

Child T

Multi-agency Concise Review (MACR)

Executive Summary

Independent Reviewers:
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24th June 2018.

EXECUTIVE SUMMARY.

- 1. Introduction:** This Multi-agency Concise Review (the review) followed an incident in December 2016. Child T (female and almost 3 years old), who was subject to a Full Care Order with Looked After Child (LAC) placed at home status, was abducted from the United Kingdom (UK) by her birth parents. The crime '*Abduction by Parent*' had been committed as the Care Order meant the Local Authority shared parental responsibility for Child T. Parents were not allowed to remove Child T from the UK without written permission from the Local Authority. This had been clearly explained to them through the Care Proceedings, the Final Care Order and at LAC Reviews. The review identified 9 areas of good practice and it was apparent that practitioners did their utmost to safeguard Child T and meet her needs.
- 2. Case summary and key learning:** The Care Order had been granted due to concerns about mother's ability to parent previous children, who were in Local Authority care outside of Salford. This Local Authority had instigated the Care Proceedings for Child T who was father's first child and no concerns about his parenting capacity were identified. He was deemed the '*primary and protective*' parent during the Care Proceedings. A key requirement on conclusion of the Proceedings was that Child T was not to be left alone with mother until she had attended counselling as recommended in an Independent Psychologist's report for Court. The report indicated that 6-10 sessions were likely to be needed. Child T's mother was a Polish migrant to the UK and father was an asylum seeker from Iran. Their relationship commenced around March 2013 and, shortly before Child T was born in January 2014, mother moved to Salford to live with father.
- 3.** Salford City Council became the Designated Authority on conclusion of the Care Proceedings in February 2015, 22 months prior to the incident. No concerns were identified about the care provided to Child T by either parent during that time. Agencies with most involvement including at 6 monthly statutory LAC Review meetings were Children's Services (LAC Social Workers and Independent Reviewing Officer), a Local Authority Day Nursery which Child T attended from May 2015 onwards and Health Visitors. Other agencies who had involvement prior to events in the week leading to the incident were a GP Practice and a Housing Officer.
- 4.** Both parents had presented as fully engaged with Child T's Care Plan and a written agreement put in place by Children's Services. The written agreement was signed by both parents and a hard copy was provided in Farsi. It stipulated mother was not to have sole care of Child T until she had attended the counselling and that parents would work openly and honestly with services. It was understood by the practitioners at LAC Reviews that mother was attending appointments but that 2 counselling sessions were still required. Child T was considered to be securely attached to both parents and progressing well. The Local Authority plan was for discharge of the Care Order in light of positive progress and the application for this had been made in October 2016.
- 5.** However, involved practitioners were unaware that, since March 2016, parents had been under investigation by a Specialist Home Office law enforcement Team - a Criminal and Financial Investigations (CFI) Team. They were both suspects in a large-scale investigation into the facilitation of Iranian nationals into the UK and money laundering by an organised crime group within which father had a lead role.
- 6.** The Investigating Officers were reliant on Greater Manchester Police (GMP) as the local Force for safeguarding information and had been advised there were no concerns on the GMP systems. Child T's LAC status was not identified as, nationally, Police Forces do not have systems to flag these children in the same way as they flag children subject to Child Protection Plans. CFI Officers didn't identify any safeguarding concerns when Child T was observed in her parents' care. These Officers make decisions on the safeguarding risks posed to dependent children on a case by case basis

through available information, organisational safeguarding guidance and the Police National Decision Model. In this case the parental criminal activity was not deemed to pose a serious risk to Child T. CFI Officers made a decision not to inform Children's Services of the planned arrests given no known safeguarding concerns and the need to maintain the investigation's security. Parents were arrested at around 6.30am on December 5th 2016 by CFI Officers with support from GMP Officers.

7. On being asked about Child T, mother said there were no suitable family members to care for her whilst they were under arrest. Because of this, and the fact that Child T's LAC status was not known to GMP/CFI Officers, she became subject to a Police Protection Order (PPO) and placed with foster carers. The next day, December 6th, following discussions between a GMP Public Protection Investigation Unit (PPIU) Officer and a Children's Services LAC Practice Manager and then further discussions within the Children's Services LAC Team, Child T was returned to parents' care following their release from custody on Police bail. A second written agreement was put in place, the key stipulation of which was that parents must inform the Local Authority if they intended to leave the local area overnight or longer.
8. A major issue was that no practitioners involved in either the arrests or in making the decision to return Child T to parents' care, understood the full picture. Key information unknown to CFI and GMP Officers was Child T's LAC status. Key information unknown to Children's Services practitioners at the point of determining whether to return Child T to parents' care was the detail of the serious crime Child T's parents were suspected of. The investigation was led by CFI Officers and details of it were recorded on CFI electronic recording systems. Involved GMP Officers had only a limited understanding of the investigation with no details available on GMP electronic recording systems. However, it was GMP Officers who had established communication processes with Children's Services and took the lead in these communications. GMP Officers also secured the PPO due to CFI Teams not having the necessary Police powers to obtain these.
9. Also, the review process itself identified evidence, unknown at the time, of parents not complying with key aspects of the Care Plan and first written agreement:
 - Mother had been caring for Child T alone at times including taking her to see a GP on 2 occasions in March 2015 shortly after the first written agreement was put in place;
 - Parents had taken Child T out of the UK on 8 occasions between May 2015 and September 2016 without seeking Local Authority permission despite having been made aware of this requirement on a number of occasions. Practitioners understood that parents had no passport for Child T and Children's Services had not supported them in applying for one as is required for a child subject to a Care Order. In reality, parents had both Polish and Iranian passports for Child T.
 - No evidence of mother having attended any counselling sessions could be identified.

Had any of this information been known to Children's Services, further actions would have been taken prior to returning Child T to parents' care and the agreed plan to discharge the Care Order would have been reviewed.

10. On December 9th, late in the evening, parents attempted to leave the UK with Child T via a Ferry Port. However, they were stop-checked by a Merseyside Police Special Branch Ports Unit Officer (Ports Officer) who identified the Police bail conditions on the Police National Computer. The Ports Officer made several attempts to contact the Investigating Officer to discuss the suspected offences and breached Police bail conditions and to agree further actions. These attempts were unsuccessful as the contact details available on the Police National Computer were those for a GMP Officer supporting the arrests and not the CFI Investigating Officer. The Ports Officer sought supervision and actions were

taken which prevented the family from leaving the UK at that time. The Ports Officer then carried out further investigations on return to duty and clarified on December 12th that the investigation was being led by the CFI Team.

11. This Team was informed immediately and there was then very prompt communication with Children's Services after which all possible actions were taken to locate the family and the Greater Manchester Children Missing from Home and Care procedure was followed. However, it was subsequently identified that the family had left Salford on December 11th by travelling through the Common Travel Area, Scotland, Northern Ireland and then to the Republic of Ireland from where they flew to Iran via Munich on December 12th.
12. There were 4 points in the review timeline at which different actions could have been taken:

Key Point in Timeline	Significant Issues
<p>The planning of the arrests by the Home Office CFI Team</p>	<ul style="list-style-type: none"> ➤ No flags for LAC on any Police systems. ➤ CFI Officers unaware of Child T's LAC status. ➤ CFI Team reliant on local Force information for safeguarding checks- this is not a robust process. Children's Services are the lead agency for safeguarding children. ➤ CFI Officers unaware of any safeguarding concerns for Child T and parental criminal activity not deemed to pose a serious risk to her- decision made by CFI Team not to contact Children's Services prior to the arrests. ➤ Children's Services were unaware of the parental involvement in serious crime. <p><i>Had Child T's LAC status been known, there would have been contact made with Children's Services at this point by CFI Officers prompting multi-agency assessment and planning prior to the arrests.</i></p> <p><i>Children's Services Care Planning would have been informed by a good understanding of the parental involvement in serious crime.</i></p>
<p>The arrest of Child T's parents at around 6.30 am on December 5th and Child T being made subject to a PPO</p>	<ul style="list-style-type: none"> ➤ Arresting Officers (CFI & GMP) unaware of Child T's LAC status and mother said there was no suitable adult to care for her. ➤ PPO deemed necessary which had to be secured by GMP as the investigating CFI Team did not have the necessary Police powers. ➤ Children's Services became aware of parents' arrests on the day and were informed the PPO had already been secured. ➤ Safeguarding decisions had to be made quickly at the point of the arrests.

	<ul style="list-style-type: none"> ➤ GMP took the lead role in safeguarding communications but was not leading the investigation and Officers were unaware of detailed information. <p><i>Had Children's Services been made aware prior to the arrests, there would have been multi-agency decision making and planning.</i></p> <p><i>The PPO was not necessary given Child T's LAC status and alternative plans could have been made for her care.</i></p> <p><i>Decisions would have been made by all the key practitioners in a timely and coordinated manner. Children's Services Care Planning would have been informed by a good understanding of the parental involvement in serious crime.</i></p>
<p>The return of Child T to her parents' care on December 6th</p>	<ul style="list-style-type: none"> ➤ GMP PPIU Officer had discussions with Children's Services due to GMP having established communication processes in place. ➤ Information held on the GMP log did not include any safeguarding concerns for Child T in relation to parents' arrests and detail of the CFI led investigation was not on the GMP systems. ➤ Children's Services made a decision to return Child T to parents' care in light of the positive progress in the case and being unaware of key information. ➤ The requirement for a Strategy Meeting or Discussion to always be held prior to a child being released from a PPO was not met. <p><i>A multi-agency Strategy Meeting involving both CFI and GMP Officers at this point would have enabled multi-agency decision making and ensured correct procedures were followed for a child made subject to a PPO. The meeting would have facilitated multi-agency discussions about the risks to Child T of both parents being involved in serious criminal activities, the nature of the activities and father's lead role, flight risk, the need to seize travel documents, the Police bail conditions and the implications of these being breached. A multi-agency plan would have been agreed and may have included Section 47 enquiries once all known information had been shared.</i></p>

<p>The first attempt to leave the UK on December 9th</p>	<ul style="list-style-type: none"> ➤ Ports Officer unable to contact the CFI Investigating Officer due to the Police National Computer including only the details of a GMP Officer involved in the arrests. ➤ Ports Officer identified the CFI Team was leading the investigation on December 12th by which point the family had already left the UK. <p><i>Had the Ports Officer been able to inform the Investigating Officer of the family attempting to leave the UK on December 9th, there would have been prompt information sharing and multi-agency planning in light of the significant, new information.</i></p>
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13. Learning has been identified in the following areas:

The interface between parental serious crime and safeguarding- criminal investigations into serious and organised crime are highly sensitive and complex. Actions required to safeguard the child have to be considered alongside ensuring complex criminal investigations are not put at risk. The risk assessment of the impacts of such crime on dependent children requires consideration of all risk and protective factors known to involved agencies. Children’s Services are the key agency to contact in relation to clarifying known safeguarding concerns.

In this case, whilst the CFI Team led the investigation, GMP and a Merseyside Police Special Branch Ports Unit Officer were also involved. The review has highlighted the following significant challenges nationally in the Home Office systems which impacted on communication processes and safeguarding decision making in this case. The involvement of 3 law enforcement agencies added further complications to an already complex situation:

- There is no system for flagging children subject to Care Orders on Police systems.
- CFI Officers obtain safeguarding information from the relevant local Police Force systems to inform safeguarding decisions. In this case, the checks could not identify that Child T was subject to a Care Order. Whilst local Force systems would identify children who are subject to Child Protection Plans, they would not identify all vulnerable children known to Children’s Services.
- Differing Police powers- although leading the investigation, the CFI Team did not have the required powers to secure the PPO.
- The Police National Computer system did not include contact details for the Investigating Officer. This case has identified the importance of information held on the Police National Computer containing sufficient detail to enable timely contact with Investigating Officers including outside of standard office hours- **see Recommendation 5.**

Children subject to Care Orders and placed at home- these children are extremely vulnerable given that they are living with parents when there has been sufficient concern about parenting capacity to warrant Care Proceedings. The review has identified the importance of practitioners understanding that children can be LAC and placed at home, their vulnerability and the terminology used. It has also identified that effective multi-agency working is required to safeguard them and that current systems in place do not always support this. For example, Police Forces not flagging LAC on their systems in the same way as they flag children subject to Child Protection Plans. Local action has been taken by

Children's Services and GMP and all LAC placed in Salford are now flagged on GMP systems- **see Recommendations 2 and 3.**

The use of written agreements- prior to the review, Children's Services had reviewed the use of written agreements and was implementing an action plan which includes the development of a policy. Good practice was seen in this case through ensuring the agreement was translated into the language of parents' choice. The review highlighted the importance of key partner agencies understanding the expectations of written agreements- **see Recommendation 1.**

Children made subject to PPOs- expected practice is there must always be a Strategy Meeting or Discussion before a child is released from the Order which didn't happen in this instance- **see Recommendation 4.**

Identification of parental disguised compliance- the review has highlighted there can be disguised compliance even in cases where parents are presenting as fully engaged with all services. It is important to obtain confirmatory evidence wherever possible in addition to parental assurances that required actions have been completed. Seeking such evidence can support professional opinions of good engagement or disprove these.

Conclusion: The following key messages have been identified for practitioners through the review:

- Effective information sharing and communication are vital if children are to be safeguarded when their parents are involved in serious crime- robust risk assessment and planning can only take place once all relevant information is known and understood. The possibility of flight risk should be actively considered in these cases.
- Practitioners working with LAC placed at home should be alert to their vulnerability and ensure they understand their responsibilities towards safeguarding them and meeting their needs.
- Whilst parental written agreements are put in place by Children's Services, involved multi-agency practitioners need to ensure they are clear about the content, that this is documented within agency records and that they understand their responsibilities towards written agreements when working with families.
- Always be alert to the possibility of disguised compliance even when parents present as fully engaged and working well with agencies.

The following recommendations for the SSCB have been made:

Recommendation 1: Children's Services to provide assurance to the SSCB to ensure the policy on written agreements reflects the learning from this case. This should include evidence of review, compliance and expectations for partner agencies.

Recommendation 2: Information sharing arrangements between Children's Services and GMP regarding LAC to be formally agreed and reflected in the updating of Salford Children's Services internal notification procedures. All agencies will need to confirm how they record if a child is LAC.

Recommendation 3: The SSCB Training Coordinator to review relevant SSCB courses including Basic Awareness, Foundation and Refresher courses to include reference to the different Care Orders and what they mean.

Recommendation 4: GMP and Children's Services should assure the SSCB that Strategy Meetings or Discussions are always held when a child has been subject to a PPO.

Recommendation 5: Home Office to provide assurance to the SSCB that the systems issues, relevant to the organisation, have been considered, systems strengthened and the learning has been disseminated to relevant departments.

Recommendation 6: Partner agencies to assure the SSCB that the learning from this Multi-agency Concise Review has been implemented and embedded into practice.