Stockport Safeguarding Children Board

Serious Case Review in the Case of Child E

Period Reviewed 6th February 2017 to 26th September 2017

Final Overview Report

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1 Introduction and Background

This Serious Case Review concerns Child E, who was injured in an incident that took place on 26th September 2017. Child E had been born prematurely (at 28 weeks gestation) in March 2017, and was living with her mother in a mother and baby foster placement at the time that the incident took place.

1.1. Family Members

Child E – Child who is the subject of the review

EM – Child E's mother

EF – Child E's father

ES – Child E's older sibling

EMGM – Child E's maternal grandmother

EPGM – Child E's paternal grandmother

1.2 Practitioners and Agencies

All practitioners are anonymised in this report. Key practitioners are referred to by initials as set out below.

All agencies are referred to by name in full on first use with abbreviations in parenthesis. All subsequent uses are abbreviated.

Key for Practitioners

EFC – Foster Carer for Child E

ESW – Social Worker for Child E

FCSSW – EFC Supervising Social Worker

CG – Children's Guardian

SHV – Stockport Health Visitor

OHV1 – Oldham Health Visitor 1

OHV2 – Oldham Health Visitor 2

YPMW – Young Parents Midwife

PA – Personal Advisor for EM

1.3 Incident Leading to the Review

On 26th September 2017 EM had been out with Child E. When EM returned, Child E was put into her cot to sleep and EM left the house. EFC's attention was raised when she heard Child E make an unusual noise (described subsequently as a gurgle), and went to see Child E in her cot. EFC picked Child E up and found Child E to be floppy and unresponsive. EFC phoned for an emergency ambulance.

Child E was transported to hospital by ambulance. Medical examination showed that Child E had suffered a serious head injury, and had been found to have multi-location subdural haemorrhage, extensive retinal haemorrhages and encephalopathy characteristic of inflicted head trauma, caused by shaking.

1.4 Brief Background to EM and Child E

EM is a young woman who is a care leaver as described by the legislation.

EM had been known to children's services from the age of two, and was placed in the care of her grandparents when she was seven years old.

As a child, EM had experienced a number of adverse experiences, which were noted by the panel as being likely to increase her vulnerabilities in childhood and adulthood. Some professionals who worked with EM felt that she presented as a young person with learning difficulties (however this was not confirmed following assessment, see page 20).

In 2014 EM met EF through social media. At this time EM was living with her maternal grandparents on a Residence Order. After starting the relationship with EF, EM's relationship with her grandparents became difficult, she began to go missing from home and her behaviour became challenging. The placement broke down and EM was accommodated under Section 20.

EF's family had been known to children's services in Staffordshire since 2004. It was noted by the panel that EF had experience adversity in childhood. At the time of the review EF was a young adult.

In 2015 EM became pregnant with ES (EF was the father of ES). During the pregnancy Greater Manchester Police (GMP) received allegations from EM that EF had threatened to harm her and the unborn baby. Information was received by GMP from EPGM in 2016 regarding her concerns about the frequency of domestic assaults that were occurring between EM and EF. At this time EM was moving between Staffordshire and Stockport.

In February 2016 ES was born. Based on the social work assessment at that time, ES was placed with EM in a mother and baby foster placement. Whilst in the placement it became apparent that EM was unable to meet ES's needs, and professionals became concerned about ES's welfare. Although unknown to professionals at the time, EM continued her relationship with EF during the placement. Ultimately EM left the placement, leaving ES in the mother and baby foster placement. EM openly resumed her relationship with EF at this time and moved to live with him in Stafford.

In August 2016 an Interim Care Order[1] was granted and ES remained in foster care. ES was made the subject of a Care and Placement Order on the 4th January 2017. During the proceedings EM spent time returning to Stockport to see family and friends, and both she and EF attended some contact sessions with ES in Stockport.

In January 2017 Staffordshire Children's Services were informed by the Community Midwife that EM was pregnant with Child E.

Child E was born prematurely in March 2017. Child E required neonatal care due to premature birth and was cared for on the Neonatal Unit (NNU) in a local hospital (SHH).

Child E was made the subject of an Interim Care Order on 17th May and remained in hospital until discharge on 5th June 2017. Child E and EM then moved to a mother and baby foster placement (IFA) in Oldham.

On 26th September 2017 the incident leading to this SCR took place.

NB: A condensed chronology of contacts and key practice events is set out in Section 3 to provide further context.

2. Methodology

Following agreement that the case met the criteria for the conduct of a Serious Case Review, under the guidance set out in Working Together to Safeguarding Children (2015), the Local Safeguarding Children Board held a scoping meeting at which terms of reference were drafted and the methodology for the review agreed.

The review was conducted using a hybrid of the Social Care Institute for Excellence (SCIE) 'Learning Together' methodology in order to identify learning from practice, whilst looking at the safeguarding system as a whole.

The review was conducted by an independent reviewer who reviewed the written information provided, including individual management reports and a full chronology of events, records, minutes of meetings and other official documents; attended serious case review panel meetings, interviewed practitioners and authored the overview report.

A panel of senior managers was convened to oversee the review as set out below:

Agency	**Designation**
CAFCASS	Improvement Manager
Children's Social Care (Stockport)	Director of Operations
Clinical Commissioning Group (Stockport)	Named Nurse for Safeguarding
Pennine Care	Named Nurse for Safeguarding (Mental Health)
Stockport NHS Foundation Trust	IMR Author

[1] http://childprotectionresource.online/category/the-law/key-legal-principles/interim-care-orders/

Stockport NHS Foundation Trust	Named Nurse for Looked After Children (LAC)
Greater Manchester Police	Serious Case Review Team
LSCB	Business Manager
Lead Reviewer	Independent
Safeguarding Unit	Head of Service, Safeguarding & Learning
Safeguarding Unit	Service Lead for Safeguarding
* Fostering Solutions	Supervising Social Worker to Foster Carer

The panel met on seven occasions.

* Fostering Solutions attended one panel meeting in order to present their updated IMR.

2.1 Terms of Reference

The initial terms of reference were modified slightly following the first panel meeting. Agencies were asked to address the following in their written reports:

1. Recognising EF's role, the relationship, and the impact on a vulnerable mother.
2. The importance of cross border information sharing.
3. Recognition of the impact of domestic abuse and the appropriate assessment of risk.
4. Checks and balances within the system and how they support the assessment of risk – covering CAFCASS, managers, Legal Services, IROs and Foster Placements. With particular focus on the assessments and the analysis that had led to the decision to place in a mother and baby foster placement.
5. The use of mother and baby foster placements in a high risk context.
6. Learning from recent serious case reviews (particularly the SCR Improvement Plan) and the impact this has had on agency considerations.

Agencies were asked to focus on the following in addressing the TORs:

- *What was your agency's role/involvement in the pre-birth period?*
- *What was your agency's involvement in the post birth period?*
- *Did your agency engage with or take into consideration the role of the birth father?*
- *Does your agency routinely enquire regarding domestic abuse and did this feature in your engagement with this family?*
- *Did your agency agree with the decisions being made? If not what actions did your agency take?*
- *Did your agency share relevant information in a timely manner with professionals across borders?*
- *Have you identified similar learning in previous reviews and if so what action has taken place or is there a plan in place to address it?*

2.2 Information Provided to the Review

Agencies that had contact with Child E, EM and EF were asked to submit individual agency chronologies and supporting management reports or short reports (depending on their level

of contact). A multi-agency combined chronology was compiled which included information from all agencies.

The following agencies provided chronologies and written reports:

- Bridgewater Community Health Trust (Oldham)
- CAFCASS
- Children's Social Care (Staffordshire)
- Children's Social Care (Stockport)
- Children's Services (Derbyshire)
- Fostering Solutions
- CCG General Practitioner (Stockport)
- CCG General Practitioner (Oldham)
- Greater Manchester Police
- NHS Foundation Trust (Stockport)
- Pennine Care (Healthy Minds)
- Staffordshire Fire and Rescue Service
- Staffordshire Intensive Prevention Service
- Staffordshire Safeguarding Children Unit
- Staffordshire Youth Offending Service
- West Midlands Ambulance Service
- University Hospital North Midlands

2.3 Practitioner Interviews

Due to an ongoing criminal investigation, it was not possible for the review to hold a multi-agency practitioner learning event. However, the reviewer conducted interviews with those practitioners who were not identified as potential witnesses in any potential criminal proceedings.

Practitioners provided important insights to the review, which have informed the analysis of practice and learning. These insights are included throughout this report. Practitioners from the following agencies were interviewed:

- CAFCASS
- Children's Social Care (Staffordshire)
- Children's Social Care (Stockport)
- Pennine Care (Healthy Minds Service)
- Neonatal Unit – NHSFT (Stockport)
- Fostering Solutions

2.4 Family Involvement

EM and EF were informed in March 2017 that a Serious Case Review was taking place, and that they would be invited to participate. Due to ongoing police investigations and care

proceedings, it was recognised that there may be some limitations to engaging EM and EF at the start of the review. The panel agreed to monitor the progress of the criminal investigation and care proceedings with a view to inviting EM and EF to participate at a suitable time.

At the time of writing neither EM nor EF have been re-contacted to participate in the review.

3. Condensed chronology and key practice events

During the period under review Child E and EM had extensive contact with a range of services across three geographical areas – Staffordshire, Stockport and Oldham.

The condensed chronology set out below provides an overview of contacts and draws out key episodes of practice (KPEs) which are pivotal to learning (KPEs are shown in bold type).

3.1 9th January to 2nd February 2017

Staffordshire Children's Services (Staffordshire CS) had direct involvement with EM from 9th January 2017, when they were notified by the Community Midwife that EM was pregnant with her second child (Child E). The case was allocated to a Child and Family Engagement Worker in the Local Support Team. At that time it was reported that EF lived with his uncle and that EM was living with EPGM. The service was made aware that ES was currently in foster care in Stockport, and that adoption proceedings were in progress.

On 19th January that case was stepped-up to Stafford SSU due to previous concerns.

Staffordshire CS established and maintained contact with EM's Personal Advisor (PA) from the leaving care team in Stockport. The service liaised with maternity and midwifery services in Staffordshire, and began to put together a plan based on EM remaining in Staffordshire during her pregnancy and post-birth.

On 2nd February EM returned a call made by the Staffordshire social worker. She said that she was currently in Stockport as she had fallen out with EPGM, and that she and EF were planning to get a flat together in Staffordshire.

3.2 Critical Timeline/Condensed Chronology covering the period 6th February to 26th September 2017

On 6th February 2017, EM attended an appointment for a scan at Stepping Hill Hospital (SHH). EM spoke to Child E's social worker in Stafford and said she had decided she wanted to live with her mother in Stockport. EM was informed that Children's Services would continue to be involved with her due to the recent history with ES. Staffordshire CS then made a referral to Stockport CS. The referral contained information about the abusive nature of EM's relationship with EF.

EM made contact with her PA, who asked her if she was still in contact with EF. EM said that she had not seen EF for several days. She later told her PA that she had spent the weekend with EF. EF accompanied EM to the next meeting with her PA.

A week later EM met with the Young Parents Midwife (YPMW) in Stockport and was confirmed as being twenty four weeks pregnant. EM told YPMW that she had an appointment to meet with Child E's social worker (ESW).

During the following week EM met with her PA and said that she was going to Stafford to collect some things. It had been planned that EM would attend the domestic abuse drop in service, but said she had not done so because she had been at a hospital appointment.

On 28th February Staffordshire CS closed the case as EM and her unborn baby were now residing in Stockport.

On 1st March ESW visited EM at home. EM told ESW that she had previously suffered from post-natal depression, and that she struggled and felt criticised in the previous mother and baby foster placement. She gave this as the reason for staying in touch with EF at that time. EM said that with this pregnancy, she would choose the baby over EF and she hoped that she would be able to care for the baby at home with the support of her mother. She said that she was struggling with anxiety but that she didn't want counselling as it would be traumatic and may affect the unborn baby. ESW completed a SCOR analysis (Strengths, Challenges, Opportunities and Risks). EM identified significant events in her past that had led to vulnerabilities and discussed how she could address these.

ESW made considerable efforts to ensure that EM understood what was expected of her, and tailored planning and direct work to meet her needs, which was good practice.

Three days after this meeting EM presented to University Hospital Staffordshire Emergency Department experiencing difficulties relating to the pregnancy. EM was admitted and was later transferred to Royal Stoke Hospital for observation. Staffordshire CS duty team were informed of the admission and they notified Stockport CS. Whilst EM was in hospital staff noted that she was visited by EF.

Following discharge from hospital EM telephoned YPMW in Stockport to say that she had been in hospital. She said that she had been Staffordshire to collect belongings. She told her PA that she was afraid of EF and would be glad to get home to Stockport.

On 8th March EM presented to SHH following further complications with her pregnancy. She was admitted for observation and monitoring and remained in hospital for three days. Whilst in hospital EM told the midwife that EF was trying to contact her by text. EM was discharged from hospital on 11th March.

Two days later a 999 call was made for an emergency ambulance to attend EM due to continuing complications with the pregnancy. EM was again admitted to SHH, and YPMW was updated about EM's history and that EF was not allowed to visit her.

ESW visited EM in hospital and asked about her visit to Staffordshire and her admission to hospital there. She said that EF had gone to hospital with her, and that he had visited the following day. ESW said he wanted to make contact with EF to arrange an assessment. EM said that she felt EF was more attached to this baby and that he would be likely to engage with ESW.

Following further complications with the pregnancy, EM was again admitted to SHH on 19th March. There were concerns about the foetal heart rate and it was decided that an emergency caesarean section should be undertaken to deliver Child E. Child E was born at 28 weeks gestation and required immediate care in the Neonatal Unit (NNU).

On 22nd March, EM contacted ESW to report that EF had been constantly texting her, saying that he wanted to speak to ESW so that he could see Child E. ESW rang EF the following day. EF said that he was hoping to get some money for travel and that he would come in for an assessment. EM later said she was receiving threatening texts from EF and that he said he would have the baby 'taken off her'. Two days later EM was discharged from hospital whilst Child E remained on the NNU.

On 29th March a social work assessment was completed by ESW. The assessment recommended that a Legal Planning Meeting[2] should take place to decide whether Child E could be kept safe and have her needs met by living with EM. (KPE1)

On 30th March a Legal Planning Meeting took place at which it was agreed to proceed to Initial Child Protection Conference, progress to Public Law Outline (PLO) and issue care proceedings. On the same day a strategy meeting took place at which it was noted that significant harm to Child E was likely, based on the recent history with ES. The strategy meeting noted that there had been some improvements with EM's thinking and engagement, but deemed that there were still risks to Child E. (KPE2)

On 1st April, EMGM spoke to the sister on NNU, saying she was concerned that the cycle that had happened with ES was beginning to happen again with Child E. EM was asked to join the conversation. The following day EM rang to say that she would not be able to attend hospital to feed Child E, as she had only just woken up.

On 3rd April, EM telephoned ESW to say that EF had been sending threatening texts to her, and had sent pictures of himself burning Child E's birth certificate and smashing up EM's make up. EM also reported these events to the midwife.

EMGM met with ESW (without EM being present) on 4th April. She told ESW that EF had been controlling in the relationship, and that EM was afraid of him. She said that EM needed a lot of support. That same day EF contacted ESW to tell them that EM had a new boyfriend and that EM didn't want EF to have anything to do with Child E. He said that he had seen this on Facebook.

On 7th April Pennine Care Mental Health Access service received a referral from YPMW for EM to access the service.

On 11th April the first PLO meeting took place and was attended by EM and EMGM. EF had been invited to the meeting but did not attend. The plan to place Child E in a foster care placement on discharge was conveyed to EM and EMGM. The recent social work assessment was discussed, together with the proposed working agreement. A cognitive

[2] https://uk.practicallaw.thomsonreuters.com/4-538-2105?transitionType=Default&contextData=(sc.Default)&firstPage=true&comp=pluk

assessment of EM was commissioned by ESW as part of the working agreement. (KPE3). This was good practice.

Between 20th and 25th April, EM visited the NNU and showed initiative in caring for Child E.

On 25th April, EM attended an appointment with the Mental Health Access Team. EM discussed her anxiety in relation to the care proceedings for Child E. She talked about her difficult childhood, and said she had experienced anxiety since 2013, and had been prescribed medication for this by her GP. EM was assessed as being suitable for referral to the Healthy Minds service, and an internal referral was made. This was given priority in line with the perinatal care pathway.

On 27th April an Initial Child Protection Conference (ICPC)[3] was held which was attended by EM and EMGM. EF was invited but did not attend. At the meeting the midwife reported that EM had provided appropriate care for Child E and EM's engagement with services was noted. Police information regarding the history and relationship with EF was discussed. The conference concluded that Child E should be made the subject of a child protection plan under the category of emotional abuse. (KPE4).

On 4th May a core group meeting was held on the NNU at which ESW informed the group that managerial approval would be required as to whether EM and Child E went to a mother and baby foster placement. He said that the decision would be communicated to EM and EMGM as soon as possible. The rationale for the proposed change in care plan is not clear from the file, and is unsupported by any Care Planning Meeting or manager's decision.

On 5th May a Public Law Outline meeting took place. The meeting was chaired by a different team leader and was attended by EM and EMGM. The team leader communicated that the Local Authority intended to issue care proceedings, and that the plan was for EM and Child E to be placed together in a mother and baby foster placement. (KPE5).

On 8th May a SWET (Social Work Evidence Template) court report was prepared by ESW. The report contained additional information that EF had attended a 90 minute appointment with ESW in Stockport. ESW noted that EF showed no insight into his own behaviour, and accepted no responsibility for his own actions.

The report requested that the Court make an Interim Care Order in respect of Child E, with a plan that Child E be placed with EM in a mother and baby foster placement. The rationale for this request was as follows "With the experience and knowledge gained from ES's situation, EM's willingness to access relationship work and counselling, and her self-reported confidence and independence, we are hopeful that a joint placement will be safe and allow EM to meet Child E's needs, and the situation of risk and neglect previously evidenced with ES will be avoided". The proposed plan included a fortnightly supervised visit with EF. This was not implemented because EF did not engage with the risk assessment. NB: The court documentation did not make it clear that the proposed contact arrangement

[3] http://greatermanchesterscb.proceduresonline.com/chapters/p_initial_cp_conf.html

was dependent on completion of a risk assessment, but this appears to have been the approach adopted.

On 9th May, NNU had a telephone conversation with ESW and was informed of the plan for a mother and baby foster placement.

That same day CAFCASS received the public law application in respect of Child E, and the case was allocated to a Family Court Advisor (CG).

The following day EF phoned ESW to say that EM had been texting him, and relayed the content of the messages. ESW then spoke to EM who initially denied sending texts, but later confirmed that she had sent texts in response to abusive messages from EF. A more forensic approach to this communication between EM and EF may have offered evidence to support a less optimistic view of their ability to remain separated.

On 12th May, Fostering Solutions received a referral from Stockport CS for a mother and baby foster placement for Child E and EM. Fostering Solutions requested further information regarding Child E's medical needs, and the intended plan for the placement.

On 17th May, a court hearing took place at which a Position Statement was filed citing CG's cautious support for the Local Authority plan. CG considered the evidence presented by the local authority and, having sought additional clarification, concurred with the proposed initial care plan. An Interim Care Order was granted and the Child Protection Plan ended at this point. CG spoke to EM and advised her that this was a 'last chance'.

Between 19th May and 23rd May it was noted by NNU that EM was not complying with the written agreement. EM's visiting pattern had changed and her involvement in providing care to Child E had reduced markedly. The NNU nurse updated ESW and informed him that EM had said she had been too unwell to attend the hospital. ESW informed NNU that EM had a new boyfriend who had just returned from a family holiday. The forthcoming discharge planning meeting was discussed.

On 22nd May, the mother and baby foster placement plan was started, which set out the details of expectations and authority regarding care of Child E, and the respective roles of EM and EFC, which included the completion of a daily log by EFC.

The following day NNU contacted ESW by telephone to report that EM was not completely focused on Child E's care. EM had been seen to have a love bite on her neck. This was recorded in the social work file.

On 25th May, a discharge planning meeting was held at NNU. In attendance were EM, EMGM, ESW, SHV and OHV1, EFC, the Paediatrician, NNU staff nurse and safeguarding nurse. (KPE6)

The meeting discussed Child E's ongoing care needs (Child E had by now been diagnosed with chronic lung disease), and how these would be met in the placement. The working agreement was discussed and EM's lack of compliance was highlighted. Pre-discharge arrangements were agreed i.e. that EM would 'room in' for four nights out of the next six.

Discharge was planned to take place on 31st May. EM did not room in that night, when reminded of the agreement she said that she was aware of it.

Over the following four days, EM was inconsistent in her commitment to attending the hospital. On 28th May, EM said she was tired but would stay over. The following night she said she felt too unwell to look after Child E. EM made a phone call and then left the hospital. The following night EM left the hospital to go home. She did not return and could not be contacted.

On 30th May, the NNU Matron rang ESW to inform him that EM had not complied with the working agreement to stay four nights, and that she had required prompting and shown avoidance. This had been discussed with EM who said that she was finding it difficult being at the hospital. SHV also made a separate telephone call to ESW regarding EM's lack of commitment. (KPE6).

A planned LAC review[4] took place that same day, which EM did not attend. The meeting recommended that a legal planning meeting should take place in light of EM's apparent disengagement.

On 30th May Child E's community health records were prepared for transfer to Oldham. The record of transfer summary from Stockport stated that EM had previously had a child removed, and that EM and Child E were moving into a mother and baby foster placement in Oldham.

On 31st May a legal planning meeting took place to discuss EM's lack of compliance with the working agreement. The legal advice to the meeting was that there was insufficient evidence to indicate the removal of Child E. It was agreed that the hospital be asked to keep Child E for a further five days, and a tight working agreement be put in place. It was agreed that if EM did not adhere to the agreement, Child E was to be removed to foster care, and preferably to a foster to adopt placement. (KPE7)

That same day OHV1 rang NNU to enquire about Child E's planned discharge, and was updated regarding the new agreement and the delayed discharge plan.

Whilst rooming in that night EM was upset, saying that she was feeling low at having to stay on the NNU, and that she would feel better if her friend could stay with her for support.

For the next five nights EM stayed overnight at the NNU and attended to all of Child E's care needs.

A meeting took place as planned on 5th June, where compliance with the written agreement over the last five days was discussed. ESW informed the meeting that Child E was to be discharged with EM to the mother and baby foster placement. Discharge plans were finalised with EM, and guidance given regarding Child E's medical needs.

ESW spoke to CG on the phone, reporting that EM had evidenced an excellent response to the professional concerns raised regarding her commitment to meeting Child E's needs. The

[4] http://survivingsafeguarding.co.uk/looked-after-child-meeting-lac/

plan was amended back to a mother and baby foster placement with CG expressing 'cautious support' and asking to be informed of any difficulties. This was optimistic, although CG was not aware of the degree of non-compliance by EM. It would have been useful if CG had explored this in more detail.

A working agreement was signed by EM and ESW, which stated that EM would have primary care of Child E, with close supervision from EFC. EM said she did not have any questions and EM and Child E were discharged to the placement.

Two days after entering the placement, EFC notified OHV1 that Child E and EM were now living in Oldham. OHV1 completed a home visit two days later, at which she noted no concerns regarding Child E's care and support. In this time period Child E was also allocated a new health visitor as OHV1 was due to take maternity leave.

On 28th June, EM attended an appointment with Healthy Minds at which she said she was stressed and unhappy living in Oldham and that she was unhappy with ESW as she felt he was undermining her by discussing 'back up' plans. (KPE8)

The Healthy Minds practitioner did not make any further enquiry about why EM was unhappy or consider sharing this information with ESW or other professionals.

On 6th July, Stockport CSC undertook a statutory visit and review of the placement, at which EM asked for contact to be extended with EMGM and her grandparents. It was agreed that contact was to take place at EFC's house and at EM's grandparents' home.

From the middle of July onwards, EFC's daily log began to indicate concerns about EM's care of Child E. (These logs were sent to ESW on a weekly basis, however ESW did not read them in detail on every occasion, and the concerns were not highlighted by the foster carer in the accompanying emails).

On 27th July, at a session with Healthy Minds, EM said that she was frustrated with her living situation and did not feel that she was getting on with EFC. The CBT Therapist recorded 'no risks identified'.

A statutory visit took place on 10th August. By this time OHV1 had left and OHV2 had taken over. EM told OHV2 that she continued to experience anxiety. OHV2 noted this and noted that she was reassured that this was being addressed by EM's engagement with CBT. There appears to have been no further enquiry made by OHV2 to check EM's account of the CBT sessions.

On 23rd August, EM did not attend a Healthy Minds appointment and was discharged from the service. This was EM's first DNA and her discharge was not in line with the service protocol. (KPE9)

EFC continued to record ongoing concerns regarding EM's behaviour and lack of attention to Child E's needs. EFC noted that EM did not take Child E out, and that EM was often outside the house smoking and on her phone, and that she had not prepared bottles in advance for Child E's feeds. This was of particular concern given Child E's specific health needs, and was contrary to medical advice.

On 6th September, a LAC review took place. In EFC's daily log for that date, she notes that both she and OHV2 had shared concerns about EM continuing to spend time outside on her phone, smoking and not putting Child E first. However, the IRO's minutes of the meeting do not convey the same strength of concern. The minutes show that EF was documenting concerns in the daily records, however these were not discussed in any detail, or with any consideration being given to their possible implications for future planning. EM was present at the meeting and said that 'it was all boring'. (KPE 10)

That same day, ESW completed social work assessments of EM and EF, and filed them with the court. The assessment of EM recognised her ongoing vulnerabilities, but also identified her motivation and commitment to care for Child E. The assessment recommended that EM and Child E should remain in the mother and baby foster placement for a further three months, whilst work in relation to domestic abuse was completed. It was proposed that one to one work be undertaken with the ASPIRE service (the local complex safeguarding team). It was proposed that Child E and EM would then move to a placement together in Stockport, with the ultimate goal of being to live in a "semi-independent or independent home" near to family support.

The assessment of EF identified some strengths, but these were assessed as limited and outweighed by other significant concerns. The assessment concluded that, if EF committed to working with ESW, and to ending his contact with EM, some level of supervised contact could be considered. There is no analysis of how realistic this was, nor is there any reference to the earlier plan to allow EF a fortnightly contact (although this was not implemented).

A final care planning meeting took place on 6th September. The minutes of the meeting record that ESW outlined the content and conclusion of the recent assessment, and this was accepted. As such, the Local Authority's agreed final care plan was to request that the Court make Child E the subject of a Section 31 Care Order. There is no evidence in the minutes or at the LAC review on 6th September of critical challenge or exploration of ESW's thinking, which would have been good practice.

On 11th September, ESW was contacted by a friend of EF who said she was going to send some screen shots from social media of EF, EM, EF's previous girlfriend, and some other friends. The text conversation was lewd in places, and EF and EM both threatened EF's girlfriend on several occasions. During the conversation, EF said that he loved EM, and EM said that she would transfer some money into his bank account for petrol so that he could pick her up.

Following this EM spoke to ESW on the phone about the comments on social media. EM said that she was just getting back at EF's girlfriend, and that she had no intention of meeting him. In what appears to have been a subsequent telephone conversation on the same day, EM told ESW that the placement was not working. There is no indication that EM's view of the placement was discussed with managers in CSC or in the Fostering Agency.

ESW checked with EFC and recorded that, although EFC was having huge difficulties getting EM back on focus, and that EM's use of the phone was an issue, EFC did not think EM had given away the address to EF or others. ESW recorded that they did not think that EM was

going to meet with EF. There is no evidence of ESW further exploring EM's report that the placement wasn't working.

EFC asked ESW to visit the placement on 14th September to discuss the 'continuing stress and challenges EM was presenting with'. EM's PA was also in attendance and the recording of the visit details that, along with EFC and EM, they talked about steps forward including independent living skills and managing household tasks. Given the frequency and nature of EFC's concerns, it would have been proportionate to have held a frank and challenging discussion with EM about what was going on for her at that time. Curiosity regarding who EM was spending time on the phone to is not apparent, nor is there consideration about the implications of EM's behaviour for the appropriateness and sustainability of the care plan.

Over the course of the next four days EFC continued to make frequent entries to the daily log, detailing concerns about EM's behaviour and her unwillingness to meet Child E's needs.

On 18th September, EFC telephoned ESW in the morning to share her concerns about EM's behaviour over the last few days. ESW said that they would discuss this with the team leader, and encouraged EFC to continue in her support of EM making "small steps".

EM took Child E to be weighed at 11.45 and did not return until 6.30 p.m. EFC discussed her concerns with ESW and with the supervising social worker. There had been sporadic telephone contact with EM during the day, who said that she was in Oldham. EM was told by ESW and EFC that she must return to the placement. When EM had not returned by 5 p.m. police were called and Child E and EM were reported missing.

The police were in attendance at the placement when EM returned. On return Child E was 'soaking wet' and her nappy was full. EM was wearing new trainers which she said she had bought that day. She said she had walked to Manchester which is why she was late. (KPE11)

On 19th September, ESW sent an email to the team leader regarding EFC's concerns, and that ESW was going to visit EM in the placement on 20th September. In a telephone conversation, EM told ESW that she did not want to attend the meeting, and that she was going to visit her grandparents with Child E. There appears to have been no challenge to EM about her decision not to attend the meeting.

On 20th September, ESW visited the placement and met with EFC and ECFSSW. EM did not attend the meeting. (KPE12)

On 21st September, EF met with ESW in Stockport. EF said that he was currently living with his brother. EF spoke about his life growing up. He said that he had been in another relationship in which his girlfriend had been pregnant, and that the baby had died. EF had brought some new clothes for Child E and was keen for these to be passed on to her.

Over the next two days EFC continued to record concerns regarding EM's lack of attention to Child E's needs.

On 26th September EM had been out with Child E and returned to the placement in the afternoon. Child E was put into her cot to sleep. EFC noted two occasions on which she

heard 'unusual' noises from Child E. She became concerned when she checked Child E and found Child E to be floppy and unresponsive. EFC telephoned for an emergency ambulance and Child E was taken to Royal Oldham Hospital and admitted. (KPE13).

4 Key Practice events evaluation and key learning from practice

4.1 KPE 1 Social Work Assessment

Child E was born prematurely before the social work assessment was finalised. Child E's level of medical need and vulnerability was therefore known. The assessment was weighted towards EM's ability to respond to Child E's needs, rather than the impact upon Child E of EM's vulnerabilities and risks. It is however clear that ESW believed that reducing EM's risks and vulnerabilities would have a positive impact on her care of Child E.

The assessment appropriately addressed areas for concern in relation to the previous mother and baby foster placement with ES, and looked at the recent history. However there was no discussion with the previous social worker, which may have provided insight into EM's behaviours and the impact on ES.

It was appropriately identified that EM would need support to address her vulnerabilities, and that this would be a key factor in EM being able to provide appropriate care to Child E. Areas identified for support were in relation to EM's relationship with EF, domestic abuse and anxiety and low mood.

The assessment noted that it was unlikely that EM would be able to keep Child E safe, and that the likelihood was that care proceedings would be sought.

The assessment would have been strengthened by building and using a more detailed chronology, and providing a more detailed exploration of the relationship between EM and EF, and how this impacted EM's ability to put the needs of Child E first. There was an absence of consideration of EF in the assessment.

Consideration should have been given to exploring the relationship between EM and EMGM with whom EM was living at that time.

4.2 KPE 2 Legal Planning Meeting and Strategy Meeting 30th March

These two meetings took place on the same day, and both identified that Child E was at risk of significant harm.

The LP meeting gave full consideration to the assessment completed by ESW. EM's relationship with EF was discussed, and it was noted that it was controlling and abusive, and that EM appeared to have difficulty in permanently separating from EF. It was noted that EM had said she wanted to stay in a relationship with EF. EM had said she was willing to attend the Freedom Programme.[5]

[5] https://freedomprogramme.co.uk/

It was noted that EF had not fully engaged with the previous social worker (in relation to ES), and that there had been no assessment of him at that time. No actions were identified in relation to an assessment of EF taking place. The meeting should have given EF and his role further consideration, and could have proposed a plan for engaging him.

The meeting agreed a clear plan that Child E should be removed at birth to a foster placement, with EM having three visits per week. It was advised that this could be reviewed if EM made improvements before Child E was discharged from hospital. However, the parameters for such a review do not appear to have been discussed at the meeting.

The actions from the meeting were appropriate i.e. to commence to PLO proceedings with a view to removal when Child E was discharged from hospital. An APR[6] worker to be allocated, continuing support from EM's PA, to engage with the Adoption Team and to identify a person to complete the PAMS (Parenting Assessment Manual) assessment (a referral for this assessment was not however made).

The minutes of the strategy discussion that took place on the same day recorded that significant harm to Child E was likely, due to the actions of EM and EF in regards to ES. It was noted that EM had left ES in the mother and baby foster care placement in August 2016, and that ES was placed for adoption in February 2017. Some improvements in EM's thinking and engagement with services were noted, however it was felt that risks still existed from evidence of ES's care.

The recorded actions from the strategy discussion were that the case should proceed to Initial Child Protection Conference, progress to Public Law Outline (PLO) and the issuing of care proceedings, which was appropriate given the identified risks.

4.3 KPE 3 Public Law Outline Meeting 11th April

This was the first Public Law Outline[7] meeting at which the plan to place Child E in foster care on discharge from hospital was conveyed to EM and EMGM. The meeting was attended by EM, EMGM, ESW, ESW's team leader, the Local Authority Solicitor and EM's solicitor. EF was invited but did not attend.

ESW fed back on his assessment and commented that EM had been more engaged since her return to Stockport. It was reported that EM had the support of EMGM, which was seen as positive. There is no apparent exploration of whether additional support was required to rebuild the relationship with EM and EMGM following a long period of separation and difficulties in EM's early childhood.

EM reported that she had not spoken to EF for six days, and that she intended to change her telephone number so that he could not contact her. EM said that she was accessing counselling, and was going to start the Freedom Programme and a confidence building course. EM had not attended the Freedom Programme at this point although it had been

[6] https://www.stockport.gov.uk/preventative-commissioning/alliance-for-positive-relationships

[7] http://www.proceduresonline.com/devon/childcare/user_controlled_lcms_area/uploaded_files/The%20Public%20Law%20Outline%20guide%20%20for%20SW%20and%20Managers.pdf

planned that she should attend several weeks previously. It would have been useful to review the written agreement with EM at this point, and to strengthen the focus on EM seeking support regarding domestic abuse. There appears to have been no exploration of the reasons for EM not attending the Freedom Programme. The meeting discussed the working agreement and the need for EM to comply with it.

The meeting discussed Child E's current health needs, and progress following premature birth. The team leader confirmed that the Local Authority planned to issue care proceedings, and that they would place Child E in foster care when she was well enough to be discharged from hospital. There appears to have been no discussion regarding potential change to the plan (which was included in ESW's report to the ICPC on 27th April).

A cognitive assessment of EM was commissioned as part of the working agreement within the PLO process, this was completed on 20th April. This was good practice.

Consideration was given to potential family members who might be able to care for Child E and/or support EM to parent Child E. Although historical information suggests that it would be unlikely, the opportunity was not taken to explore whether the wider family would have offered a suitable placement for Child E.

Although EF was not present at the meeting, the only reference to him in the working agreement was, that he was to have no contact with Child E whilst she was in hospital. It would have been useful if the meeting had given consideration to interim planning in relation to EF.

4.4 KPE 4 Initial Child Protection Conference 27th April

The ICPC was chaired by the IRO, and was well attended with representatives from social care and health agencies (including YPMW and SHV), police also attended the meeting. EM and EMGM were in attendance.

YPMW provided a written report which noted that EM's stay in hospital over the first ten days after birth had begun to make her feel quite anxious, and that this affected her appetite. EM was therefore discharged home on 28th March, with a plan for visits to Child E at the NNU. It was reported that EM had sought support for her anxiety and low mood, and YPMW had made a referral to mental health services.

Police information provided to the ICPC cited ongoing significant concerns regarding the history of domestic abuse between EM and EF, threats made by EF to harm ES, and a strong recommendation that the case should progress to proceedings.

The conclusion of the conference was that Child E should be made the subject of a Child Protection Plan under the category of Emotional Abuse.

There was appropriate discussion regarding ongoing risk factors in EM's relationship with EF, although there was little further discussion regarding EF's role. The meeting acknowledged that EM had shown motivation to address making changes to her

relationship with EF, although there was no enquiry as to whether she had engaged with the Freedom Programme (which she had not).

It was noted that EMGM was being very supportive of Child E, and that this was positive. EM and EMGM said they both agreed that Child E needed to be subject to Child Protection planning.

It appears that a change in thinking from the decision made at the Legal Planning Meeting on 30th March is hinted at in ESW's report presented to this meeting. ESW's report concludes "Consideration at ICPC, PLO and Legal Planning Meetings needs to take place to see whether Child E can be kept safe and have her needs met by EM living at her mums, or more likely Child E living in foster care with EM, or with EM visiting her at high frequency". The rationale for the change in care plan is not clear from the file, and is unsupported by any Care Planning meeting or manager's decision.

4.5 KPE 5 PLO Meeting 5th May

A second PLO meeting was held on 5th May, which was chaired by a team leader from the locality, rather than the team leader responsible for managing the case (as the original team leader was not available to attend the meeting).

The meeting noted that a psychological and cognitive assessment had been completed, and that it had concluded that EM did not have a learning disability. ESW spoke about the possibility of completing a 'PAMS' assessment.

Within the meeting, EM was informed that the plan had changed, and that instead of Child E being placed in foster care, the plan was now to place both Child E and EM together in a mother and baby foster placement. There is no indication of where the change of plan had been agreed. There is no rationale given for the change in care plan in the file, nor is there any record of the change being supported by a Care Planning Meeting or manager's decision.

Given the serious nature of the issues relating to ES being removed, coupled with the relatively short period of engagement, and the lack of engagement with domestic abuse services, it is questionable whether the change to a more optimistic care plan was warranted.

It is possible that EM's assurances that she had separated from EF may have influenced care planning at this stage. However, it was known that EM had continued to have contact with EF via text messaging. Whilst this contact was largely negative (and much of the content was controlling and abusive by EF) the opportunity to further explore the contacts does not appear to have been taken.

There was too much emphasis placed on EM's engagement which appears to have been superficial at this time. EM had not accessed the Freedom Programme although she had given reasons for not doing so. With the benefit of hindsight it is apparent that there was no recognition or exploration of potential lack of engagement by EM.

4.6 KPE 6 Discharge Planning Meeting 25th May

The Discharge Planning Meeting was well attended. The practical aspects of Child E's care were discussed and it was noted that everything was in place for discharge. EM had been appropriately informed regarding Child E's care needs. It is not apparent that EFC had specific contact with the NNU regarding Child E's needs, and this may have been beneficial. All relevant services in Oldham had been notified of Child E's discharge.

It was reported that ESW was working with EM and that key points to work on had been agreed, including EM giving up smoking. GP registration had been completed and other issues such as anxiety management, ensuring general baby care equipment was in place and working together with EFC in relation to looking after Child E were discussed.

It was noted on the discharge planning template that the child protection plan was now a Looked after Child plan, and it was agreed that discharge would take place on 31st May as planned.

There appears to have been no discussion regarding the potential significance of EM's on-going communication with EF, or exploration of the reasons given for her non-attendance at the Freedom Programme.

It was known at this time that EM had begun a new relationship, however there appears to have been no discussion about the impact this may have had on EM's commitment to caring for Child E.

4.7 KPE7 Urgent Legal Planning Meeting 31st May

An urgent LPM was convened to address concerns about EM's lack of compliance with the written agreement in the six days prior to discharge. Information was provided to the meeting in relation to EM not attending the hospital for overnight stays, as required in the written agreement.

The LPM was timely and illustrates responsiveness to the levels of concern at that time. However, in considering the significance of EM's lack of commitment to caring for Child E, it appears that EM's recent ten days of disengagement from hospital visiting was seen as a discrete episode. There is limited reference in the minutes to the chronological context of this behaviour.

Options were considered which included seeking a foster to adopt placement for Child E, however the legal advice was that the local authority did not have sufficient evidence of EM's inability to parent Child E to indicate immediate removal. The agreed plan was to ask the hospital to extend Child E's admission by a further five days, setting out the expectations for EM to comply with the agreement. This was to be put in place to test EM's commitment to meeting Child E's needs. In the context of recent and historic events, it is unclear as to why a period of five days was deemed likely to provide sufficient evidence of a reduction in risk or lack of commitment.

The plan to extend Child E's hospital admission therefore only narrowly addressed the issue of EM's lack of attendance on the ward, and her lack of compliance with the written agreement. It would have been beneficial to consider more broadly the longer-term

implications of EM's lack of engagement, not only in relation to hospital visiting and meeting Child E's needs, but also to engagement with other supportive interventions.

The establishment of some detail about EM's reported new relationship would also have been of value.

There is no indication that detailed information regarding lack of compliance was communicated to CG at this time, nor is there any indication that CG actively pursued information regarding EM's progress, and any risks that may be developing or emerging.

It is of note that the attending solicitor was not the solicitor with original responsibility for the case (and also not for the case of ES). This may have had some relevance to the approach taken.

4.7 KPE8 Session with Healthy Minds 28th June 2017

At this session EM reported feelings of frustration with ESW as she felt they were undermining her by discussing 'back up' plans. EM expressed frustration at living in Oldham away from her family. She reported that she was 'overthinking' things and that she felt 'stressed' and 'unhappy'.

As a result of EM's comments the CBT Therapist 'abandoned' the planned Trauma Focused CBT session to allow LB to 'off load'. The Therapist queried the ongoing efficacy of Trauma Focused CBT at this time due to EM's ongoing social situation in relation to court proceedings. The Therapist documented "*No risks were identified during the session"*.

This was a missed opportunity to initiate contact with ESW, particularly as EM had said that she was unhappy in the mother and baby foster placement, and the was expressing frustration with the agreed plan.

The Therapist's reconsideration of appropriate interventions was also of significance, and it would have been good practice to share this with ESW due to its potential impact on EM being able to address historic risk factors.

4.8 KPE9 Discharge from Healthy Minds 29th August 2017

On 23rd August EM did not attend her appointment with Healthy Minds and was subsequently discharged from the service.

The process of discharge was not in line with service protocol, as this was EM's first DNA (did not attend). The service protocol asks staff to check the Pennine Care PLUS (Clinical record look up system) prior to discharge following non-attendance and the services should allow patients 3 DNA or last minute cancellation appointments over the course of therapy *(Healthy Minds Trust-wide Operational Policy, CL121, p. 23*). This is particularly pertinent in cases where there are known social stressors or issues, such as providing therapy during the postnatal period.

A letter was sent to EM's GP on 24th August, summarizing her treatment with Healthy Minds. The Therapist did not check the PC-PLUS system, did not contact the EM to check the reasons for the DNA and did not contact EFC or ESW. There is no evidence that the CBT Therapist discussed the case with her manager or Clinical Supervisor.

There is no indication that EM discussed her discharge with ESW and consequently no consideration of the impact that no longer attending for CBT may have on EM and, by direct association, the potential impact on Child E.

4.8 KPE10 LAC Review 6th September 2017

The first LAC Review of the foster placement took place on 6th September. EFC noted in her record made on the same day that "the IRO asked did I have any worries?" EFC said she was concerned about EM smoking, and that EM put this before attending to Child E's needs. EFC also recorded that OHV2 had said that she wasn't very happy as she had told EM to take Child E out every day, and she hadn't done that since OHV2 had been to see EM two weeks previously.

The IRO's minutes of the meeting do not convey the same strength of concern as that recorded in EFC's daily record. The minutes indicate that there was some reference to the issues raised within EFC's daily records, but that these were not discussed in any detail, or with any consideration being given to their possible implications for future planning. It would have been useful to consider the lived experience of Child E, and hold a discussion about how EM's behaviour impacted on Child E's daily lived experience.

There is no evidence of rigor and challenge in the IRO's scrutiny of the case at this stage. This is absent from the minutes of the meeting and in the recommendations made after the review.

4.9 KPE11 Police Call Out 18th September

When EM failed to return to the placement after taking Child E to be weighed, EFC appropriately telephoned ESW and raised her concerns with them. ESW said that they felt that EM would return soon, and said that they would try to contact her, which they did. Although ESW and EFC both spoke to EM, and to each other, there does not appear to have been a consensus between them on how to address the situation.

EFC sought guidance from FCSSW and was advised to report EM and Child E to the police as being missing. ESW spoke to EFC and told her that EM had just got mixed up, and that she would be back soon. When EM had not returned at 5pm, it was agreed by EFC and ESW that the police should be contacted.

When EM returned to the placement that evening the police were in attendance. EM said that she had walked to Manchester, and that is why she was late. EFC noted that Child E's clothes were soaking wet and that her nappy was "excessively wet and full of faeces".

Almost immediately after the police had left, EFC noted that EM went outside and was on her 'phone and was smoking. EFC noticed that EM was wearing a new pair of trainers which she said she had bought that day. EFC doubted that EM had money to buy trainers and noted this.

This was a serious incident in which EM showed no acknowledgement of the concerns of EFC and ESW. There were noted to be worrying similarities to EM's behaviours with ES. She was uncooperative, and was aware that she was breaking the written agreement.

It appears that EFC and ESW initially differed in their views regarding EM's behaviour, however both ultimately agreed that the level of concern was sufficient to involve police. However, there is no indication of a shared agreed approach to escalation of concerns between ESW and EFC.

ESW contacted the team leader by email the day after the incident and said that they would be visiting the placement on 20th September. Given the seriousness of the situation, and the condition in which Child E had been returned to the placement, it may have been more appropriate for ESW to visit the placement on 19th September. By this time the daily logs provided by EFC show evidence of a frequent lack of commitment by EM to respond to Child E's needs.

There is evidence within OHV2's records that domestic abuse was discussed with EM in the context of historic relationships. EM made no disclosure of current abuse to OHV1 or OHV2, nor did she give any indication that she was in a relationship with anyone, and both HVs accepted EM's account. As a result no risk assessment was completed.

KPE 12 ESW Visit on 20th September

On 20th September, ESW visited the placement as planned. Only ESW and EFC were present at the meeting. EM had told ESW that she would not be attending the meeting. The events that took place on 18th September were discussed and the possibility of EM having been with EF on that day was raised.

ESW said that they had spoken to EF on the afternoon of 18th September and, although ESW did not directly ask EF if he was with EM, ESW said that EF didn't sound as if he was outside in the same way that EM did when ESW had spoken to her.

EFC expressed concern that Child E had only been fed three of her usual five bottles on that day. EFC raised ongoing concerns in relation to EM's care of Child E and described Child E as an "unhappy baby"

Given the seriousness of EM's actions, and the similarities in behaviour to her care of ES, greater curiosity should have been applied by ESW regarding what had happened on that day.

EM was not at the placement for the meeting on 20th September. She had told ESW that she did not want to be there and would be visiting her grandparents. This does not appear to have been challenged by either ESW or EFC. It would have been proportionate for ESW to have held a frank conversation with EM at the soonest possible opportunity, and to have

asked for an account of what had happened and discussed the risks to Child E. There is no indication that this took place.

ESW interpreted EM's behaviour as a reaction to being challenged about her behaviours earlier that week and to being 'trapped up in the placement for a long time'.

The actions from the meeting were to allow EM more free time out of the placement in the hope that she might be more accepting of established boundaries. Whilst this is not an unreasonable theory, it places too great an emphasis on the needs of EM and gives insufficient consideration to the risks to Child E and to the feasibility of the longer term care plan.

There is no reference in the file to managerial and IRO oversight at this time, which could have enabled critical and reflective challenge of ESW's thinking.

There is a strong emphasis on the needs of EM and little apparent focus on the impact of EM's behaviour on Child E. There is little evidence of Child E's lived experience and safety being paramount and Child E's needs appear to be overshadowed by those of EM.

There is no indication of discussion regarding escalation of concerns at this meeting.

KPE 13 Incident in which Child E was injured

Appropriate action was taken by EFC when she became concerned about Child E's presentation.

Child E was taken by emergency ambulance to the local hospital where Child E received appropriate assessment and care.

5 Learning drawn from the Terms of Reference

NB: Only agencies who were involved during the period under review are included in this section of the report.

5.1 Did agencies recognise EF's role, the relationship, and its impact on a vulnerable mother?

The relationship between EM and EF was known by all agencies, and all agencies recognised that the relationship presented potential risk to both Child E and EM. Despite EM's assurances to the contrary, her relationship with EF continued throughout the period under review in one way or another.

It was recognised by agencies that, because of her life experiences and vulnerabilities, EM needed help and support to make wise decisions about continuing her relationship with EF. It was known to Children's Social Care in Stockport that the couple had separated on many occasions, but had always resumed their relationship. It is also clear that on numerous occasions EM was not truthful about her ongoing contact with EF.

The suggestion that EM would be able to separate from EF is one that appears to have been accepted at face value. There would have been benefit in exploring this more fully, and with

the application of a greater degree of challenge and scepticism regarding the feasibility of a permanent and complete separation. There was a lack of recognition that EF, as Child E's father, would have had a lifelong connection with Child E and that, despite the quality of the relationship between EM and EF, it would have been realistic to presume that, as Child E's parents, the relationship may well have continued.

EF was invited to attend PLO meetings, Court Hearings and the ICPC but did not do so. This is particularly significant given that contact with Child E following birth was withheld pending full assessment. This decision was not supported by a court order, and marked a divergence from the approach taken in the later stages of involvement with ES where EF was offered supervised contact. EF indicated to ESW that he wanted to be involved in Child E's life and on occasion made proactive contact with ESW. ESW spoke to EF on a number of occasions and attempted to arrange assessment sessions with him, EF only presented for one face to face assessment session with ESW.

In the social work assessment completed for Court on 28th July, the conclusion drawn was that EF was unable to identify or accept the level of risk he presented to EM (and Child E) and that further sessions would be required if supervised contact were to be considered (as referred to earlier the plan was not implemented as EF did not engage with the risk assessment).

Within the social work assessment, ESW reported that they had spoken to EF's mother. Given her level of contact with EF and EM, and her helpful contribution in the case of ES, this was appropriate, and is evidence of good practice.

ESW did not take the opportunity to view any of the files or visit practitioners in Staffordshire which would have been appropriate.

EF was not considered by health staff whilst Child E and her mother were living in Oldham. OHV1 and OHV2 were of the view that Child E's parents were separated and that there was no contact. This was self-report information from EM and was un-corroborated by further enquiry.

During the CBT sessions with EM there were opportunities to explore safeguarding issues more fully. Questions could have included how EM was getting on as a parent, feelings towards Child E and current supports. This may have led to conversations regarding contact with previous partners and an exploration of any issues relating to domestic abuse

The CBT therapist noted that EM was receiving derogatory and abusive text messages from her ex-boyfriend which are not documented or further explored.

In line with Trust policy all information should have been shared with Children's Services as an indication of potential increased levels of risk.

5.3 Did agencies recognise domestic abuse and appropriately assess risks?

All agencies recognised that there was ongoing domestic abuse in the relationship between EM and EF. EM appeared willing to share information regarding the abusive nature of the relationship with professionals.

EF was rightly identified as the primary perpetrator of abuse. There were occasions where EM was verbally abusive and aggressive to EF (this may have been in response to provocation and fear of EF, however there are also indicators of a mutually abusive relationship).
The relationship was volatile and there is evidence of coercion and control from both EF and EM, which appeared to be woven into their relationship. The complexities associated with the inter-dependency of the relationship were never fully explored.

EF's mother reported to police that she had ongoing concerns about the volatile nature of the relationship. She reported that EM had hit EF over the head with a bottle, and that she was very concerned about the potential for future violence between EF and EM.

The inherent risk to EM (and by association Child E) of being in an abusive relationship was recognised by professionals, however there is no indication that formal risk assessment took place (i.e. no use of the RIC assessment tool[8]) which may have enabled a greater understanding of the nature of the abuse and of EM's perception of risk.

There is evidence within OHV2's records that domestic abuse was discussed with EM in the context of historic relationships; EM made no disclosure of current abuse or gave any indication that she was in a relationship with anyone to OHV1 and OHV2 and both believed that EM was not in a relationship, therefore no risk assessment was completed.

Professionals were aware that EF frequently contacted EM via text and social media, on many occasions the messages were threatening and abusive. This was rightly interpreted by practitioners as coercive and controlling behaviour on the part of EF. The possibility of mutual coercion and control and interdependency was however not explored. This is not to suggest that EM was not a victim of domestic abuse, however an objective and informed appraisal of the nature of the relationship was not evident.

There appears to have been an over-reliance on EM's self-reporting and her accounts that she had 'not seen' EF and that she did not want to continue the relationship. However, it is also clear that EM minimised (or failed to recognise) the risks of continuing her relationship with EF. It is known from research that this is not unusual and that it can take many years for victims to acknowledge the reality and impact of domestic abuse in their lives.

Professionals recognised the importance of enabling EM to receive specialist support in relation to domestic abuse. EM agreed to engage with the Freedom Programme, but concluded that she felt uncomfortable with group sessions. A referral was subsequently made to the Alliance for Positive Relationships (APR) but this service was unable to extend its provision to Oldham, where EM was living at that time. Therefore EM did not access support in relation to domestic abuse, which had been acknowledged as a fundamental requirement in reducing risk to Child E.

[8] https://www.cscb-new.co.uk/wp-content/uploads/2015/11/CAADA-DASH-risk-assessment-for-MARAC-agencies.pdf

In assessing the impact of domestic abuse in this case, it would have been useful to be able to draw on the response of both parents to sessions of work directly addressing the issue. It is significant that this opportunity does not appear to have been offered to EF. It is not clear whether issues of domestic abuse were discussed directly with EF, nor is there any indication of whether he was encouraged to seek support to address his behaviours (e.g. via a perpetrator programme).

The referral for CBT included the identification of domestic abuse as a key issue, however EM did not identify this as a risk and told the CBT therapist that she was not at risk as she had separated from EF. In any event, the CBT didn't contribute to professionals' thinking or assessment, as there was no communication either way.

EM's engagement with CBT did not contribute to professional thinking or assessment as it was unknown to other agencies.

5.4 How did agencies ensure cross border information sharing?

EM received services in three Local Authority areas, Oldham, Stockport and Stafford. Child E received services in Oldham and Stockport.

Communication and information sharing between Stafford and Stockport Children's Social Care was of a high standard.

The NNU communicated effectively with Oldham health services, as did the Stockport Health Visitor. As Child E became fit for discharge the NNU held a Discharge Planning meeting to which practitioners from Oldham were invited.

SHV appropriately shared with the core group members that out of Borough placement would necessitate a change in health visitor and the transfer of health visiting care was arranged.

In relation to transfer to OHV1 a face to face or telephone conversation between health practitioners is always recommended when child protection cases are transferred. It is not apparent why this did not happen.

Agency reports and practitioner interviews highlighted three areas where improvements could be made:

1. Communication of the discharge planning meeting to OHV1 – this took place only a day before the meeting was due to take place. However OHV1 prioritised the meeting and attended, which was good practice.
2. Scanning of the notes by OHV1 – this was delayed by six weeks – it is not clear why this delay took place.
3. Healthy Minds were not invited to attend multi-agency groups, discussions and communications nor did anyone from the service make enquiries regarding attendance at meetings.

Practitioners highlighted that there were many 'ad hoc' and opportunistic communications regarding Child E's care needs whilst on the NNU, this was seen as a positive with professionals taking opportunities to discuss the case.

ESW and EFC reported frequent communication, they held a weekly meeting during the period that EM was attending counselling sessions and maintained frequent telephone communication. EFC completed daily logs and sent these to ESW (although these were not always read by ESW).

The daily logs contained information that was often repetitive, although EFC did document increasing concerns in the daily log. Practitioners told the review that there was frequent communication between ESW and EFC by telephone, and that the daily log was not the only means of communication. However, it is apparent that EFC's concerns did not lead to formal escalation. The review cannot say with any certainty why EFC did not formally escalate her concerns.

Practitioners told the review that the placement in Oldham meant that co-working often took place by phone or email, rather than face to face. However, this was not seen by practitioners to be a major obstacle to effective joint working.

Whilst agencies shared information as set out above, the review has concluded that all agencies might have applied greater professional curiosity and exploration of what was happening for Child E and EM 'below the surface'.

5.5 What checks and balances are in the system and how do they support the assessment of risk (with particular focus on assessments and analysis that led to the decision to place Child E)?

An overview of agency checks and balances within individual agencies was provided in the written reports, a summary is shown below (alphabetically).

It appears that the application of checks and balances was sometimes inconsistent and in some circumstances diminished over time. The application of checks and balances across agency systems is of particular relevance in terms of learning.

5.5.1. Bridgewater Healthcare Trust

OHV1 and OHV2 were not involved in the care of Child E until after she was discharged from hospital, when the decision to place in a mother and baby foster placement had already been made.

5.5.2. CAFCASS

A key point identified by CAFCASS is the system of self-regulation for CGs. The CGs involved with Child E and ES were both accredited self-regulators. The system permits them to file reports and close cases without management oversight, this accreditation remains under review.

There was an expectation from CAFCASS that Child E would have been seen and that independent enquiries, including liaison with the IRO, was in progress on behalf of Child E. However, this did not happen.

This was a case which could have benefitted from case discussion initiated by the CG or the service manager, although would not have routinely attracted the need for oversight, as the child was in a mother and baby foster placement. Given that the history (with ES) weighed against the care plan, it would have been useful for there to have been further exploration of the detail of this reported progress.

It appears that there were assumptions that the placement was a 'safe' environment, however this should not have precluded CG from undertaking a visit and applying more rigour to the role of independent court guardian for the child.

5.5.3. Fostering Solutions

Fostering Solutions reported that they have a robust assessment process for the approval of Parent and Child foster carers, including specific training, support and reviewing of placements. There is a robust matching system in place and where possible and appropriate pre placement meetings and introductions take place.

There are specific recording and monitoring systems in place with the ESSW having at least weekly monitoring and oversight of the placement. Parent and Child specific agreements, risk assessments and recording documents were used and shared with ESW and EM for the duration of the placement (it should be noted that ESW did not always read the daily logs in detail). Fostering Solutions said they felt assured that key concerns were raised separately with ESW via telephone calls and reporting to ESSW.

The review has concluded that the process for escalation of concerns between EFC and ESW was not clear or consistent. Similarly it is not evident that the way in which EFC discussed her concerns with EM was consistent and/or supported by ESW. Interactions would also have been strengthened if EFC had discussed with ESW and EM aspects of the placement that were going well.

5.5.4. NNU

Initially a senior nurse in NNU was leading on the transfer of Child E's care onto the NNU and ensuring safeguarding risks were identified. The senior nurse was vigilant and called ESW to arrange a safeguarding meeting. However, as Child E's stay continued to eleven weeks, this level of continuity diminished.

The NNU was informed of the ICPC being held and it was considered that NNU's information for conference had been shared in a timely manner, with ESW and YPMW. The attending practitioners at the ICPC appropriately shared information at the conference.

A visiting log recording EM's pattern of visiting was maintained and shared. Notes were made by EFC regarding EM's capability in providing Child E's care. In general EM's care-

giving did not raise concern with staff, and there had not been a need to repeat instruction or advice given. However, it was noted that EM was demonstrating an emerging pattern of behaviour similar to that which took place with ES. This was identified as a cause for concern.

The assessments of EM's interaction, care and relationship with Child E, and the potential risk that EF posed were consistently implemented throughout Child E's stay on NNU.

SHV's focus of intervention was on gaining understanding of Child E's health and medical needs, historic safeguarding issues, safeguarding progress and establishing contact with the family in preparation for Child E's discharge. Contact with EM was planned following the initial case conference but did not occur.

Liaison with multi-agency practitioners involved in Child E's care identified that EM had missed the GP appointment for her postnatal examination, and this was appropriately shared at the meeting and with the health visitor.

Overall there was a recognition of the value of supervision with the Matron and Senior Sister offering managerial oversight. In addition, support and advice was sought from the specialist nurse in relation to safeguarding supervision carried out on the NNU.

The safeguarding assessments were documented on the relevant safeguarding record and held at the front of the records. As Child E's stay on NNU lengthened the health records became very large with the result that it was difficult to negotiate the documentation to readily access the safeguarding assessments.

Child E's care on the NNU was of a high standard and demonstrates good practice.

5.5.5. Pennine Care (Healthy Minds)

For every face-to-face assessment the Access Team complete a Trust Approved Risk Assessment (TARA). The TARA is a risk assessment tool that addresses relevant areas of risk.

The TARA has a safeguarding section, which provides a checklist to address any safeguarding issues that may arise in the interview. Should a practitioner have any concerns in relation to risk or safeguarding concerns it is expected that the case would be discussed in clinical or managerial supervision with the team manager. If indicated further consultation can be sought with the PCFT peri-natal practitioner or a Consultant Psychiatrist. This case was not actively discussed in clinical or managerial supervision at any time.

All face to face assessments completed by the Access Team that identify children living within the household of the service user, or whom the service user may have regular contact with, are referred to the relevant safeguarding pathway, as per the "*Stockport Joint Service Protocol to meet the needs of children, young people and unborn babies whose parents or carers have mental health problems"* (Stockport Children's Services and Stockport Adult Mental Health Services, 2017).

Should any concerns be raised in relation to the impact a person's mental health may have on their children, the Access Team will contact CSC by telephone to seek advice and document the discussion.

Following advice received they may then make an online referral to CSC, and will email the CSC contact centre to make a referral. The Access Team will contact the multi-agency safeguarding hub (MASSH) with any immediate child protection concerns. In addition practitioners can seek safeguarding consultation from the PCFT safeguarding team.

It is routine and accepted clinical practice for the Healthy Minds team to document any risks highlighted in therapy sessions in their PCMIS electronic records system.

Documentation and assessment tools were robust and effectively used when assessing EM's mental health and any associated risk. Healthy Minds accepted EM within their time standard and prioritized her treatment due to her perinatal status. Treatment outcome scores (PHQ, GAD) indicated that EM's treatment had been effective. Assessments were conducted within the accepted practice of the service and did not fall outside of the typical standard.

The process of EM's discharge was not in line with service protocol, as this was her first DNA (did not attend).

There is no evidence that the CBT Therapist discussed the case with her manager or Clinical Supervisor.

5.5.6. Stockport Children's Social Care

It was noted that the assessment of risk could have been more critically explored and challenged by the consistent application of checks and balances, including management oversight, which may have led to a greater degree of caution being applied to some of the care planning decisions. Frequent and ad hoc discussions with the team leader are noted which allowed the sharing of factual information but may not have encouraged reflective challenge.

There is limited reference to the CG within the social work records. Following the LAC Review of 30th May 2017, the IRO recommended that the social worker consult with CG about the apparent decline in EM's engagement. In the subsequent care planning meeting on 31st May, the social worker reported that the Guardian "appeared to not have any strong views". This is slightly at odds with the Guardian's statement of 16th May in which she outlines some concerns, but offers "cautious support" to the care plan.

Oversight by the service lead is present however, there is no record of the service leader decision to change the care plan from Child E being placed in a foster placement by herself to one with EM.

The service leader was not notified of the events of 16th and 19th September 2017 (although the team leader and IRO were).

The care planning in this case was always supported by, and consistent with legal advice. This is particularly significant given that the Local Authority's legal representative was, in the main, the same solicitor who dealt with the case of ES.

In the legal planning meeting of 31st May, a decision was made for Child E to remain in hospital for a further five days to test EM's commitment. Individuals within the social work team have reflected on their disinclination to go against legal advice. Whilst legal advice needs to be considered seriously, it may be that social workers need to reclaim confidence in their professional judgement in circumstances where it conflicts with the legal advice given.

Independent Reviewing Officer

The IRO chaired three meetings in relation to Child E.

At the LAC meeting on 6th September serious concerns were raised regarding EM's care of child E. However the IRO did not express a view about what the care plan ought to be as a consequence of these concerns. The significance of this observation is that is reflects an omission of professional opinion and apparent preference for referral to process which is seen elsewhere in this case.

5.6 How do agencies use mother and baby foster placements, taking into account specific vulnerabilities as they apply in this case?

All agencies recognised the value of mother and baby foster placements as a means of offering the opportunity to maintain and promote the early attachment between a parent and their child.

5.6.1. Bridgewater Healthcare Trust

Discussion and reflection with OHV2 has highlighted that, due to Child E's status as a looked after child and because of the perceived level of supervision within this kind of placement, OHV2 felt reassured the Child E was 'safe'.

5.6.2. CAFCASS

CAFCASS supports the use of mother and baby foster placements on a case by case basis determined by the individual needs of each child. In respect of Child E it was recognised that the issues relating to the care provided to ES in a similar setting were at risk of re-occurring. Based on the evidence available it was considered that, with a clear written agreement in place, these risks could be monitored.

Given that the alternative plan for Child E would have been adoption, CG considered that the placement would provide a secure basis from which assessments could be undertaken.

Up until the injuries sustained by Child E, CAFCASS was not provided with any indication that the placement was in difficulty, and did not make any enquiries to find out whether this was the case.

5.6.3. Fostering Solutions

It was noted by Fostering Solutions that mother and baby foster placements can result in significant pressure on the foster carer, as placements can impact heavily on family life. However the agency acknowledges the value of these settings.

Fostering Solutions highlighted that one of the key differences between parent and child fostering and other types of fostering is the foster carer's role in assessment. Foster carers are required to record their observations of the parent on a daily basis. EM was made fully aware that EFC's observations were part of the assessment process.

The importance of ongoing and dynamic risk assessments was highlighted in relation to co-ordination and monitoring of these placements. Fostering Solutions concluded that risk assessment was clearly evident during EM and Child E's placement and that decisions whilst in the placement were made and agreed by all the professionals involved, as well as with EM.

5.6.4. NNU

NNU prepared well for the discharge to mother and baby foster placement. Particular attention was given to Child E's medical needs and that EM would be required to meet these needs day and night. It was of concern to nurses on the NNU that the initial 'staying-over' period was unsuccessful, and that EM did not wake to provide Child E's overnight care. It was concluded that the hospital environment may have influenced EM's ability to carry out care as expected.

It was considered by NNU practitioners that the decision to place Child E in the mother and baby foster placement for a continued period of social care assessments, with the prompts and supervision of EFC, would enable EM's parenting capacity to be further explored in a setting that was safe for Child E.

EFC was present at the Discharge Planning Meeting and was aware of the health and medical need discussions in preparation for Child E's discharge. EFC spent time with mother on NNU in preparation for discharge.

5.6.5. Pennine Care

Pennine Care did not have contact with the mother and baby foster placement and it has been acknowledged that, because of this, opportunities to contribute to discharge planning for the placement were missed.

Healthy Minds had not been invited to multi-agency meetings nor did the service make enquiries in relation to the contact that EM had with CSC.

Healthy Minds staff were not invited to any discharge planning meetings on the paediatric ward before Child E's discharge. Had this happened it would have assisted in information sharing and in building a picture of EM's feelings and concerns.

5.6.6. Stockport Children's Social Care

Mother and baby foster placements offer the opportunity to maintain and promote the early attachment between a parent and their child. This is significant, and its value is well understood.

The CSC individual management report makes the important point that, whilst acknowledging the merits of this placement choice in some circumstances, in those cases where the placement is intended to perform an assessment (as well as accommodation) function, particular clarity is required in relation to both the intended purpose, mechanisms for assessment and review and exit strategy.

There are cases where the question of practical parenting capacity is central to professional concern. In these cases, and where there is evidence-based optimism about capacity and motivation to learn, a mother and baby foster placement may be a valuable option to short-term care planning

It is noted that, in cases where significant risk factors other than basic care exist, the agreement for a mother and baby foster placement needs to be supported by the following:

a. Assessment based confidence in parental ability to reduce the identified area of risk in a sustained way, and supported by targeted work to address this.
b. Considered thought about the function of the placement in managing risk presented by family and environmental factors. There is a danger that mother and baby foster placements may unintentionally mask or temporarily suspend this type of risk, and it was the view of the author of the IMR for CSC that this is what happened in the case of Child E. Indeed, the social worker commented that they thought that EM would have been less able to resist communication from EF had she been in a different environment.
c. The role of the foster carer in mother and baby foster placements, and their contribution to the on-going assessment of risk is complex.

Clarity of expectations from all parties needs to established and reviewed frequently, with an established pathway for managerial oversight being in place.

5.7 How did learning from previous SCRs and the learning and improvement plan impact decision making in this case?

Agencies previous serious case reviews, both national and local, as a source of learning that informs good practice. Examples were given of how agencies use this learning to develop and inform practice.

6 Findings

Agencies were asked to identify learning for their agency in their individual reports, and to produce single agency action plans. These are not reproduced in detail in this report. The following is a summary of key learning.

6.1 Learning from Practice in the Case

- The initial social work assessment largely contained good identification of the areas of concern, and some considered thought about the implications for EM's ability to parent Child E. However, it would have benefitted from fuller exploration of the chronological context' the nature and function of the relationship between EM and EF and the risk presented by EF individually.

- Whilst Child E was in hospital, and when in the mother and baby foster placement, EM demonstrated on several occasions a lack of compliance with the agreed plan. This was not always well explored or challenged and there was consequently no significant change of course in the planning, even when EM's behaviour indicated that she was unable to safely care for Child E.

- EM appears to have minimised the impact of the abusive relationship with EF upon both Child E and herself.

- The Freedom Programme was identified as a means of helping EM to explore domestic abuse however EM did not attend the Programme (although she did give credible reasons for non-attendance). Therefore the risks presented by EM's relationship with EF do not appear to have been fully recognised or explored.

- There was a lack of focus on EF. His role appears to have been perceived as entirely negative by professionals. It is apparent that EF was reluctant to engage in formal processes, however a stronger focus on including him in case discussions and attempts to establish further information about him would have been helpful.

- There was over optimism regarding EM and EF being willing or able to separate. There was a lack of recognition that as Child E's birth father, EF would be likely to have a lifelong connection with her. Greater exploration of how realistic the expectation of permanent separation was would have assisted with strategies to address the risks associated with their relationship. All professional accepted that EM had separated from EF without question.

- EM was not always open and honest with professionals and her self-reporting was taken at face value. . There could have been more rigour and healthy scepticism about what EM said which would have contributed to a more accurate assessment of her commitment and motivation.

- At various points prior to the incident of harm, CG's contact with the EM and Child E fell below that expected, as outlined in CAFCASS' Operating Framework. The Framework provides clear guidance on all areas of case management.

- There is an expectation that Child E would have been seen by CG and that independent enquiries, including liaison with the IRO, would have been in progress on behalf of Child E, which did not take place.

- There is no evidence of dynamic risk assessment taking place whilst Child E and EM were in the mother and baby foster placement.

- There is no evidence of an agreed approach to escalation between EFC and ESW. It would have been good practice to formalise this approach using existing guidance (the review notes that this guidance should be reviewed and strengthened if necessary in relation to mother and baby foster placements).

- The purpose of the 'daily log' and an agreed process of escalation, including the role of the supervising social worker, needs to be clearly defined. In this case, the daily logs were not an effective risk management tool, although EFC may have seen them as such. Opportunities for escalation were not taken by the fostering agency.

- The need to address specific issues in relation to the role of the foster carer (where the placement has elements of assessments attached) is highlighted.

- Professionals from a number of agencies expressed the view that Child E being in hospital, and subsequently in a mother and baby foster placement, led to a false sense of security about her safety and may have affected vigilance in relation to any safeguarding concerns.'

- The review highlights the complexity of the role of the foster carer in mother and baby foster placements, and their contribution to the on-going assessment of risk. Although the foster carer is not the assessor, their observations make a significant contribution towards the assessment process. There is potential conflict in the dual role of assessment contributor and parental supporter.

- The contribution of the foster carer via daily observation records relies on their ability to identify key issues and events, and the confidence to alert the social worker to issues of particular concern. This may not always fall within their area of expertise.

- Possible safeguarding issues could have been more fully explored by Healthy Minds as they had significant contact with EM during the early part of the mother and baby foster placement. Opportunities were missed to explore the reasons for EM attending court for a parenting assessment and EM's feelings about this. Healthy Minds could also have explored the reasons for ES being taken into care. Issues regarding domestic violence could also have been more fully explored including ongoing contact with EF.

- The absence of Healthy Minds in the multi-agency team around the family was a significant gap. The service was not included from the outset in multi-agency oversight of the case. However Healthy Minds were not proactive in addressing safeguarding issues, and the CBT provided to EM ended prematurely.

- EM's discharge from the service was not in accordance with the service policy.

- The Healthy Minds service identified a need to strengthen practitioner learning in relation to exploration of safeguarding issues and professional curiosity to triangulate information provided by service users.

- Out of area placements present some challenges to multi-agency working, however these are not insurmountable.

- It is of note that domestic abuse support services were less easily available to EM due to her move out of area.

- Perhaps the most significant issue regarding out of area placement in this case is the impact that it had on EM. It is not apparent that the risk of EM 'rebelling against' the placement and being unable to settle were given full consideration.

6.2. Wider Findings

This section covers other important findings drawn from the case review that do not directly relate to the terms of reference, but are deemed to be significant. This learning is drawn from IMR's and from practitioner conversations.

- The Stockport health visiting service involvement with the neonatal unit highlighted some ambiguity in the role of the health visitor when a baby is admitted directly to a neonatal unit. In this case this led to a delay in the health visitor intervention and assessment with the family after discharge.

- It would have been good practice for Child E and EM's GP to have made further enquiries about EF and his involvement with Child E.

- Both the lack of acknowledgement of the receipt of Child E's records into the health visiting team and the lack of any documentation within Child E's Oldham health visiting records evidences that it is likely that the records and their contents were not reviewed when they arrived. OHV2 has stated that she cannot remember ever seeing the paper records from Stockport. It is likely that they were received by the team administrator and immediately filed although this cannot be definitively verified. Discussion with team members around why this might have occurred has highlighted that the change from paper records to an electronic system was on-going but that some staff did not feel fully competent in the use of the new system. This was compounded by many families having two sets of records, one paper and one electronic.

- Fostering Solutions highlighted the difficult relationship dynamics that were created by EMGM having frequent access visits. There were differing perspectives of EMGM's influence on EM and this could have been explored further between Fostering Solutions and CSC.

7. Recommendations

7.1 SSCB should receive assurance from partners that the Greater Manchester Escalation Policy is understood and applied across the local partnership, and includes arrangements in foster placements.

7.2 SSCB should receive assurance that all plans include multi-agency involvement and that there is a single plan rather than multiple plans/agreement. They should incorporate any written agreements if applicable and are specific to meeting the needs of the child.

7.3 SSCB should receive assurance that actions identified for this review in relation to mother and baby foster placements (which have now been implemented) are embedding into practice.

7.4 SSCB should receive assurance that adult facing services are applying learning from previous SCRs and SARs in relation to the links with services for adults and children and that all services apply the principles of 'Think Family'.

7.5 SSCB should receive assurance that all agencies are able to respond appropriately to issues of domestic abuse.

7.6 SSCB should receive assurance from partners that the SCR Improvement Plan is being embedded into practice.