and misuse substances is challenging, can be overwhelming and can often result in practitioners focusing their energy and concerns on the adult, rather than on the child(ren). ***Practitioners need time, space, guidance, support and opportunity for reflection from their employing organisations to maintain focus on the child in when working with families where adults' circumstances are those experienced by KW***. While the Joint Review has not identified a lack of opportunity for reflective practice in any participating agency, this is such a significant area of practice development for all practitioners that there is benefit in Local Safeguarding Children Boards gaining assurance on a periodic basis that such opportunities are made available and encouraged within organisations supporting families and safeguarding children from abuse and neglect.

In undertaking assessments where children and young people have been neglected, it is not only important to focus on a child's wishes, feelings and needs as well as those of the parent, but also, having understood their needs, to translate them into actions with the whole family that address the parents' harmful behaviours and achieve measurable, improved outcomes for children and young people. Working with adults in circumstances like those of KW is difficult and best achieved with the involvement of specialist mental health and substance use support. This episode shows SW 2 engaging well with RMNH 1 and also sharing information with Adult Social Care. However, actively involving specialists at an earlier stage to advise and inform the child protection plan could have given the core group and SW 2 more of an understanding of how to work effectively with KW and influence her behaviours. This would have been of particular benefit, given the context of her avoidant behaviour and subsequent lack of formal diagnosis or understanding of her mental health and alcohol use. ***Seeking specialist involvement from adult mental health and substance use practitioners can help safeguarding core groups be aware of the risk of being over optimistic*** and of believing a convincing parent reporting their substance use and the impact on their day to day living. ***This is an important area of learning for this Joint Review.***

On 09.06.2014, nineteen days after KG had returned again to live with their grandparents, a Review Child Protection Case Conference was held. This multi-agency meeting agreed unanimously that KG's name should be removed from a Child Protection Plan and 'stepped down' to a Team around the Child Plan led by the social worker. The evidence that supported this decision was that he had moved to live with his grandparents. However, as the Joint Review Panel has discussed and Stockport Children's Social Care and Early Help Service as well as other partner agencies identified in their IMRs, all other evidence pointed to KG being at significant emotional risk at this point, given his mother's mental ill health, there remained no engagement with her and history showed that he often stayed with his grandparents for a relatively short time before returning home. There was an absence of a robust contingency plan having been developed to accompany the 'step down' and mitigate against KG's risk of harm from KW's behaviour, regardless of where she lived.

Over recent years, much more has been learned about childhood neglect and its impact on children's development and their mental health. The greater Manchester Neglect Strategy (2017), to which Stockport works, comments that, '*Child neglect is a complex issue; too often it takes us too long to recognise the impact it is having on our children'*.

Working Together to Safeguard Children[9] provides an overarching definition of neglect:

"*The persistent failure to meet a child's basic physical and/ or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maltreatment substance abuse. Once a child is born, neglect may involve a parent or carer failing to:*

- *Provide adequate food, clothing and shelter (including exclusion from home or abandonment);*
- *Protect a child from physical and emotional harm or danger;*
- *Ensure adequate supervision (including the use of inadequate care-givers); or*
- *Ensure access to appropriate medical care and treatment*

It may also include neglect of, or unresponsiveness to, a child's basic emotional needs."

[9] Department of Education (2015), page 93

These criteria were all features of KG's life at different points of the period time under review. This had not changed as he moved to stay at his grandparents' home.

Good practice in working with families where children have been neglected is based on thorough and careful recording and analysis of relevant events in a child's life and understanding the parent's history to inform understanding of their behaviours as adults and of potentially effective interventions. As noted already, little was known about KW's own childhood and her past; she was a fiercely private person. Neglect is cumulative and made up of the consequences of repeated failure to meet a child's basic needs; often that cumulative impact begins to be seen as children become teenagers. At the start of the time period for this this Joint Review, KG was 13; he had already experienced some years of neglect and this didn't change prior to his mother's death.

The very nature of neglect means that good recording and good skills in interpreting chronologies are vital practitioner attributes. The Joint Review did not receive information that indicated that this work had taken place with this family. Stockport Children's Social Care and Early Help Service has commented in its IMR that the decision to step down from the TAC plan and close the case was not completed on the system until three months had passed.

There is important learning from this review about using the tools and guidance that are issued by SSCB through its extensive neglect training and as part of the Greater Manchester Neglect Strategy to bring a systematic approach to understanding families and improving outcomes for children and young people. In particular, chronologies help understand what is happening for a child over a period of time, revealing patterns and trends and revealing gaps and omissions. ***Learning from this review includes the importance of encouraging and supporting a systematic approach to understanding a family's history, analysing chronologies to understand behaviour patterns and requiring and supporting practitioners to record well.***

3.2.3.3 Learning: Balancing the wishes and rights of adults with care and support needs and their children

KW's wishes and needs, while not expressed verbally, were well-known to agencies; in essence, they were to leave her be. KW, when with full mental capacity had this right as an individual. And agencies understood that, and respected it. They therefore allowed her to make decisions that were not necessarily in her best interests. This was absolutely in line with the Mental Capacity Act (2005) principle:' *People have the right to make decisions that others might regard as unwise or eccentric. You cannot treat someone as lacking capacity for this reason. Everyone has their own values, beliefs and preferences which may not be the same as those of other people'.*

Underpinning this is the basic rights set out in the Human Rights Act (1998): the right to liberty (Article 5) and the right to private and family life (Article 8). However, those rights extend only as far as the person's choices impact on the human rights of another. KW's choices were impacting entirely on the rights of her children to their human rights and specifically, her actions, or inactions impacted on KG's right (Article 3) not to be tortured or treated in an inhuman or degrading way. This latter article encompasses experiencing harm that causes distress and suffering and is directly relevant to KG's experience.

In addition to KW's choices regarding her own life impacting on KG and his brother, the decisions she made in relation to KG's wellbeing, such as refusing consent for support from carers' support services or health assessments impacted on his rights. Practitioners struggled with how to handle

her refusal to provide consent. Practitioners would benefit from practical support to assist them in such situations.

The response of practitioners to KW and KG and his brother as a family would have been improved if there had been an understanding of the interplay between their rights and the need to ensure that essential human rights were addressed before considering the rights a person has under legislation such as the Mental Capacity Act (2005).

Practitioners need to be skilled in understanding and promoting the duties set out in the Human Rights Act (1998) and the way in which they can work with families to both support these rights, but also ensure that others in the family network have their rights supported as well. More information about this approach is available on the British Institute of Human Rights Website: https://www.bihr.org.uk/ . ***Practitioners need practical and focused support and guidance about how to balance parental refusal of consent for access to services and support that a child or young person needs.***

3.3 Key Practice Episode 3: 07.04.2016 – 09.05.2016

3.3.1 Why this episode is of significance:

This episode is important because it covers the period of time when:

- KW alleged that her eldest son, (who was living with her again) had been discussing how to end her life with friends in her house and she had asked him to leave, which he did;
- KG was living with KW and on 15.04.2016 was so worried about her mental health problems that he called an ambulance but would only talk to paramedics in the street;
- KW was 'covered in faeces' and 'incoherent'. She was taken in an ambulance to Stepping Hill against her expressed wishes, under the powers of the Mental Capacity Act (2005) and KG went to stay with his grandparents; KW self-discharged a few days later;
- KG returned home and KW's sister became involved, seeking help from a range of agencies;
- Five months later, after her death, KG referred to this admission as being the last time his mother had left the house.

3.3.2 Brief summary of episode:

On 07.04.2016, KW telephoned GM Police to raise her concern that her eldest son, (KG's brother) and his friend were in discussion how to kill her and make it look as though she had experienced a heart attack. Checks were completed by the radio operator and the matter reviewed with a plan for an appointment at 15:00 that day, but the incident was not the allocated at 15.00 and a visit did not take place until later that day, a police officer attended and undertook a DASH, (Domestic Abuse, Stalking and Honour Based Violence) risk assessment. The risk assessment concluded that the risk was medium because KW's eldest son had left the property; no information was provided or sought regarding KG, it is not known if he was present at the time of the visit. When a specialist officer reviewed the incident, a domestic abuse marker was placed on the property, and KW referred to Adult Social Care. On receipt of this referral, Adult Social Care sent a further referral to the MASSH.

This was received on 14.04.2016. MASSH staff spoke with KW and with her father, who had been caring for KG previously; both refused support.

On Friday 15.04.2016 at 02:37am, KG had been so concerned by his mother's paranoid behaviour and threats that he left the house and called 111, talking to NW Ambulance staff on the street, as he was fearful of returning. KG also described his mother as being 'covered in faeces'.

NW Ambulance Service staff were greatly concerned for KW, highlighting her apparent malnutrition, the number of empty alcohol bottles in her room and her presentation and mental state. They considered that she needed to attend hospital, although not necessarily immediately, but they considered she did not have the mental capacity to decide whether or not to do so. The crew contacted an Out of Hours GP who advised they should take her if they were concerned for her welfare, but otherwise, as this was now 4.25am, to wait to see a GP from her own surgery. The Out of Hours GP was aware of KG's presence. It is not possible to know what information was sent to the GP practice as the electronic transfer was not working well at that time. (This has been since rectified).

Information about this incident was received by the MASSH the same day, (it was a Friday) and it was decided that a Rapid Response CAF Coordinator be allocated on the Monday, 18.04.2016. Later that evening, KW's sister called the Out of Hours Service, expressing great concern about KW and KG's welfare. The Out of Hours Service responded by conducting an unannounced visit at the home the following day, but they received no answer at the door. They also contact GMP on 16th April 2016 at 17:12 hrs. The log was risk assessed and closed; a police officer was not allocated to the incident. The following day, on the Sunday afternoon, KW telephoned Police to 'complain' about KG. A response officer was allocated and upon arrival requested an ambulance attend; paramedics described her as '*not making sense'* when they arrived, being confused, resistant to treatment, emaciated and, '*covered in dried faecal matter'*. She refused to go to hospital and so ambulance staff made a Best Interests decision under the Mental Capacity Act (2005) and took her to the Emergency Department at Stepping Hill Hospital.

On Monday 18.04.2016, the MASSH progressed the decision made on the previous Friday 15.04.16 and allocated a Rapid response CAF Coordinator. As a decision had been made the MASSH did not review the records about what had happened over the weekend and therefore did not review the decision that had previously been made. In the IMR, Stockport Children's Social Care and Early Help Service acknowledges that had the weekend's events been reviewed in the MASSH, a different decision would have been made to initiate a statutory social work assessment.

On 21.04.2016, KW advised medical staff on the ward that she wished to go home and would be discharging herself. She was advised by WRR 1 that her White Blood Cell Count and her Electrolyte Imbalance could lead to sepsis, cardiac arrest and death. She was considered to have mental capacity to make this decision and against medical advice, went home. Five days later, Werneth School informed Children's Social Care that KG had returned home again.

3.3.3 Evaluation of Professional Practice

This final Key Practice Episode shows a number of concerns that have been discussed at earlier points in this report, particularly in terms of learning around multi-agency safeguarding and managing risk, child and self-neglect. However, KW's health had deteriorated further by this time and so the concerns, risks and potential impact of harm were greater.

3.3.3.1 Learning: Think Family / Strengthen Families and Communities

This short period of time, essentially just a few weeks, was, in hindsight, the start of KW's physical, emotional and mental decline that culminated in a final crisis five months later. KW had been treated for cancer in the previous year, having undergone surgery and chemotherapy. KW participated in the treatment regimens and attended the majority of appointments. She had not, however attended mental health service appointments with an Early Intervention Team Practitioner, EITP 1, who had taken responsibility for supporting her from RMNH 1. KW was therefore discharged from the Early Intervention Team in March 2015, a year before this episode.

KW's mental health problems had reportedly been fairly stable during this period, however, and in September 2015, she had been admitted to Stepping Hill Hospital with physical problems associated with her health programme and had received an Occupational Therapy assessment. She had refused an Adult Social Care assessment, but no concerns were recorded about her mental health problems. Subsequently, however, her mental wellbeing declined in March / April 2016.

KW's concerns about her eldest son's behaviour on 07.04.2016 were handled by GM Police as a domestic abuse concern and a referral was made to Adult Social Care. However this was not accepted as a safeguarding adult's referral, by the receiving agency, Adult Social Care. That decision is Adult Social Care's legal duty. However, by making this referral, GMP was working in partnership and sharing important information of concern about the family. On receipt, Adult Social Care ATM CS 1 checked the system and noted that Children's Services had involvement with the family and so passed the referral to the MASSH. The MASSH received this on 14.04.2016, seven days later. The reason for this delay is unclear.

On receipt of this referral, MASSH SSW 1 decided to contact the family and ensured that both KW and her father were spoken to. KW's father commented that KG had just returned home and both he and KW refused support. This information did not alert the MASSH to take different action, despite the history that was known and the potential risks to KG. No further action was taken as a result. It would have been appropriate practice to speak with KG at this point and conduct a home visit to establish an understanding of the home situation and his current lived experience; the description of the incident on 07.04.2016 was concerning, especially when seen in the context of the family's history.

In addition, given the fact that this information had been received as a result of information being shared by Adult Social Care, it would have been a good opportunity for the MASSH to build on that ***commendable positive practice*** and a cross-adults and children approach to convene a multi-agency, children and adults safeguarding risk strategy meeting. This would have enabled all practitioners in adults and children's services across health and social care, together with GM Police to share their concerns, reflect on the history and develop a robust plan, with, ideally KW, her parents and KG. This learning is in some ways at the heart of this review; often practitioners in adults services and in children's services are focused on their own area of work and either do not consider broadening their considerations to include the other, or feel uncomfortable about doing so, as a result of a lack of understanding of its culture, legal frameworks or practice. There has been considerable work undertaken in Stockport in the past year embedding an increased joined-up approach between adults and children's services. This is not just positive, it is essential, as situations such as this illustrate.

Nationwide, the division between adult and children's social care is wide, having been separated as a result of the introduction of the NHS and Community Care Act (1990) and the Children Act (1989). The 'Think Family' initiative, introduced as part of the 'Every Child Matters' programme in 2003 acknowledged this and has had a positive impact in some areas. This initiative, which has had various

names in different parts of the country is intended to encourage practitioners to see the whole family and consider how their needs interact. This consideration is informed by understanding individual needs, while also considering how these relate together to inform an assessment of the needs and strengths of a whole family**.**

The work of the MOSAIC Service in Stockport is a good example of this approach. Strategically, the local authority, together with partners in Stockport have already identified the significant benefits of aligning services across family experiences to deliver joined-up outcomes with communities and citizens. The commitment in the Stockport Council Plan 2018[10] to progress this approach with the development of an '*All-age, Strengthening Families and Communities Strategy'* will involve , 'closer alignment and pooling of resources, structures and systems across our partners, targeting resources to build personal and community resilience of those most in need whilst maximising the potential of inclusive, universal provision'. This strategic commitment is intended to achieve this important cultural and systemic change. ***This is significant learning from this Joint Review; Adult and Children's services must work together to consider risk where families include an adult with care and support needs and a child experiencing or at risk of harm.***

While the Joint Review is aware and supportive of significant work being undertaken by the local authority and its partners to address this issue, it remains an area of important learning that requires emphasis in this report; ***the 'Stockport All-age, Strengthening Families and Communities Strategy' is intended to make a substantial difference to the ability of agencies to follow restorative practice principles and improve outcomes for both children and adults in families and communities. This is an area of essential learning for Stockport from this Joint Review and the approach set out in the Council Plan 2018-19 provides the strategic blueprint for its achievement.***

The following day, on 15.04.2016, KG, who was 16, was so worried about how his mother was behaving that had called 111 for help and would only speak with ambulance staff outside the house, because he was so anxious about her and scared. This was at 02.37 in the morning. KG subsequently discussed what had happened that night with the SSCB Manager and one of the Joint Review Authors. He described a level of paranoia, where KW accused him of trying to harm her and suggesting the air was full of sulphur; this must have been frightening for him and his decision to call emergency services, which felt, he explained later, like a betrayal, illustrates how worried he was. It also indicates the high threshold he had for concern about what was happening at home and what his 'normality' felt like.

The ambulance crew recorded on this visit that KW seemed to be self-neglecting; little had changed since their last visit two weeks before. On examination it was recorded that KW was emaciated, and was living in the bedroom, surrounded by alcohol bottles; her clothes were covered in vomit and faeces. KW refused further treatment and both the NWAS crew and the Advanced Paramedic considered that she lacked capacity to make decisions about further treatment; this was confirmed by their assessment of her capacity in respect of this decision. The NWAS crew decided to check this decision with an Out of Hours GP on call. This service is provided by, 'Mastercall'. Mastercall records state that a call was received 15.04.2016 at 4.25am from NWAS. The CCG advised the Joint Review that NWAS reported to Mastercall that KW, '*lacks capacity, change of medication, unable to obtain full history'*.

The Mastercall electronic record of 15.04.2016 states that:

[10] Stockport Council Plan 2018 ~ 19

'Ambulance crew concerned feeling she needs visit but not immediately i.e. not within next few hours, requesting visit though because they are not happy with patient.
Conclusion of Dr – GP to visit today.

Advice to ambulance crew: if they are concerned about patient welfare to take her into hospital on mental capacity act'.

The Out of Hours (OOH) GP was aware that KW's16 year old son was present. The CCG advised the Joint Review that, '*There is a robust electronic transfer from Mastercall to GP practices every morning however at this time the GP practices system had not been updated to the current system and any information was by e mail which the practice then transferred to the records. There is no evidence on the GP file that this information was received however as stated in the GP IMR there were some issues about the formatting of data when it was transferred.*

If the OOH GP had recognised this as a safeguarding issue, the GP should have raised a safeguarding alert and the safeguarding lead at Mastercall would have followed this up in the morning with the GP and if deemed appropriate social services'.

Two days later, when an ambulance visited again, on 17.04.2016, the NWAS crew repeated an assessment of her capacity to make decisions about her health and treatment needs and made a decision in KW's best interests, transporting her to hospital. This ***reference to and use of the Mental Capacity Act (2005) is positive and should be commended as good practice.***

4. Recommendations

This Joint Review has sought to identify learning themes that can enable Stockport SCCB and SSAB to support agencies in the area to learn and develop their thinking. The following form recommendations for the Board that are based on the learning identified throughout this process.

4.1 Information sharing

The Joint Review has identified several examples of agencies sharing information about risk in a proportionate and appropriate ways that is good practice. This is to be commended.

4.2 Partnership working

The Joint Review identified occasions where individual practitioners had focused solely on their own area of specialism in relation to both KW and KG, rather than also thinking more widely about their significant role within a safeguarding partnership. It is important that practitioners have confidence in the significance of their role and how it is necessary for a partnership to work effectively and achieve positive outcomes.

4.3 Understanding that an adult's right to make 'unwise decisions' under the Mental Capacity Act (2005) does not supersede a child's human rights.

There were a number of occasions within this Joint Review where KG was not perceived as a child and where his own human rights were not considered because KW's were being understood through the lens of the Mental Capacity Act (2005), with its (vital) emphasis on self-determination, choice and control. That consideration, and the important stress on enabling adults to make their own decisions, regardless of how 'unwise'[11] they are can mean that practitioners working with adults do not consider the child's needs and that their energy and focus is on that 'unwise decision'. This can result in the practitioner's duties in safeguarding the human rights of that child are missed. This area of learning links with that concerning 'Think Family' / Strengthening Families and Communities. It is an essential and important message for all of those working in adults' services; understand the person's needs, but don't forget the potential impact of these on others for whom we have duties.

Additionally, practitioners need practical and focused support and guidance about how to balance parental refusal of consent for access to services and support for that child or young person's needs.

4.4 The importance of conducting honest and respectfully challenging conversations

Practitioners working in safeguarding adults and children have to be able to conduct professionally challenging conversations. However, all of us working in the field know how hard that can be. Practitioners need support in training and supervision to reflect and consider ways in which those conversations can be conducted in order to achieve positive and outcomes for adults and children that balance empowerment and protection.

4.5 Working with people and partners to develop multi-agency, realistic risk assessments and plans

Risk assessment is fundamental to achieving positive outcomes in safeguarding adults and children. This Joint Review found that practice could have been enhanced had there been joint risk assessment and planning that included KW, KG and, where appropriate, other family members. Working across boundaries and partnerships and with people themselves allows for risk management plans that are owned by the person, that allow early and effective identification of risk, improved information sharing, joint decision making and coordinated action. This approach should be encouraged across both safeguarding adults and children services.

4.6 Understanding the needs of carers

This Joint Review identified learning in respect of working with both adult and child carers. This is an important area of work that would benefit form a joint approach across both adult and children services. It is likely that the approach in Stockport to working with both adult and child carers has

[11] Mental Capacity Act (2005) Principle 4: A person is not to be treated as unable to make a decision merely because he makes an unwise decision.

changed in the past few years, but the two boards are asked to consider whether or not this is an area that remains one that could benefit from further work.

4.7 Hearing the voice of the child and young person

Working Together 2015[12] states that:

'*Effective safeguarding arrangements in every local area should be underpinned by two key principles:*

1. *safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and*
2. *a child-centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children'*.

The second principle was communicated initially by Lord Laming as a fundamental learning point from the Victoria Climbié Inquiry[13], of which he was chairman.

Child Protection practice has changed significantly since Victoria's death, and the need to talk to children in order to safeguard them effectively is well-understood. This Joint Review found that this was not achieved well in these circumstances and the Joining Review authors have reflected on whether this has been due, perhaps to KG being a teenager and to his apparent maturity. The Review asks that practitioners working in Stockport with children and young people are reminded therefore of the importance of hearing the young person's voice and ensuring it is neither missed nor given less credence as a result of the strength of the voices of adults around them. This reminder should also highlight the important role that advocacy services can play in supporting young people to express their views. Additionally, the SSCB is asked to seek assurance that practice is widespread in services providing support to children and young adults.

4.8 Understanding and working with people who self-neglect

As noted in this Joint review, self-neglect is a challenging area of work for practitioners and agencies and an increasingly identified feature of some adults' lives. The Joint Review has highlighted the need for adult services in Stockport, (in common with the majority in England) to consider self-neglect in a the context of findings made by Michael Preston Shoot, Suzie Braye and David Orr in their 2015 publication of research on the subject[14]. They highlighted five important themes from their research interviews with people who self-neglect:

- the importance of relationships
- 'finding' the person
- legal literacy
- creative interventions
- effective multi-agency working.

[12] Working together to safeguard children: A guide to inter-agency working to safeguard and promote the welfare of children - HM Government: March 2015

[13] The Victoria Climbié Inquiry – Report of an Inquiry by Lord Laming
Presented to Parliament by the Secretary of State for Health and the Secretary of State for the Home Department January 2003

[14] Self-neglect policy and practice: key research messages - Suzy Braye, David Orr and Michael Preston-Shoot – SCIE 2015

This Joint Review has noted that all of these themes resonate with KW's experience and asks that the important learning set out in that research is considered by the Stockport SAB and where considered helpful disseminated to those working with adults and families in Stockport. This should include consideration of the Mental Capacity Act (2005) requirements in relation to self-neglect.

4.9 Child neglect: understanding the causes and links to adult self-neglect

The Review Panel in this Joint Review understood only too well the link between KW's self-neglect and the neglect of her children. However, this was aided by the advantage of hindsight. This Joint Review asks that practitioners are urged to seek support in situations as complex as that experienced by this family. The learning from this Joint Review has shown that practice can be supported and enhanced by involvement of practitioners from mental health services. These may be statutory agencies or perhaps third sector, but seeking that support in children's safeguarding services is vital. Additionally, enabling those practitioners to have the time and opportunity and providing them with the skills to self and peer reflect on their work is important. This Joint Review recommends that this approach is endorsed and encouraged across adult and children's services in Stockport.

4.10 Think Family: Strengthening Families and Communities

This learning is a significant area of focus for this Joint Review that was understood at an early stage of the review process. The need for services to work across boundaries and in partnership within adult and children's services is now a given, but the gulf *between* adult and children's services that was initiated with the enactment of the Children Act (1989) and the NHS and Community Care Act (1990) has resulted for some services in a lack of understanding, coordination and joint working between the two. The 'Think Family' policy that was promoted as part of the 'Every Child Matters' programme in 2003 was important in helping agencies to enable practitioners to work holistically with families as a whole, providing families with high challenge and high support within a restorative practice context. In Stockport, this approach has been successful and acknowledged by Ofsted[15], which rated its services for children and young people in need of help and protection as 'good' in August 2017. Further, Stockport intends to embed a strategic approach to Strengthening Families and Communities as part of the Council Plan 2018-19. This Joint Review supports these plans and wishes to endorse Stockport's commitment to espousing restorative practice and ensuring that practitioners understand the need to work with whole families, not just individuals. Working in partnership with parents and children as both individuals and families achieves a positive, inclusive approach to developing and delivering services that reflect what families say they want and leads to better outcomes.

Emma Mortimer
Dr Paul Kingston
March 2018

[15] Stockport Metropolitan Borough Council: Inspection of services for children in need of help and protection, children looked after and care leavers (Ofsted - August 2017)

Appendix 2 – Practitioner Key

Abbreviation / key	Role	Employing Agency
FSW 1	Family Support Worker	Stockport Children's Services: Early Help & Prevention
SW 1	Social Worker	Stockport Children's Services: Children's Social Care
SSW 1	Social Work Student	Stockport Children's Services: Children's Social Care, based at Werneth School
HSW 1	Hospital Social Worker	Stockport Adult Social Care, based in Stepping Hill Hospital
SWTM 1	Social Work Team Manager 1	Stockport Children's Services: Children's Social Care
HOO 1	Housing Options Officer 1	Stockport Homes, Housing Options Team
RMNH 1	Registered Mental Health Nurse 1	Pennine Care NHS Foundation Trust
OT 1	Occupational Therapist 1	Stockport NHS Foundation Trust
PN 1	Practice Nurse 1	NHS Stockport Clinical Commissioning Group
ATM CS 1	Assistant Team Manager, Contact Centre 1	Stockport Adult Social Care Contact Centre
MASSH SSW 1	MASSH Senior Social Worker 1	Stockport Family: Multi-agency Safeguarding and Support Hub
MASSH SSW 2	MASSH Senior Social Worker 2	Stockport Family: Multi-agency Safeguarding and Support Hub
OOH SW 1	Out of Hours Social Worker 1	Stockport Council Adults and Children's Social Care Services
SR 1	Specialist Registrar 1	Stockport NHS Foundation Trust, Stepping Hill Hospital
WRR 1	Ward Round Registrar 1	Stockport NHS Foundation Trust, Stepping Hill Hospital
EDD 1	Emergency Department Doctor 1	Stockport NHS Foundation Trust, Stepping Hill Hospital
RRCC 1	Rapid Response CAF Coordinator 1	Stockport Family

Abbreviation / key	Role	Employing Agency
GP 1	General Practitioner 1	BL Medical Practice
GP 2	General Practitioner 2	BL Medical Practice
SN 1	School Nurse 1	Stockport NHS Foundation Trust (SFT) School Nursing Service
PM 1	Pastoral Manager, Werneth School	Werneth School
PO 1	Police Officer 1	Greater Manchester Police
EITP 1	Early Intervention Team Practitioner 1	Pennine Mental Health NHS Foundation Trust

Appendix 3 – Glossary of Terms

Abbreviation	Term
CAF	Common Assessment Framework
CCG	Clinical Commissioning Group
GMP	Greater Manchester Police
GP	General Practitioner
NWAS	North West Ambulance Service
OOH	Out of Hospital
SAR	Safeguarding Adults Review
SCR	Serious Case Review
SSAB	Stockport Safeguarding Adults Board
SSCB	Stockport Safeguarding Children Board