Local Child Safeguarding Practice Review

Melody

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Contents

1. Introduction

1.1 The purpose of this Local Child Safeguarding Practice Review is to consider learning for partners working with children and families in Warrington, specifically to identify learning from the partnership working with Melody (not her real name) and the adults around her in the months leading up to her suffering a significant injury.

1.2 A rapid review panel was convened on 11th February following notification to Warrington Safeguarding Partnership (WSP) on 3rd February 2021 that Melody had suffered an injury on 19th January 2021. The rapid review panel felt that the child safeguarding practice review criteria was met and that a local review was proportionate. Some panel members felt that there were significant issues of national interest and asked the national panel to consider this.

1.3 On 16th March 2021 the National Panel confirmed they would not be pursuing a national review but agreed with the decision of Warrington Safeguarding Partnership to carry out a local child safeguarding practice review.

1.4 A review panel was convened including:

- Warrington Borough Council (WBC), Safeguarding and Quality Assurance, Partnership Advisor – CSPR Author
- Warrington Clinical Commissioning Group (CCG), Partnership Advisor
- WBC, Children in Need
- WBC, Legal Services, Legal Advisor to WSP
- WBC, Adult Social Care
- Cheshire Constabulary
- Warrington & Halton Hospital
- Beamont Primary School
- NSPCC
- Merseycare (previously North West Borough Healthcare (NWBH))
- Partnerships Manager, Safeguarding Partnerships Team
- Independent Scrutiny Lead for WSP

1.5 The WSP strategic safeguarding partners agreed with the review panel recommendation to commission myself, Fiona Cowan, WSP Advisor and Head of Service for children's safeguarding and quality assurance for WBC Children's Service, as lead reviewer and author. I have completed this review with support from Pauline Owens, WSP Advisor and Designated Nurse for Children in Care and Child Protection for Warrington CCG, and Paul Duffy, Safeguarding Partnerships Manager. Richard Strachan, WSP Independent Scrutiny Lead, has provided oversight and challenge.

1.6 I have 21 years of post-qualifying experience of working in child protection and safeguarding. In considering the requirement for 'independence' the panel agreed that I could bring an independent view to the review as my service were not involved in working with the family prior to the incident. The inclusion of the Independent Scrutiny Lead on the panel provided additional independent scrutiny of the review process.

1.7 Pauline has 46 years nursing experience as both and Adult Nurse and Children's nurse and has worked specifically in child protection and safeguarding since 2000. Pauline has no direct contact with the family in her role as Designated Nurse.

1.8 An action plan was generated to ensure timely and efficient sharing of learning already identified via the rapid review process.

2. Methodology

2.1 The period covered by the review is from January 2020 as this was the first reported possible safeguarding concern noted by a professional working with Melody's mum. Prior to this date Melody had been subject of a child and family assessment in 2016 where there was no further intervention. At the time of the incident Melody was not open to statutory services.

2.2 A review panel was convened on the 1st June 2021 where the methodology for the review and the author were agreed.

2.3 The review recognises the complex circumstances in which professionals work together to safeguarding children and looks to understand the underlying reasons that led to the decisions and actions of practitioners and managers.

2.4 The agreed methodology;

- Multi-agency chronology updated to include times.
- New information gathering form completed by Adult Services quality assurance team.
- Reflective conversations with practitioners involved with Melody and her family, undertaken jointly by the author and the WSP Advisor from the CCG:
    - Approved Mental Health Professional (AMHP), WBC Adult Services
    - Consultant Paediatrician, Warrington Hospital
    - Duty Social Worker, WBC Children's Services
    - Duty Manager, WBC Children's Services
    - Helpline Development & Quality Manager & Helpline Service Head, NSPCC
    - Mental Health Practitioner, Merseycare (NHS)
    - Staff Nurse, Warrington Hospital
    - Safeguarding Coordinator, Beamont Primary School
    - Three Police Constables
    - Street Triage Officer
- Two separate reflective learning circles held, informed by practitioner conversations, with first line managers and then second line managers:
    - First Line Managers
        - Team Manager, WBC Children's Services
        - Lead AMHP, WBC Adult Services
        - Recovery Team Manager, Merseycare
    - Second Line Managers
        - Service Manager, WBC Children's Services
        - Head of Service, WBC Assessment & Care Management, Adult Services (covers the AMHP Service)
        - Two Matrons for Quality, Merseycare
        - Independent Scrutiny Lead WSP
- Reflective conversations with Cheshire Constabulary managers who were not able to attend the learning circles:
    - Detective Inspector, Cheshire Constabulary
    - Police Seargeant, Cheshire Constabulary
- Learning circle with panel members held, informed by learning from each of the previous learning events (practitioner conversations and manager learning circles)

3. What the review needed to understand:

- Delay in information sharing from NSPCC to the Multi-Agency Safeguarding Hub (MASH).
- Delays in sending Vulnerable Person Assessment (VPA) to MASH and the language used when describing incidents in relation to children.
- The multiple contacts to MASH screened as no further action – was the rule of 3 considered?
- Were practitioners working together to consider the lived experience of Melody? Did they demonstrate professional curiosity? Was consideration given to the impact of Adam's mental health for Melody? Specifically;
  - GP Contacts where parental mental health is discussed.
  - Agency response to contact from Adam's daughter and friend; delays in the decision that a Mental Health Act (MHA) assessment was required.
  - Recovery Team visit to Adam – were they aware that a child was in the home?
  - Out of Hours Approved Mental Health Practitioner (OOH AMHP) decision to defer the MHA assessment until the following day.
  - Barriers to information sharing between Adult Services and Police.
  - Police decision not to physically see Melody on a number of occasions.
- Was enough consideration given to the possibility that Melody was sexually assaulted during the attack?
- Discharge of Melody from the hospital to her mum's care without a discharge meeting.

The review will also consider the impact of the Covid pandemic for partners and partnership working.

4. Brief Summary

Family (All names have been changed)					
Child:	Melody	**Mum:**	Angela	**Dad:**	Brian
		Mum's 1st partner:	John	**Mum's 2nd partner:**	Adam

4.1 Melody is a little girl with mousey blonde hair. She likes arts and crafts and likes to play on her scooter.

4.2 When she was born Melody lived with her mum Angela, dad Brian and her older siblings, the youngest of whom was a teenager. Melody's parents had been together for over 15 years when she was born and were known to WBC Children's Services since 2013 in relation to their teenage daughter who was at risk of exploitation. There were some concerns about parental use of alcohol in the home but an assessment of the family concluded in 2016 that there was no need for WBC Children's services to be involved in relation to Melody. Melody's sister remained subject of a child in need plan for a further 12 months.

4.3 Melody attended nursery occasionally before starting at the linked primary school.

4.4 In August 2019 Cheshire Constabulary (Police) referred the family to WBC Children's Services after attending the home following reports of arguments. Brian reported at the time that he had threatened to commit suicide after learning that Angela had had an affair. He returned to the family home to live after moving out for a brief time. Police visually checked on Melody during this visit. No further action was taken by WBC Children's Services.

4.5 It is believed that Melody's parents separated between August 2019 and early 2020, and Melody and Angela moved to a new home. Melody transferred to Beaumont Primary School in September 2020 just before schools were closed due to the Covid-19 pandemic.

4.6 8th October 2020 Police were called to Angela's home where she was reportedly arguing with her new partner, John. Melody was spoken to by officers and appeared upset when telling them that the adults were shouting. Efforts were made to secure witness reports but the adults in the house made no allegations and neighbours refused to make any reports. Background checks were sought on all adults in the house. The Police removed John and recorded a VPA and referred to MASH on 9th October 2020.

4.7 MASH screening completed, including discussion with the school safeguarding lead who had no concerns to share. No further action was taken.

4.8 On 23rd October 2020 School made a home visit to see Melody as they were unable to make contact with Angela.

4.9 5th November 2020 Probation referred to MASH stating that John was a risk to children due to domestic abuse, having stabbed his previous partner whilst she was holding their child in her arms. Screening was commenced, including discussion with Angela, school and health professionals. Angela immediately stated she had already ended the relationship with John given the risks shared with her during a visit to Probation with John.

4.10 The social worker had completed the screening and sent it for authorisation when a referral from NSPCC was received and recorded within the same MASH screening tool. This was sent via email to MASH from NSPCC on 6th November but had been received by the NSPCC via three separate emails on 9th, 10th and 11th September 2020. The anonymous referral alleged that Angela was neglecting, and physically and emotionally abusing Melody, and using alcohol and drugs. MASH screening included further discussion with the school safeguarding lead, health professional, Angela and Brian. School reiterated that they had no concerns about Melody's care and could not corroborate the allegations made in the anonymous referral. Angela denied the allegations when they were put to her and believed it was Brian and his new partner being malicious. Brian stated that he was not aware of any drug use.

4.11 MASH screening concluded that social work intervention was not required and Angela declined offers of support from early help. School and Probation agreed to refer back to MASH if further concerns were noted.

4.12 On 8th December 2020, Police were called after Adam entered a Vape Shop to complain his e-cigarette was faulty and an argument broke out when the shop owner refused to refund him money. Adam made threats and caused damage to a wall.

4.13 On 11th December 2020, Melody presented at school with a red rash/ mark under her chin. School questioned Melody but she did not know how she had done it. Angela stated she had seen it and that Melody must have 'slept on something funny during the night'.

4.14 Angela stated a new relationship with Adam who has a longstanding history of Bipolar Affective Disorder managed through the shared care of his GP and 3-6 monthly reviews by a Consultant Psychiatrist. Support needed in the interim is provided via the Daily Duty Officer at Warrington Recovery Team, Merseycare. It is not clear when the relationship started and the first evidence of this within the multi-agency chronology was 5th January 2021 when Adam contacted Angela's GP expressing concern about her mental health.

4.15 There was some question by professional about whether the relationship had started before this as Adam had cancelled his psychiatrist appointment on 4th November 2020 citing child care as the reason. If he was referring to Melody in this conversation then Angela was still in a relationship with John at this stage having attended Probation with John on 3rd November 2020.

4.16 6th January 2021, Angela and Adam attended the GP to discuss her mental health. Reported concerns she could have Bipolar. Angela reported no thoughts of self-harm or harm to others, stated her daughter was her protective factor. GP referred to crisis team, mental health services, and gave advice in relation to alcohol consumption and signposted to Pathways.

4.17 8th January 2021 Clinic reschedule Adam's psychiatrist appointment due to clinical demands on medical staff in light of Covid-19 third wave. New appointment booked for the following month.

4.18 Between 8th and 15th January 2021 School attempted to make contact with Angela as Melody had not accessed remote education. Some calls are successful and expectations were set out, Angela agreed to access the work. Some calls result in Angela hanging up once she knows who has called. On the 15th January 2021 they were able to speak to Melody herself. As acknowledged in the rapid review, school staff were tenacious and persistent during lockdown in speaking with and having sight of Melody.

4.19 14th January 2021 Brian contacted by school about Melody's poor attendance prior to Christmas and that she is not accessing the remote education. Brian reported that he has no contact. School report that he states that "Mum has problems but it is not his place to say".

4.20 19th January 2021:

4.21 At 4.04am Adam was in Tesco acting aggressive and reportedly having a mental health episode. Police record this as mental health and he was mumbling about being a 'ninja'. Adam leaves voluntarily.

4.22 At 9.48am Adam reports to Police via 999 that he has been sexually abused by his father who abused him as a child up until he was 19 years old. Adam was described as very difficult to understand as he was speaking very fast and rambling. He went onto say his father has been killing people and has hidden evidence in the loft.

4.23 At 12.39pm Adam's daughter telephoned the Recovery Team to advise of concerns about her father's presentation. She reported he was staying at his girlfriend's home with her 5 year old daughter. She reported bizarre and aggressive behaviour. The Recovery Team advise her to ring the police and they contacted the AMHP to request a MHA assessment who requested the Recovery Team visit Adam to undertake a visual assessment of his presentation.

4.24 At 12.50pm Adam's daughter rang the police and informed them that her father was not taking his medication, had set his hand on fire and punched the walls. She also informed that he was living with a 5 year old child and her mother is scared of Adam. The Police received a further call from a friend of Adam's at 3.55pm who also stated that his mental health was deteriorating and that he could be a danger to himself and others. This caller stated that Adam was living with Angela and Melody. No action was taken by the Police.

4.25 The Recovery Team Nurse visited Adam at 3.48pm and he immediately became angry, insisting that he did not wish to speak with the nurse and demanding that she left. The Nurse agreed to leave as requested to avoid increased risk of escalating aggression and potential impact to the child who was present in the address. The Nurse made a second request for a MHA Assessment immediately after leaving the property.

4.26 Adults First Response Team allocated the MHA to an OOH AMHP due to the timing of the request which is recorded as complete at 4.47pm having been started at 3.30pm after the initial phone call from the Recovery Team. The AMHP had a long telephone conversation with Angela just before 6pm when she was walking to Adam's flat to collect some things. She had left Melody in Adam's care as she stated she had no concerns that he would present a risk to her. Angela did not think a MHA was required and stated that Adam was mainly calm. The AMHP made the decision to defer the assessment to the following morning.

4.27 20th January 2021:

4.28 At 1.30am Adam called the Police from outside Angela's house. Police attended and Adam claimed that Melody had hit him on the head with a baseball bat. Police spoke to Angela who stated that Melody was in bed. Police did not see or speak to Melody. Adam was escorted into Angela's house with Angela stating that she could care for him.

4.29 At 4am Adam rang 999 stating he could hear a child crying. Police attended Adam's home address where he was naked on the porch. The records state that officers were asked to visit Angela's home to check on Melody. They visit but do not see Melody as Angela tells them she is asleep and fine.

4.30 At 12pm a family member contacted the Police to inform them that Melody had facial injuries having been left with Adam the previous evening. Police speak to Angela but do not visit. Police updated the VPA that was awaiting review from the previous attendance to include child safeguarding concern and submit this to MASH.

4.31 At 12.48pm the safeguarding coordinator from Beamont primary school visit Melody's home address as she had not accessed online education. Angela stated that Melody was at her sisters and she was going to collect her.

4.32 Melody was seen at Warrington Hospital at 3pm with multiple bruising to face, right ear, neck, and bite marks to right arm.

4.33 Melody was treated and spoken to by nurses and a child protection medical was completed by the consultant paediatrician. A strategy meeting was held with WBC Children's Services, Police and School and a duty social worker and police attended the hospital and spoke with Angela. Consultant paediatrician, Police and social worker agreed that Melody could be discharged. She was medically fit for discharge by 9pm and although the consultant offered Melody and Angela a bed for the night Melody was discharged home with Angela.

4.34 A further strategy discussion was convened the following morning and Melody was brought into care.

5. Voice of the Child

5.1 It was not appropriate to speak directly with Melody about the review, given her age and potential distress it may cause her. However, the review has tried to put Melody's voice at the centre of all the conversations and learning events. General updates have been provided to practitioners on her progress since coming into care. Any views she has shared with her social worker and the independent reviewing officer have been shared with the reviewer.

5.2 Melody has told her social worker, when asked if there is anything she wants to share with the professionals involved in her care planning, "please let them know what he did to me".

6. Views of Parents

6.1 Pauline Owens spoke directly to Melody's mum prior to the rapid review meeting and her views were shared in that forum. Mum stated that she did not wish to participate in the review. She did not provide any rationale and agreed to accept a leaflet explaining the process and how to contact the WSP team.

6.2 The author made a number of attempts to speak to Melody's father but he has not responded.

7. Analysis & Recommendations

7.1 Each of the questions raised during the rapid review process will be considered in this section.

7.2 <u>Delay in information sharing from NSPCC to MASH</u>

7.2.1 The rapid review was curious about the use of an electronic referral system reported by the NSPCC Helpline and the efficacy of such in managing safeguarding matters. In the course of review it has become clear that there was some misunderstanding about what part of the Helpline system is automated and what part of the system is managed manually using an electronic system. The Helpline does not use an automated system to assess information or make decisions on referrals. The referral process is electronic (not automated) and a new automated quality assurance process was initiated in November 2020. The Helpline confirmed that priority one referrals are made via telephone contact, followed up by email, and all other referrals by email once triaged and prioritised.

7.2.2 The Helpline have acknowledged that there was a practice error in allocating the initial information which was intended for referral to Warrington Children's Services. This meant that the information was not captured by the systems process which actioned referrals.

7.2.3 This human error was a result of how the practitioner used the system and was addressed with them as soon as it was identified and additional training was provided. The electronic referral system has also been updated and improved so that no steps in the process can be skipped or missed going forward.

7.2.4 When asked about quality assurance mechanisms the Helpline manager explained that they used to have a manual system to check for this type of error but it was felt internally that an automated quality assurance tool would be more robust and this was developed. It was during the transition from the old manual system to the new automated system that the error with this referral occurred.

7.2.5 The Helpline data indicates that since the change to the automated checking process that was introduced in November 2020, there have been 19 occasions of the same error being made; these have been identified by the automated check and rectified by the Helpline within one working day.

7.2.6 The Helpline believe that this data indicates that the change has resulted in an increased level of confidence that the system will automatically flag any errors in processing referrals which are reviewed by a manager who ensures they are sent out without any unacceptable delay.

7.2.7 The Helpline also outlined their workforce development and learning processes in light of the human element of the delay in the referral for Melody.

7.2.8 The Helpline stated that there is a robust induction process that includes classroom-based learning, mentoring and buddying schemes for the initial six weeks of employment or longer, if required. Each member of staff then follows a competency process through which they demonstrate and evidence their ability to manage the varied and complex work that the Helpline receives.

7.2.9 Ongoing learning and development is monitored in supervision and through a Safeguarding and Quality Assessment Framework. All Helpline calls are recorded and contacts can be viewed to ensure that assessment and safeguarding action is in line with Helpline standards, policies and procedures. This would include routine and randomised checks as part of the quality assurance process and that any additional contacts can be audited for any other purpose. This would include internal inspection and case reviews as well as being part of a continuous learning and development framework.

7.2.10 Practice issues that are identified for individual staff are responded to in the live environment and through ongoing and regular supervision with their line manager.

7.2.11 Any practice issues that are identified as a service-wide issue are responded to by updating practice guidance and/or by rolling out training, either formally or informally through Team Development Days, for all relevant staff grades.

7.2.12 The author met with the Helpline managers during the review and was impressed with their commitment and passion for their role in safeguarding children. They state their purpose is more than information gathering and hold a strong desire to work with partners and believe they do this well. They advocate for their model and national presence in the public conscience as one of the children's safeguarding services and receiver of safeguarding concerns. They believe that many people feel more confident to share worries about children via the helpline (telephone and electronic) knowing that their anonymity will be maintained.

7.2.13 The NSPCC are recognised as a national agent of safeguarding for children. The rapid review panel was curious about the positioning of the NSPCC as a prominent receiver and processor of safeguarding concerns, sometimes to the exclusion of the local authority, and whether this impacts on timely safeguarding of children. Where referrers choose to report safeguarding concerns to the NSPCC rather than directly to children services this imposes an additional stage in information moving from the point of source, via the helpline and triage process, to the local authority, exacerbated in this case, by human error and change of quality assurance process. It is accepted that this positioning and national communication strategy may also elicit contacts and reports of safeguarding concerns that may not be reported at all if the only route was directly to children's services.

7.2.14 The triage process utilises a priority matrix to decide the risk and therefore the timeframe by which information should be shared. This risk assessment utilises only information held within the NSPCC system and is not always informed by intelligence held within other agencies. The hypothesis being that when assessing 'cumulative risk', a risk factor appropriately included within the matrix, vital information held by the local authority may not be included in the decision to refer; the time difference being immediately or within 2 working days.

7.2.15 The priority matrix is not aligned to any specific local authority threshold criteria and the information sharing agreement has not been reviewed or updated since 2015 when it was verbally agreed according to the Helpline Manager. It was the NSPCC Helpline manager's understanding that the information sharing agreement between the NSPCC Helpline and local authorities was

developed via the ADCS group and there is no evidence available to state whether this has been reviewed since inception.

7.2.16 **Impact of Covid-19**:

7.2.17 Covid-19 has had a significant impact on the Helpline as they have seen an increase in contacts from 49,000 up to 85,000. These numbers include both electronic and telephone contacts.

Recommendations

1. **NSPCC to lead on a review of Information sharing agreements between NSPCC and Local Authorities via the ADCS group.**
2. **NSPCC to consider the question of the additional stage from source to referral to Children's Services and provide assurance that the delays in passing referrals from the Helpline to Children's Services in Melody's case was a local and acute issue that has been addressed as reported.**
3. **National Safeguarding Practice Review Panel to consider the issues of national interest posed by the author.**

7.3 Delays in sending VPA's (Vulnerable Person Assessment) to MASH and the language used when describing incidents in relation to children

7.3.1 The Police officer completed an incident report at 2.20am on 20th January 2020 which informed completion of a VPA in relation to Adam that was submitted for review by an independent review officer. The language used in this report focuses on the risks to the adult and whilst it does pose the suggestion that '*Relevant agencies to be made aware of the current situation between [Adam] and [Angela] and safeguarding [Melody]*' this is the only reference to safeguarding in relation to Melody.

7.3.2 The rest of the report includes statements offered as fact such as;

- *Harm - [Adam] has been hit over the head with a bat by [Angela's] 5 year old daughter.*
- *Investigation - no further investigation required, [Melody] is below the age of criminal responsibility.*
- *Vulnerability – [Adam] is very vulnerable due to his mental health. [Angela] is vulnerable due to her living alone at her address with [Melody].*

7.3.3 This last statement offers no professional curiosity of Melody's vulnerability as a child living with an adult with significant mental health issues. The language is very adult focused and suggests that a 5 year old child is capable of causing harm and the reason it is not being investigated is due to her not being at an age of criminal responsibility, rather than being a vulnerable child. There is no evidence that the officers in attendance sought to understand the reasons Melody may have hit Adam; was it an accident, or in order to defend herself? The officer has stated in the 'voice of the child' section of the report that it was an accident but provides no rationale for this conclusion and goes on to state that Melody had gone to bed. He did not check on Melody or speak to her during this attendance.

7.3.4 The VPA submitted for internal review was graded as a standard risk which would require a submission to relevant partners within 24 hours, although this decision is made on a case by case basis. It did not reflect the same information the officer later recorded in his report which stated

that Adam had said he '*didn't feel safe in there, it's bedlam, its mad in there even for me, I could see her madness*' which may have resulted in a higher risk grading and referral to WBC Children's Services. This was a missed opportunity to alert partners to the level of Adam's mental health state. Had the officer completing this VPA included the full detail it could have been assessed at a higher risk level at the point of review and submitted earlier.

7.3.5 This information would not have influenced the OOH AMHP's decision not to undertake the MHA assessment at the time of the referral (19th January) as it occurred after this. However, had the Police referred to the OOH AMHP at the time of the incident this may have brought forward the assessment.

7.3.6 Whilst the VPA was awaiting review the Police received information at midday from Melody's sister that she had a mark on her face. When they spoke to Angela on the phone she confirmed that Adam had pushed Melody and she had an injury. The VPA was then updated with a request for a strategy discussion and submitted to WBC Children's Services at 2.09pm on 20th January 2021.

7.3.7 As a general standard, as described in practitioner conversations, VPAs graded as medium or standard risk should be submitted within 24 hours and when convenient to do so and in this case, as the VPA had been initially deemed as standard risk it was submitted within timescales. However, as stated above this VPA should have been rated initially as high risk given the behaviours and vulnerabilities that the officers were dealing with and should have been shared with WBC Children's Services immediately.

7.3.8 Once the new information came to light about the injuries to Melody and the VPA reassessed as high risk a referral to WBC Children's Services was made 2 hours later.

7.3.9 Cheshire Constabulary completed reflective learning sessions with each of the officers involved in the attendances. Senior leaders have been clear that there is an expectation that officers must see children and they must assess the risk in relation to safeguarding children as well as the adults and accurately record this in the VPA.

7.3.10 This review has identified previous attendances (noted in the summary) where officers did see Melody, spoke with her directly and provided accurate and detailed record in the VPA which was submitted in a timely manner. There is no evidence within this review that the actions taken by the officers attending the callout described above is indicative of Cheshire Constabulary's approach to children. Rather it is in relation to individual attitudes and practice issues which Cheshire Constabulary have reassured are being addressed.

Recommendations

4. **Cheshire Constabulary to provide assurance to WSP that police colleagues understand and can apply the 'Think Family' model of safeguarding, and can apply child focused language in VPAs.**

7.4 The multiple contacts to MASH screened as no further action – was the rule of 3 considered?

Multiple contacts

Any previous contacts are considered alongside the new contact. Where it is established there has been 3 or more contacts in a 12 month period our policy states that we should progress to a child and family assessment unless there is a clear rationale as to why not. The MASH social worker will consider all of the contacts cumulatively to ensure families receive the right support and protection when necessary. The social worker will ensure that this is made clear within the analysis for the authorising manager. Where a decision is taken not to progress to a child and family assessment a clear rationale of the decision will be documented within the MASH form by the social and the MASH manager. (MASH Operating Protocol)

7.4.1 The information from Probation was the second contact in the previous 12 months and had been screened during the day and appropriate discussions were held with both parents, probation staff and with school staff in order to establish if the concerns were substantiated. The screening included requests for information from partners including Police, school and health and it is clear that the information was received and taken into account. The screening had been concluded and sent to the manager for authorisation and was appropriately concluding not to open to social work services.

7.4.2 Before this screening was authorised the information from the NSPCC was received as a new referral. The customer advisor who accepted the NSPCC referral acknowledges this is the 3rd referral and requests that the social worker considers if this requires a child and family assessment under the rule of 3. Whilst this new information was a separate referral it was recorded on the same MASH screening form which does make the form confusing to read, although the social worker has made some attempts to clearly define the separate screening activity.

7.4.3 In unpicking why a new referral was not completed on a separate form it would appear that it was the view of the staff that they could not have more than one screening tool open on the system at the same time. The Service Manager has clarified that this is not the case and also posed the question that if a referral is being screened from another source it may feel like duplication to start another MASH to seek updates from the same partners. It is clear that the information from the NSPCC was different from that shared by Probation and it is the author's view that this should be recorded on a separate form.

7.4.4 The social worker acknowledges, in the analysis of the NSPCC information, that this was the 3rd referral in a 12 month period and provides a rationale for why she is not suggesting a child and family assessment. The manager also provides a rationale for agreeing with the social work decision but does not specifically provide a rationale for not initiating the rule of 3 policy.

7.4.5 The Service Manager has implemented a more robust quality assurance framework in relation to MASH screenings. This includes:

- Weekly audits and monthly live audits to capture 3 plus contacts and review decision making. The team and managers are aware that this should be named with a clear rationale. The audits pick up any gaps and they are then brought to live audit to discuss and then taken back to the team in one to one supervision. Screenings can and will be reopened if required. The Quality Assurance Manager supports these audits and produces a monthly report which addresses any areas of learning for the team and this is presented to the leadership team in monthly performance meetings.

- Group supervisions and multi-agency team meetings. Curiosity is a key learning point and something that continues to be explored in both team meetings and one to one supervisions when exploring screening examples. More group supervisions and multi-agency team meetings are being implemented.

- Redesigning the MASH form. There is an expectation that the authorising manager will send back to the screening social worker to complete further screening if gaps are identified such as not multi-agency, led by single source of information, parent led, fathers missed off, no voice of the child / window into the child's journey etc. The form is being redesigned to support mandatory elements.

7.4.6 The Service Manager states that it is not standard practice during the screening process to seek information from the parents' health records which is a missed opportunity to inform an understanding of health issues impacting on parenting capacity and potential validity of self-reporting. The rapid review panel had wondered if this information been sought during the screening would it have altered the outcome decision. Having reviewed the screening and the information available it is the author's view that this information would not likely have altered the outcome given Angela's report of low mood and diagnosis of depression was 9 months earlier and there was no noted impact for Melody identified by the school who had regular contact with Melody and Angela.

7.4.7 In looking at the previous MASH screening completed on 9th October 2020 following a VPA submitted to children services after the Police attended an incident when reports of arguing and possible escalation to violence were made there is a clear missed opportunity. The VPA submitted contains information about John and his MAPPA status and this was not addressed in the screening which focused on the incident. There was a lack of professional curiosity and follow-up conversations with Police about why John was subject of MAPPA. This was a missed opportunity to share the risks with Angela which could have informed an earlier decision for her to end the relationship with John.

7.4.8 Although Police records state that the VPA and Operation Encompass notifications were sent to school these were not received by school. Police records also stated that John had MAPPA status and a referral was made to Probation but there is no record of this being received by Liverpool Probation where the case was being managed.

7.4.9 Probation officers became aware that John was in a relationship with Angela when John informed his Probation officer of the incident at his appointment on 14th October 2020. He did not mention Melody. The offender manager requested information from Merseyside Police who provided details on 21st October outlining the incident. There is no mention of a child in the initial email – but a further email was received which stated that a 5 year child lived at the address but didn't state she was present at the incident.

7.4.10 On 26th October 2020 the offender manager discussed the case with their line manager and it was agreed that a warning should be issued to John due to the behaviour and also agreed for a discussion to take place with John and new partner Angela to explore disclosure. This meeting took place on 4th November 2020, following a failed attendance on 28th October 2020, and Angela was informed of John's offences. Angela was informed that a referral to WBC Children's Services would be made which was completed on 5th November 2020.

7.4.11 Senior leaders have stated that the offender manager could have acted sooner as they were aware of the child residing at the address on 21st October 2020, however, the offender manager did take action to engage John and Angela in the process although this then meant the referral was delayed by 2 weeks. Probation do not currently sit within the MASH and do not regularly attend multi-agency meetings which limits their ability to engage in regular child safeguarding discussions.

Recommendations

5. **WSP to request assurance from WBC Children's Social Care about the consistency of the application of the 'rule of three' protocol and other wider MASH processes that the panel raised questions about during the review.**

6. **Cheshire Constabulary to review processes through which referrals to schools and probation services have not been received so that WSP can receive assurance as to proper resolution of these issues.**

7.5 Were practitioners working together to consider the lived experience of Melody? Did they demonstrate professional curiosity? Was consideration given to the impact of Adam's mental health for Melody? Specifically;

7.5.1 GP Contacts where adult mental health is discussed

7.5.1.1 It was clear at the rapid review from all the information gathered that the GP had demonstrated persistence in following up missed appointments and checking in with Angela when she did not attend appointments in relation to her own mental health. There is evidence of good communications between the different health settings and records being kept up to date.

7.5.1.2 What is not clear is any professional curiosity in relation to the impact of Angela's mental health on her parenting ability. There were a number of missed opportunities to further explore this;

- When Angela told the GP she did not want to be a mum anymore
- When Adam made contact with Angela's GP who followed this up with an appointment with Angela where mental health and excessive alcohol use were discussed.

7.5.1.3 It appears that there had been no consideration of the impact on Angela's ability to care for her 5 year old child if she is consuming 3-4 bottles of wine per day. It is a significant amount of alcohol and has the potential to impact on how Angela would respond to Melody, her ability to keep her safe and meet her basic needs. Whilst Angela stated Melody was her protective factor, Angela's mental health combined with alcohol misuse is concerning. There appears to have been no exploration or challenge to Angela's statement that '*Melody was a protective factor*' and an acceptance that a child could be a 'protective factor'. This places an unrealistic and inappropriate responsibility on children to safeguard their parent and allows practitioners to relinquish their own safeguarding responsibility.

7.5.1.4 There is a wealth of empirical evidence available to indicate that living with a parent who is suffering parental mental ill health can have a detrimental effect on the child, both emotionally, physically and developmentally.

7.5.1.5 There is nothing recorded that a referral to early help had been considered, or any safeguarding advice support, no communication with the health visitor is evident from the records to suggest this case was shared or communication took place. There is a lack of evidence of a 'Think Family' model of safeguarding or keeping the child at the centre.

7.5.1.6 There has been training provided to GPs via the Clinical Commissioning Group (CCG) in relation to the 'Think Family' model of safeguarding and a 'learning from reviews' session is planned with all GPs in Warrington in October 2021.

7.5.1.7 The GP involved in this case has reflected on their approach to the consultations and has taken learning from this including seeking safeguarding advice from the safeguarding team. The Partnership was not assured that this was a one off incident given similar learning from other reviews.

7.5.1.8 Impact of Covid-19

7.5.1.9 Although both Angela and Adam did access GP provision, for themselves and for Melody, decreased footfall to surgeries and increasing use of telephone and e-consultation reduces the opportunity to observe and identify non-verbal communication. It should also be acknowledged that this was also noted and agreed as an issue during the rapid review in relation to the school staff and their ability to 'see' children and parents.

Recommendations

7. **Warrington CCG to provide assurance to WSP that GPs understand and can apply the 'Think Family' model of safeguarding.**

8. **Audit reports to be shared with the WSP as assurance that this is not systemic.**

7.5.2 Agency response to contact from Adam's daughter and friend; delays in the decision that a MHA assessment was required.

7.5.2.1 The Recovery Team acted promptly when they received the call from Adam's daughter and it was considered positive that they take the reports from family seriously and start from the basis that family know the patient much better than any professional. Whilst it is important that family are taken seriously a degree of caution should also be applied when taking at face value what is self-reported and what is reported by family members with a vested interest in the outcome. This will be explored more later in the report.

7.5.2.2 Adam's daughter was advised by the Recovery Team to contact the Police to request support in managing the risks. The responsibility for safeguarding and managing risk should have been taken by the practitioner and a direct call to the Police should have been made. It is possible that the consultation with the police officer in the street triage team was viewed as 'informing the Police' however this was not the view of the officer in the street triage team. This was a missed opportunity to share information with WBC Children's Services and the Local Police and/or Public Protection Unit and secure an emergency response.

7.5.2.3 The Police logged these calls for information, did not attend and did not complete a VPA or refer to either adult services or children's services. This was a missed opportunity to alert WBC Children's Services earlier of the potential risks to Melody and to share information with the practitioners assessing Adam's mental health.

7.5.2.4 There was a lack of co-ordination in the responses to the initial calls from Adam's daughter. The recovery team requested that the AMHP complete a mental health act assessment based on their prior knowledge of Adam's mental health and presentation when in crisis. The first

response team (AMHP) requested support from the Street Triage team who refused to undertake a joint visit as Adam was open to the Recovery Team. The AMHP then stated that is was 'standard practice' that the recovery team must try to assess Adam face to face before they would consider a MHA, requesting that a more informal and least restrictive assessment be completed first.

7.5.2.5 The recovery team practitioner did not believe this was necessary given the aggression demonstrated by Adam on the telephone. There was a sense from this practitioner that she was being asked to 'tick a box' and believed it would have been safer for the AMHP and police to go out.

7.5.2.6 There was some confusion during conversations with practitioners about street triage and they were often referred to as 'Operation Emblem', which was the pilot programme that trialled the street triage model. Operation Emblem was also cited as the reason the AMHP requested the recovery team visit Adam prior to requesting a mental health act assessment.

7.5.2.7 There were a number of delays from the time the initial referral was made by Adam's daughter at 12.39pm on the 19th January 2021 that prevented practitioners from safeguarding Melody and preventing the assault. The first of these being 3 hours from the decision not to accept the request for a MHA until the recovery team had visited Adam face to face.

7.5.2.8 In response to the initial referral from the Recovery Team Nurse the AMHP spoke with Adam's daughter to gain an understanding of the current situation. It was noted that Melody was at the same address as Adam and not in school. Consideration was given to the relationship between Adam and Melody and it is reported that this was positive and that Adam would 'be ok with her'. The report then goes on to suggest that Adam's views of his father were erratic; believing one minute he is the devil and the next the best dad ever. There was no professional curiosity or assessment of how Adam's views of Melody may also change from one minute to the next given his mental health crisis and his reported drug use.

7.5.2.9 Whilst the AMHP did check on MOSAIC to see if Melody had a social worker this was a missed opportunity to refer Melody to WBC Children's Services for assessment.

7.5.2.10 The AMHP discussed the referral with another AMHP and they agreed to request the Street Triage Team (referred to as Operation Emblem) to undertake a joint visit with the Recovery Team Nurse. This request was refused due to it being an open case to the Recovery Team. This resulted in the request for the recovery team to visit Adam. This added unnecessary delay and senior leaders were clear in their view that there is flexibility within the 'standard practice' and that the MHA assessment could and should have been initiated by the AMHP based on the initial assessment from the Recovery Team Nurse. This was a vital missed opportunity to complete the assessment and remove Adam from Melody's home earlier and potentially prevent the assault that took place later that day.

7.5.2.11 When the recovery team had visited and reported back to the AMHP it was later in the afternoon and the AMHP discussed the referral with his manager who stated that Adam's partner was responsible for the safeguarding of her child and that she could call emergency services if needed. It is possible that the record does not accurately reflect the discussion and inaccurately implies a perspective that it is only a parental responsibility for the child's welfare and safety, whereas clearly all agencies have a safeguarding responsibility. Training and development needs are being explored with the staff who were involved in the discussion.

7.5.2.12 The AMHP had a further conversation with the Recovery Team Nurse who stated that the Mental Health Act assessment could take place tomorrow if it wasn't for the child being there and would prefer it to happen tonight. This demonstrates some understanding of safeguarding children but did not result in a referral to WBC Children's services. Further discussion with Adam's daughter confirmed the situation was unstable and that an assessment should happen that night. It was also noted that Angela was continually texting Adam's daughter asking her for help and wanted the assessment to take place as soon as possible.

7.5.2.13 The AMHP informed Adam's daughter that if the situation escalates she should use 999 to contact the police. Given the mental health history and current presentation it is the author's view that it was not reasonable for Adam's daughter to be left with the responsibility to manage the situation.

7.5.2.14 There appears to have been a number of assumptions made by a number of practitioners in the course of dealing with Adam's mental health crisis which demonstrates that 'safeguarding children is someone else's responsibility';

- Someone else was referring Melody to children's services
- Adam had not previously harmed Melody
- Angela was able to safeguard both Adam and Melody.

7.5.2.15 The daytime AMHP then referred the assessment request to the OOH AMHP for action as it was late afternoon. There is an agreement in place that OOH's staff should cease working at 4pm to ensure they have had a break before starting the shift. In practice, due to the workloads and pressure on staff who are AMHPs, this does not always happen. In this case, it is noted that OOH AMHP took the call from the daytime AMHP staff whilst travelling home (he stopped to take the call). This environment is not ideal to establish, gather and weigh key information.

7.5.2.16 At no point during this 5 hour window were the Police requested to support by anyone other than Adam's daughter at 12.50pm and Adam's friend at 3.55pm, both of which report significant concerns about Adam's mental health crisis and the fact he was with a 5 year old child.

Recommendations

9. **Clarity is required for all staff across the partnership around roles and expectations for AMHP and Warrington Recovery Team in managing MHA referrals and assessments.**
10. **Clarity is required for all staff across the partnership around the role of Street Triage and the distinction from the Police Protection Unit and Local Policing Units.**
11. **A more timely and coordinated response is required and considerations given to how Adult's Services can develop stronger links with the MASH, particularly WBC Children's Services and the Police.**
12. **Information sharing between Adult Services and the Police needs to be timelier and coordinated when managing safeguarding.**

13. **WBC Adult Social Care and Warrington Recovery Team to raise awareness of the referral processes into children's services and embed the 'Think Family' model of safeguarding.**

14. **The author to attend the monthly AMHP hub to share the learning from this review.**

7.5.3 Recovery Team visit to Adam – were they aware that a child was in the home?

7.5.3.1 There was some confusion at the rapid review about whether the Recovery Team were aware that a child was living in the property where Adam was suffering a mental health crisis. The conversations with practitioners appears to conflict with the recorded information provided to the review process. The referral to the recovery team that was made by Adam's daughter on the 19th January 2021 clearly states that there was a child at the house. However, the practitioner who visited stated that she had not been informed by the AMHP that there was a child in the home before the visit.

7.5.3.2 The practitioner has reflected on the visit and had witnessed Melody on the stairs. Adam's daughter was present also as was Angela who appeared to be protective of her child. The practitioner's rationale for leaving was to not aggravate Adam any more due to the child being at the property and the potential distress it may cause her. Melody did not appear distressed or phased by Adam's presentation, which in itself should have raised some professional curiosity about why a young child was not reacting to the aggressive and bizarre behaviours of an adult. Was this because she has seen it before and has become desensitised? This should have been explored further and not taken on face value that Angela had the ability to safeguard Melody. This was a missed opportunity to safeguard and a referral to WBC Children's Services should have been made.

7.5.3.3 The practitioner reflected that she should have contacted the Police and WBC Children's Services immediately she left the property and recognises that there had been an assumption that the AMHP had referred it into MASH.

7.5.3.4 Warrington Recovery Team leaders have recognised during this review that there was a lack of safeguarding specific guidance for working with adults who experience thoughts to harm children. They have stated that the rapid review provided necessary challenge around promoting effective responses when faced with adults that experience thoughts of causing harm to children in any way. This triggered discussions across the health economy to seek out assurance of existing practice guidance and process for considering safeguarding children when risk assessing and safety planning for adults experiencing thoughts of harm to others. They found a lack of any guidance or specific process in regards to Thoughts to Harm Children (locally and nationally) and have taken the early lessons learned as part of the safeguarding practice review as an opportunity to create some.

7.5.3.5 The Parental Mental Health Toolkit navigates staff to take an all-round view of the impact parental mental health can have on the wellbeing of children; a Think Family approach. Using a 'Traffic Light' principle, the toolkit will navigate users towards tools to measure need, direct to local threshold documents, support pathways and procedures for escalation & resolution. The tool encapsulates situations of harm via emotional, physical, sexual abuse & neglect as a result of parental mental health disorder and supports timely and effective localised response. Within the tool staff can access practical guidance for considering safeguarding

children within adult presentations that include Thoughts to Sexually and Physically Harm Children as well as paying due consideration to the push/pull factors of extra-familial harm and exploitation of children in families and directs users to Pan Cheshire & Mersey Child Exploitation Resources.

7.5.3.6 Impact of Covid-19

7.5.3.7 Consideration was given to whether Covid-19 restrictions impacted on the initial decision by the recovery team to request the MHA prior to making a face to face visit, as per usual processes. In this case Covid-19 did not have a significant impact as all acutely mental health patients received the same service as pre lock down. On the day of the event, the team had no staff shortages and there was a second on call for Duty, so there would be no delay in undertaking the home visit.

7.5.4 OOH AMHP – Decision to defer the Mental Health Act assessment until the following day.

7.5.4.1 The OOH AMHP has reflected on the actions and decisions taken on the evening of 19th January 2021 and has accepted a number of learning points;

- Should have sought information from the Police (considered in the next section)
- Should not have accepted Angela's assurances at face value
- Should have referred Melody to children services

7.5.4.2 Returning to a previous statement that the Recovery Team 'start from the basis that family know the patient much better than any professional' it is would appear that this ethos was also applied by the AMHP during his enquiries. The OOH AMHP spoke with Angela and accepted her word that Adam did not present a risk to Melody and that he had shown no aggression towards her. There was a lack of professional curiosity and action to safeguard Melody. It should be noted that it is likely that the assault on Melody was taking place whilst the OOH AMHP was on the telephone to Angela as she was on her way to collect some of Adam's belongings from his home when they spoke. The OOH AMHP has reflected a great deal on his actions and decisions and feels a sense of guilt but it is unlikely that the decision of the OOH AMHP could have prevented the assault taking place. Action earlier in the day was required.

7.5.4.3 The OOH AMHP has reflected on some of the rationale for his decision making and the barriers that impact on interventions.

7.5.4.4 AMHPs have to weigh up the necessity of completing an assessment at a particular time versus the distress that this may cause to the household later at night. A lack of hospital beds is a regular challenge for AMHPs and whilst both the daytime AMHP and the OOH AMHP had placed a search for a bed none were available. A search for a private bed can only take place once the assessment has been completed. It is stated that Adam's daughter, in discussion with OOH AMHP, expressed her concern that Adam would run away if he could not be immediately taken to a mental health bed once he was made aware that a MHA was to take place.

7.5.4.5 It has been stated a number of times during the review that the AMHP service is not a 'blue light' service and the Mental Health Act and Code of Practice requires that the assessment is planned in an appropriate way. It is stated that where the MH Act assessment cannot take place straight away then risk has to be managed by the emergency services; in this situation, the police. This statement itself reveals the lack of 'Think Family' approach and lack of consideration of risks to the child when the focus of the assessment is an adult.

7.5.4.6 The OOH AMHP had measured the risks of the situation based on the information he had and made a decision informed by the assertion by Angela that Adam did not present an immediate risk to himself or to her and Melody. At no point did the OOH AMHP seek to gather or share information or intelligence from the Police Public Protection Unit which meant that there was some pertinent information that was not known regarding the previous incident attended by Police at Tesco, and the phone calls made by Adam to police during that day. This was a missed opportunity and the OOH AMHP accepts that delaying the MHA assessment until the following day was not the right decision.

Recommendations

15. **WBC Adult Social Care to reflect on the expectations and demands of staff who work out of hours as part of a current review of out of hours services, particularly the AMHP cover – daytime and out of hours.**

16. **Training with practitioners across adult's services in relation to assumptions about family knowing the patient best – not accepting on face value assertions from family that they can safeguard their child.**

7.5.5 Barriers to information sharing between Adult social care and Police

7.5.5.1 It was clear when speaking to practitioners in adults' services that they do not have the same access to Police information that children's social workers in the MASH have. Adult workers, including AMHPS are expected to complete a request for information form which would bring inherent delays in assessing and responding. There is an informal 'do me a favour' arrangement whereby individual relationships between adult social workers and police practitioners can result in more timely sharing of information but this was not utilised on this occasion.

7.5.5.2 This review emphasises the importance of establishing good and close communication at referral and throughout, between the AMHPs and the police. The AMHPs could have contacted the police at the end of each point of decision making to ensure that action or the lack of action was shared, given the police are the emergency response agency in this case. Likewise police could have provided an update to the AMHP on any involvement they were having.

7.5.5.3 An underlying issue appears to be that direct communication from AMHP to the police is experienced as a significant challenge during an assessment and is time consuming in a situation where time is critical. During a MHA assessment AMHPs are reporting they have to ring 101 each time they want to talk to the police about the case and can experience long waits, sometimes several, on the line during the one assessment. They are also required to complete a form which they send to the police requesting information, taking time to gain a response for what is perceived as essential safeguarding information. The OOH AMHP felt that it would be very helpful to look at the process used in child protection and whether adult social care and the police can look to develop a more direct and effective communication route for this key area moving forward and sharing critical information.

7.5.5.4 There was some frustration noted that since the separation of the AMHPs from Health practitioners working together has become less effective and more challenging. AMHPs used to have access to the health system (RIO) but this access was revoked following the change to GDPR.

Recommendations

17. **Review of how Adult Services work with Police and WBC Children's Services**
    - **Develop an information sharing process**
    - **Consider an Adult's MASH or Adult Services inclusion in Children's MASH.**

18. **Strengthen links AMHP and mental health services to share information**
    - **Access to RIO for appropriate professionals.**

7.5.6 Police decision not to physically see Melody on a number of occasions

7.5.6.1 When exploring the Police response to Adam's allegation that Melody had hit him with a bat the author posed a number of questions to managers about the information available to attending officers.

7.5.6.2 Attending Police officers have limited support from the control room and do not routinely receive a chronology of previous attendances or concerns. This is only available when control have the capacity to do so and leaves the Police managing a crisis as a single issue rather than a series of incidents that cumulatively would impact on their decision making.

7.5.6.3 The Police Sergeant attending on the 20th January was aware of the previous Police attendance to Adam when he was acting aggressively in public in the early hours of 19th January but was not aware of the 2 calls from Adam's friend and daughter.

7.5.6.4 When officers attended the call from Adam in the early hours of 20th January where he was stating he had been assaulted by Melody they did not visibly check on Melody when leaving him at the address with her. It is likely Melody was already significantly injured and she was left in the address with Adam still in crisis. This was a missed opportunity to safeguard Melody and ensure she received required treatment. It also left her vulnerable to further assault.

7.5.6.5 Although officers did have some worries about leaving Melody with Adam in the house they took Angela's word that she could protect both Adam and Melody.

7.5.6.6 Reflective discussions with the sergeant attending considered that his decision making was influenced by a number of factors:

- Adam's statement that he was due to have a mental health act assessment later that day.
- Angela's statement that she could protect both Adam and Melody.

7.5.6.7 A further call from Adam 2 hours later when he was at his own address and still presenting as in mental health crisis was attended by the same officer. Adam had called 999 stating he could hear a child crying. No child could be heard crying and the attendance did not result in a

conversation with Adam. It is stated in the police records that the officer requested a patrol visit Angela's address to check on Melody.

7.5.6.8 There were some inconsistencies between the reflective conversations facilitated by police managers and the conversations held with practitioner as part of the review. Although the information provided to the rapid review stated that learning had been taken from the reflective conversation and it was accepted that Melody should have been seen in person and that section 136 of the mental health act should have taken primacy, one of the practitioner conversations did not reflect this learning. The practitioner stated that he had not requested another patrol see Melody as he had been reassured that Angela was able to safeguard. This provides a rationale, albeit unsatisfactory, about why the officers asked to attend Angela's home for a second time did not see Melody in person.

7.5.6.9 The author escalated this inconsistency to senior leaders who immediately sought to reinforce the learning with the individual and provided reassurance that was being addressed and monitored.

7.5.6.10 There was a lack of professional curiosity about why Adam was back at his own address when Police had previously left him in the care of Angela. The officer attending this call did not speak to Adam. Officers attending Angela's address did not ask her why he was no longer there and did not see Melody as they took Angela's word that she was safe and well. This was a missed opportunity to safeguard Melody and ensure she received required treatment.

Recommendations

19. **A question for Cheshire Constabulary to consider; does the lack of routine support from control prevent officers demonstrating professional curiosity and asking control for information?**

20. **Cheshire Constabulary to provide assurance that officers understand the expectations of senior leaders that children must be seen when attending a safeguarding call.**

7.6 Was enough consideration given to the possibility that Melody was sexually assaulted during the attack?

7.6.1 When it became clear that the injuries Melody suffered (biting, strangulation), confirmed by the child protection medical, were also described by Angela as a feature of her and Adam's sexual habits the partners in the strategy meeting discussed the possibility of a sexual assault. The Police consulted the SARC on the 21st January 2021, on behalf of the strategy meeting members, for advice on whether to undertake a medical to assess for a sexual assault. The advice was that it would not be in Melody's best interests to attend for another medical given she had just had a child protection medical. As more information about the number of baths Melody appeared to have had in the hours after the assault the Police again sought advice from the SARC who advised the same and suggested to see if Melody shared anything in her interviews and conversations.

7.7 Discharge of Melody from the hospital to her mum's care without a discharge meeting.

7.7.1 A strategy meeting was convened, chaired by the social work manager and attended by police public protection unit and school staff. There was some professional curiosity about Angela's part in the assault and a section 47 agreed, with plans for a further strategy meeting the following morning.

7.7.2 In speaking with the practitioners involved in the immediate enquiries at the hospital on the evening of 20th January 2021 it is evident that they were of the view that they had worked well together during this time. The social worker, police officer and consultant paediatrician met to discuss what information they had gathered from conversations with Angela and from speaking with Melody. All 3 partner representatives came to the view that Angela was not an immediate safeguarding risk to Melody and there was no evidence to suggest that it was not safe for her to return home to mum's care that night given Adam had been sectioned and was detained in hospital.

7.7.3 The social worker stated that her manager agreed with this decision and it was agreed that a follow-up visit would take place the next morning to inform a further strategy. Although this meeting was not formally convened as a 'discharge planning meeting' it was clearly concerned with agreeing the next steps in terms of investigation and discharge for Melody.

7.7.4 At the time this decision was made, not all information was available to the practitioners; the social worker was new to Warrington Borough Council (had been in post for only 3 days) did not have access to WBC Children's Services records and was being supported by a manager who had also only been 3 days in post in Warrington. Her manager was in consultation with a duty manager who was consulting with the Service Manager. The Service Manager states that she did not think that Melody should be discharged home that evening without further information and reassurance that Angela was not a risk factor, however, there was no legal advice sought to support this position. There appears to have been a significant breakdown in communication between the conversation between the service manager and the duty manger and the conversations between the social worker and her manager. The message that was relayed to the social worker and the hospital was that she should not go home without a discharge planning meeting; not that she should not go home.

7.7.5 As Melody and Angela started to speak to the nurses there were some worries that Angela's version of events was changing and that she was not being completely honest. There was some professional curiosity demonstrated by the consultant paediatrician and she made contact with the Police officer to share the new information and check if it was still appropriate for Melody to go home with mum. The consultant has since reflected that she still had some doubts and offered Angela a room for her and Melody to stay in the hospital overnight. Angela refused and took Melody home at 9.30pm.

7.7.6 When asked why she did not share this new information with WBC Children's Services she reflected that she would do this in future and only rang the Police as she had the officer's direct phone number. The hospital has a safeguarding team to whom practitioners can speak if they wish to discuss a safeguarding concern but this team is only available 9am to 5pm and so neither the consultant nor the nurses caring for Melody would have been able to discuss the new information or their doubts.

7.7.7 The lines of communication within children services became blurred with the number of managers involved and only one of whom was in direct contact with the social worker. Rather than a manager making a call to the hospital this should have been relayed directly to the social worker.

7.7.8 Impact of Covid-19

7.7.9 During the rapid review consideration was given to whether the decision to discharge had been impacted by Covid-19 but it is clear from the above that this was not the case as a bed was available.

Recommendations

21. **WBC Children's Services to ensure that induction for new managers is completed on their first day and review their lines of communication, internally and externally.**
22. **All partners to review the availability of advice and support to practitioners out of hours.**
23. **Partners to ensure that all staff have the relevant skills and training in managing child protection out of hours.**

Independent overview of Melody's CSPR

I am an independent safeguarding partnerships manager, employed by the core partners of lead agencies in Warrington to manage the safeguarding adults board and safeguarding children's partnership.

I sat as a member of the panel in Melody's review, and took part in four meetings. I observed the discussions, challenges, and deliberations of officers representing all of the services that had a connection with Melody's case.

My first observation is that this was a thorough, comprehensive and professional review. The review of the circumstances and background to the harm done to Melody was proportionate and appropriate, and met the requirements of such a review set out in section 17 of the child and social work act 2017. The review was detailed and thorough and, in my view, met all of the considerations about what happened to Melody as I would have expected it to. The author presented the information clearly and drew conclusions from evidence found.

I agree with the panel's view that it would not have been appropriate to have sought direct involvement from Melody in this review and support the approach taken to ask the social worker to engage with Melody about her views. Melody asked that the panel should know what was done to her by the perpetrator. I can assure Melody that this was uppermost in the panellists' minds and that they were very clear about all of the evidence available to them and were tenacious in their efforts to uncover everything that happened on the day in question so as best to be able to help practitioners learn from this and improve their practice so that we can try to stop this happening ever again to someone else.

I find that the recommendations are proportionate. I support the approach proposed to seek to strengthen operational and commercial agreement between NSPCC and WBC to expedite the passing of the baton from one agency to the other and assure the safeguarding partnership that there are more robust processes in place to prevent referrals and vital information from falling through the gap. Given what was found, I also support the recommendation for Cheshire Constabulary and Warrington CCG to assure the partnership that for officers and health partners to be able to apply the principles of 'Think Family' in pursuing their duties is incredibly important, as this demonstrated some of the clearer missed opportunities to prevent harm to

Melody as well as to see that she received help sooner. I welcome an exercise to seek certainty around how the 'rule of three' approach is applied in the MASH, and having heard these discussions in the panel, feel that this will help practitioners' understanding. All in all, my view is that the 23 recommendations are valid and, once the action plan has been completed, that the impact of practice improvement will be significant.

In summary, the basic expectation of safety that Melody has a right to was not met at several points in this deeply distressing case. At the time Melody was assaulted, some agencies knew of the danger she was likely to be in, but a failure to work together along with individual lapses in judgement in critical moments meant that Melody was not safeguarded. The review into the circumstances that caused this is, in my judgement, appropriate and proportionate. The conclusions drawn by the author and supported by the panel have led to recommendations that can be impactful and will generate actions that can meet the findings contained in this report so that collectively we can learn and improve.

Paul Duffy – Safeguarding Partnerships Manager

Recommendations

1. **NSPCC to lead on a review of Information sharing agreements between NSPCC and Local Authorities via the ADCS group.**
2. **NSPCC to consider the question of the additional stage from source to referral to Children's Services and provide assurance that the delays in passing referrals from the Helpline to Children's Services in Melody's case was a local and acute issue that has been addressed as reported.**
3. **National Safeguarding Practice Review Panel to consider the issues of national interest posed by the author.**
4. **Cheshire Constabulary to provide assurance to WSP that police colleagues understand and can apply the 'Think Family' model of safeguarding, and can apply child focused language in VPAs.**
5. **WSP to request assurance from WBC Children's Social Care about the consistency of the application of the 'rule of three' protocol and other wider MASH processes that the panel raised questions about during the review.**
6. **Cheshire Constabulary to review processes through which referrals to schools and probation services have not been received so that WSP can receive assurance as to proper resolution of these issues.**
7. **Warrington CCG to provide assurance to WSP that GPs understand and can apply the 'Think Family' model of safeguarding.**
8. **Audit reports to be shared with the WSP as assurance that this is not systemic.**
9. **Clarity is required for all staff across the partnership around roles and expectations for AMHP and Warrington Recovery Team in managing MHA referrals and assessments.**
10. **Clarity is required for all staff across the partnership around the role of Street Triage and the distinction from the Police Protection Unit and Local Policing Units.**
11. **A more timely and coordinated response is required and considerations given to how Adult's Services can develop stronger links with the MASH, particularly WBC Children's Services and the Police.**
12. **Information sharing between Adult Services and the Police needs to be timelier and coordinated when managing safeguarding.**
13. **WBC Adult Social Care and Warrington Recovery Team to raise awareness of the referral processes into children's services and embed the 'Think Family' model of safeguarding.**
14. **The author to attend the monthly AMHP hub to share the learning from this review.**
15. **WBC Adult Social Care to reflect on the expectations and demands of staff who work out of hours as part of a current review of out of hours services, particularly the AMHP cover – daytime and out of hours.**
16. **Training with practitioners across adult's services in relation to assumptions about family knowing the patient best – not accepting on face value assertions from family that they can safeguard their child.**
17. **Review of how Adult Services work with Police and WBC Children's Services**
    i. **Develop an information sharing process**
    ii. **Consider an Adult's MASH or Adult Services inclusion in Children's MASH.**
18. **Strengthen links AMHP and mental health services to share information**
    i. **Access to RIO for appropriate professionals.**
19. **A question for Cheshire Constabulary to consider; does the lack of routine support from control prevent officers demonstrating professional curiosity and asking control for information?**
20. **Cheshire Constabulary to provide assurance that officers understand the expectations of senior leaders that children must be seen when attending a safeguarding call.**
21. **WBC Children's Services to ensure that induction for new managers is completed on their first day and review their lines of communication, internally and externally.**
22. **All partners to review the availability of advice and support to practitioners out of hours.**
23. **Partners to ensure that all staff have the relevant skills and training in managing child protection out of hours.**