Manchester Safeguarding Partnership

Safeguarding Adult Review

Adult Olia and Baby W

This report was commissioned and prepared on behalf of the Manchester Safeguarding Partnership

Independent Reviewer: Jane Wiffin

Ratified by MSP Adult Executive Group on 15th September 2020

Published by the MSP on 8th January 2021

Contents		
Section		Page Number

1. Introduction, process and methodology

Reason for this Safeguarding Adult Review (SAR)

1.1 This SAR was commissioned by Manchester Safeguarding Adults Board because Olia and her new born baby, Baby W, were found dead at their home. Police were called to an address in a neighbouring authority by a neighbour who reported concerns for the welfare of the person who lived there. The police forced entry and found Olia[1] dead on the floor with a small baby (Baby W) who was also found to be dead.

1.2 Olia sought antenatal care as soon as she was pregnant with Baby W and she told professionals that this was her first pregnancy. Information then emerged that she had three older children removed from her care in London because of significant concerns about neglect and her own mental health difficulties. A referral was made to children's social care and they struggled to make contact with her because of confusion about her address and her reluctance to see professionals. She then went overseas for a period of time without telling anyone. The police were notified of her return and she was met at the airport by social workers. Professionals were unable to make contact with Olia for the last few weeks of the pregnancy.

Methodology and Process of the SAR

1.3 A Local Safeguarding Adults Board (SAB[2]) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014[i] sets out the criteria for a Safeguarding Adults Review (SAR). A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if: (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and the adult has died. Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to: (a) identifying the lessons to be learnt from the adult's case, and (b) applying those lessons to future cases. It was agreed that this would be a SAR with the involvement of children's services. The purpose of any review is to establish whether there are

[1] An anonymised name

[2] https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/role-and-duties.asp

lessons to be learned about the way in which local professionals and agencies worked together to safeguard Olia and Baby W, to consider what this tells us about the safeguarding adult and children's processes in Manchester and to consider whether there are wider systemic issues which have influenced practice.

1.4 This SAR has been undertaken using a systems approach. It has been led by Jane Wiffin who is independent of all services and organisations in Manchester and the neighbouring authority. Chronologies were sought from all agencies in contact with Olia and the unborn Baby W. The timescales for review were agreed to be from when Olia was first in contact with services in Manchester until the day she and Baby W were found deceased. Information was also sought about Olia's background, her contact with services in London and the removal of her three previous children. All agencies who provided chronologies were asked to complete a critical appraisal form; each agency was asked to consider the quality of practice from their agency's perspective, focusing on strengths and weaknesses, and considering key messages and recommendations.

1.5 A multi-agency panel was convened to oversee the SAR process, review the critical appraisal documents and undertake the analysis of practice. Members of this panel conducted interviews with the few professionals who had known Olia. The Panel sought advice about Olia's cultural background and a specialist community advisor with knowledge of effective cultural working and knowledge of Olia's home country joined the panel. This input was essential and invaluable in helping the panel to think about the importance of Olia's African heritage, her cultural background and understanding her circumstances and vulnerabilities.

2. Family Background

Family				
	Names[3]		Ethnicity	Age at beginning of review period
Olia	Olia	Mother of all children	Black African	35
Baby W		father 2 – see below	Black African	Died at birth
Father 1	Adi		Black African	n/k
Father 2	Peril		Black African	35
Half Sibling/Daughter	Tayo	Placed with father 1 who is her father and his new family	Black African	14
Half Sibling/Son	Amoke	Placed with Father 1 who is not his father; his Father is father 2 who lives with his family in Africa	Black African	12
Half Sibling/Son	Kayim	Removed at birth and placed for adoption. His father is thought to be father 2.	Black African	10

2.1 Little was known about Olia's background during the time she had contact with professionals in Manchester. This historical information was

[3] All names are anonymised

taken from the care proceeding initiated for her older children in a London Borough. It is provided to give some perspective on Olia's life, but most of this was not known until much later.

2.2 Olia was born in Africa. Her first language is an African language (not given for reasons of respect for Olia's confidentiality). She was the youngest of five children. Her father was a pastor and her mother stayed at home. No professionals have had any contact with this family as their exact whereabouts are unknown.

2.3 When Olia was 20, she came to the UK/London with an adult, who she described as a sister[4], on a student visa. Olia had been brought to look after this older adult's children and to do housework. After a year, Olia left because she was unhappy; she remained in London and continued to attend church regularly which was important to her. She met Adi three months later at the church they both attended. They moved in together when Olia was pregnant with Tayo. Olia reported that Adi left when Tayo was three months old and that he was abusive. Adi disputes this and there was never any evidence that this was so. Adi sought contact with Tayo, but Olia was said to have stopped this.

2.4 Two years later Olia was pregnant again with Amoke and he was born without concern. There is little information about the father of this child except that he lived in Africa and occasionally visited London. When Tayo was 4 and Amoke 2, Olia sought help with housing, but was told that she was not entitled because of her temporary immigration status. Olia took steps to address this, and a year later she was granted indefinite leave to remain[5] in the UK. She returned to the housing department who told her to ask children's services for help. This she did, but the family were not provided with housing and over the next few years they lived an itinerant lifestyle because of financial issues, moving from one inappropriate property to the next. This must have been a difficult time for the family. Support which addressed this family's socio-economic deprivations and housing needs at the time may well have prevented these children from having to come into care

2.5 When Tayo was 7 and Amoke 5, there were concerns about mother's mental health, her neglect of the children, serious physical abuse and the itinerant nature of their circumstances. Support was provided, but Olia refused to engage with it; there were increasing incidents of

[4] They were unrelated

[5] Indefinite leave to remain (ILR) or permanent residency (PR) is an immigration status granted to a person who does not hold the right of abode in the United Kingdom (UK), but who has been admitted to the UK without any time limit on his or her stay and who is free to take up employment or study.

significant physical abuse and neglect and care proceedings were sought[6]. The courts decided that the children had experienced significant harm whilst living with Olia and that she remained unprepared to address these concerns. The children were initially placed with foster carers whilst family members were sought to provide alternative care. Initially, Olia did not engage with the proceedings and did not regularly attend the contact arranged for the children. Tayo's father Adi was located and he sought to have Tayo placed with him and his new family. Tayo said she would not move without Amoke. At this point Olia re-engaged with the court proceedings and a number of assessments were completed. Olia had a specialist culturally sensitive parenting assessment which concluded that she could not care for the two children. This was because she found it hard to engage with the children during assessment sessions, she was believed to be overly focussed on God, the role God would play in resolving their current difficulties and she was at times making inappropriate and offensive comments about Adi, undermining the contact that Tayo had started with her father.

2.6 A psychiatric assessment[7] was completed of Olia and this concluded that she was experiencing paranoid schizophrenia. Olia was highly critical of this assessment, and refuted strongly that she could be considered mentally ill. She declined the offer of ongoing mental health support.

2.7 It was agreed that the children could not be placed with Olia, and after a positive assessment of Adi and his new partner, both children were placed with them under a Residence Order[8] for Tayo and Special Guardianship[9] for Amoke.

2.8 Olia continued to have supervised contact with both children, however over time there were many concerns about her emotional instability, lack of focus on the children and she continued to seek to

[6] [6] Care Proceedings are Court Proceedings issued by the Children's Services department of the Local Authority where an application is made for a "Care Order" or "Supervision Order" in respect of a child. If Children's Services believe a child is at risk of significant harm, they can apply to court for permission to take action to protect the child – these are known as Care Proceedings.

[7] There is no information available about the assessment process or whether it was culturally sensitive

[8] A Residence Order is a legal order which says who a child should live with and gives that person parental responsibility for the child. It does not take away parental responsibility from the child's parents. A residence order can last until the age of 18, or can be ended earlier by the court.

[9] A special guardian is someone who has a Special Guardianship Order for a child. This order may be made by the court when a child is living permanently with someone other than their parents (such as relatives or long-term foster carers). A Special Guardian has parental responsibility for the child

undermine the placement with Adi. Olia told children's services she did not want any contact with the children until they were returned to her, and father 2's care.

2.8 Two years later Olia was pregnant. A pre-birth assessment was started, but there were concerns that Olia would not access mental health services and ultimately this child, Kayim, was removed from her care at birth and later adopted. This London CSC could have reflected on Olia's cultural background and context, what access to mental health services might mean and what further avenue of support could be found. Olia implied that the father of this child was the same as Amoke, a pastor who lived in Africa. There was evidence that she remained in London in itinerant circumstances. There is no evidence that she was provided with support after the children were removed from her care beyond the offer of mental health services which she refused.

3. Chronology of professional Involvement

3.1 In July 2015 (two years after she had been known to be in London) Olia registered with a GP Practice (GP Practice 1) in Manchester. Some months later she saw a GP for a pregnancy test. This was negative. Olia returned to GP Practice 1 some 11 months later requesting a further pregnancy test. When this was also found to be negative, Olia told the GP that she thought the test was inaccurate and would go to hospital for further testing. She could not be persuaded of the reliability of the test. Three days later Olia asked to see a different GP and she reported that she had a positive pregnancy test and asked to be referred for midwifery care. She had her first midwifery appointment shortly afterwards.

3.2 A scan was undertaken in August 2016 where it was shown that Olia was not pregnant and she was informed of this. She continued to seek antenatal care from a number of different community midwives and she reported that professionals had been lying to her about not being pregnant. She saw the community midwife at GP Practice 1 in September 2016 who was concerned about Olia's presentation and suggested that she see her GP regarding her mental health. Olia did not do this. The community midwife also reviewed Olia's records and found that Olia had had three previous children removed from her care. She made a referral to the children's MASH team which focussed on the wellbeing of these three children; she confirmed that Olia was not pregnant. The children's Multi-Agency Safeguarding Hub (MASH) team contacted the London Borough responsible for the three children and was assured they were all safe and well. As Olia was not pregnant and there were no concerns about a child, this referral of concern led to no further action. There was no thought given to whether she needed support in her own right or what that support could be. Manchester does not have a specific service for women who have had previous children removed.

3.3 The information about the referral to children's MASH team and the concerns about Olia believing she was pregnant when she was not was not recorded on the GP1 system due to an administrative error and Olia told her GP that she had a miscarriage. The information about this referral and it's concerns was not known by any agency who had subsequent contact with Olia.

3.4 In February 2017 Olia contacted the police to report problems with her Landlord (property1). She then said she was moving out and did not

need further help. She told housing sometime later that she had lived at another address from March 2017 to March 2018; property 2.

3.5 In early March 2017 Olia attended GP Practice 1 and was seen by a trainee GP which meant that the trainee GP was able to spend time with Olia and do an assessment of her needs and circumstances. She gave no clear reason for attending, but appeared muddled to the trainee GP who noted that she moved quickly from one topic to the next. Olia wanted fertility testing because she reported she had a miscarriage the year before. The GP noted a recent history of seeking confirmations of pregnancy; she did not find the information about children having previously been removed from Olia's care and there would be no marker on the records helping to indicate this historical information. Olia said that she lived alone, that she had two children that lived with their father in London and she had a partner who lived in Africa who she visited twice a year. She said she wanted to get pregnant by this person.

3.6 The trainee GP was concerned as this was a different social history to the one given previously where Olia had said she lived with her husband and they had one child living with them and was concerned about Olia's mental health. Olia denied low mood, said she had no problems with sleeping, but was asking for sleeping tablets. Olia said she had no thoughts of self-harm or suicide. The trainee GP felt that Olia was experiencing delusional thought patterns, but Olia refuted this, said she no longer wanted to discuss it or access services to help. The trainee GP thought no further action could be taken because Olia had refused the offer of a referral to mental health services or any other service and there were not sufficient concerns to warrant action that would compel her to access services. Olia did ask for a sick note for abdominal pain, for the job centre. The trainee GP said her current health symptoms would not warrant this. Finding 2 looks at culturally competent practice, and the trainee GP could have reflected on Olia's cultural background and context, what access to mental health services might mean and what further avenue of support could be found; there are a number of centres which provide support to women from the country Olia originated from to which she could have been signposted.

3.7 Two weeks later Olia contacted the police again to report a dispute with her landlady at a new address (property 3). This was assessed as civil dispute about a cooker and £50. No further action was necessary.

3.8 In January 2018 Olia was three months pregnant. She changed GP practices at this time and was seen on two occasions in January regarding the pregnancy. She had her first appointment with the Community Midwife in January 2018 and gave her address as property 4. Mother's recent history of reporting a pregnancy when none existed was known, but not the historical concerns about her mental health or the history of her older children having been removed from her care due to neglect and physical abuse. This information had been the subject of a referral to Manchester Children Services (CSC) from a community midwife 17 months earlier but was not available, which seems to be due to an administrative error.

3.9 In February 2018 Olia failed to attend her second hospital appointment and in line with policy she was visited (at property 4) and found to be well. She said her next of kin was her sister who lived at the same address as her. (See section 3.35 for information that became available as part of the review about the unsuitability of this accommodation).

3.10 At her hospital midwifery appointment Olia reported this was her first pregnancy. She was asked about any history of mental health concerns, alcohol or drug use, domestic abuse or any previous contact with children's services. Olia replied no to all questions and gave no indication of any vulnerability. She reported her partner lived in Africa and her sister was her next of kin; the address given was the same as her own. She attended for a dating scan the next day, but failed to attend the next appointment and a further follow up appointment was offered. Olia was seen on a number of occasions over the next few weeks by the midwifery team and was found to be well; there were no concerns.

3.11 In March 2018 Olia asked the hospital midwifery team for a sick note for work and she was advised to see her GP, which she did not do. She was advised to seek parent education as a first-time mother which she did not do. From this point her care was transferred to the community midwifery team as would be expected given Olia's reported circumstances and lack of any concern about her wellbeing.

3.12 In April 2018 Olia called the police to report that she had been locked in her house by her landlord (property 5) and that she was 5 months pregnant. The matter was resolved and Olia said that she was in the process of moving out of the property.

3.13 That same day Olia went to the housing team and an appointment was made for the next day. At this appointment Olia said she had

been living in the YHA for the last two nights (property 6). Olia said her last settled address had been property 5 and she had been there for a month as a lodger, but had been asked to leave because she was pregnant. Olia reported to have lived at another address previously, but this was not suitable for children. She was placed in a hotel/temporary accommodation (property 7), a link worker was allocated to her and attempted to visit Olia immediately, without success. Six days later Olia was placed in temporary accommodation in a neighbouring authority (property 8) and she was due to be allocated a support worker from the area she had moved to[10]. It is unclear the extent to which Olia's pregnancy was discussed and the due date known.

3.14 Towards the end of April 2018 Olia went to see GP Practice 2 and asked for a fitness to fly certificate as she wished to go and see her partner in Africa. She was seen by the Advanced Nurse Practitioner (ANP)[11] who felt that Olia was evasive about why she needed the certificate. The ANP reflected that Olia had booked her pregnancy late (27 weeks) and that this was unusual for a first-time mother. She appropriately asked that Olia's midwifery records be sought and her GP records reviewed.

3.15 This review highlighted that Olia had three other children who had been removed from her care when she lived in London and there were also concerns about her mental health. Midwifery records confirmed that in August 2016 there had been concerns about Olia's lack of acceptance that she was not pregnant. Information about the referral of concern completed by the community midwife were not available because of an administrative error.

3.16 The Senior Safeguarding Midwife at Manchester Foundation Trust (MFT) received information from the Advanced Health Practitioner at the GP Practice informing her of the obstetric and social care history for Olia. The Senior Safeguarding Midwife made an immediate safeguarding referral to Manchester Children's Services (CSC) requesting an urgent pre-birth assessment; the GP surgery and the community midwifery team were copied into this correspondence.

[10] The Homeless team now try and allocate all single pregnant females a support worker within a week when they are placed in a temporary accommodation. The Homeless team also place all single pregnant women who live in Manchester properties in Manchester rather than the wider greater Manchester area.

[11] Advanced Nurse Practitioners are Registered Nurses who have done extra training and academic qualifications to be able to examine, assess, make diagnoses, treat, prescribe and make referrals for patients who present with undiagnosed/undifferentiated problems

3.17 The GP reception staff rang Olia and ask her to come into the surgery. She refused to do so, but she said she might ring on Monday; she did not ring. The GP surgery tried again a week later to speak to Olia without success.

3.18 The children's safeguarding referral was sent on Friday 27 April 2018 and reviewed by children's Multi Agency Safeguarding Hub (MASH[12]) team on the following Wednesday[13]. All known information was shared. Olia was 7 months pregnant, had concealed that previous children had been removed from her care because of neglect and that she had historical mental health difficulties. She was also planning to travel to Africa. The information about the concerns raised by the community midwife in 2016 were not known due to an administrative error[14]. Children's social care decided that an assessment would be started under the auspices of child in need rather than child protection. It is the view of this review that child protection inquiries should have been initiated given concerns about mother's mental health, her concealment of previous children coming into care, the imminence of the birth of the baby and her overall vulnerability. This would have provided an opportunity to consider Olia's needs for support and to take account sensitively of the impact of previous children being removed and her readiness to be a new parent.

3.19 On 1 May 2018 Olia contacted the neighbouring authorities adult social care by phone asking for advice about housing. A food voucher was issued, which she collected and she was advised to contact the Citizens Advice Bureau and Housing Benefit. The neighbouring authority were not aware that mother was known to Manchester services or was pregnant.

3.20 A social worker (SW1) from Manchester Children's Social Care was allocated to start the CSC assessment. This social worker was chosen because she was of the same ethnicity as Olia and it was felt this matching could help to engage Olia. A telephone call was made to Olia who said she could not speak and asked SW1 to ring back. The address provided to children's social care was property 4, which Olia had given to the community midwifery service. Olia had not told

[12] Multi-agency safeguarding models are where a hub of key agencies (which can include children's services, police, health, education, probation and youth offending) are co-located or have an agreed protocol in place to promote better information-sharing, decision-making and communication in relation to concerns about children. The aim is that referrals are responded to in a coordinated, appropriate and timely way.

[13] This was a Bank Holiday weekend

[14] The computerised system for the Children's MASH team in Manchester has been updated and this problem of having separate records from an unborn baby and mother has been reported to have been addressed.

professionals that she had moved to temporary homeless accommodation in the neighbouring authority. Two visits were attempted by SW1 and the property appeared abandoned and boarded up. SW1 contacted the community midwife and the number given by Olia of her next of kin, who she said was her sister, was provided. Contact was attempted using this number without success. SW1 asked GP Practice 2 to alert other surgeries about Olia in case she tried to register somewhere else.

3.21 On 17 May 2018 a further home visit was attempted by SW1 to property 3, another address Olia had provided to the community midwifery team. Olia was not there and it remained empty and looked abandoned. SW1 reported Olia as a cause of welfare concern to the police. All the recent information was provided. The police created a missing persons alert and background checks were completed. Initial checks could not confirm whether she had left the country. This information was communicated to all involved agencies who were asked to alert the police and children's services if Olia made contact with them; no one was aware of Olia's contact with the homeless team and they were not aware that she was missing. It is not clear why the alert did not come to this team. The London Borough where Olia had lived was contacted and full background information was sent over immediately. Information was shared between health agencies about Olia's mental health difficulties. Midwifery services developed a safeguarding care plan outlining the steps needed to be taken if Olia attended a hospital or other health services.

3.22 SW1 discussed Olia and the unborn Baby W in supervision with the team manager. It was agreed that when Olia was located, care proceedings would be initiated and it was likely that Baby W would be removed from Olia's care at birth. There was insufficient discussion of the need for a birth plan and preparation for the arrival of the baby.

3.23 During this time the homeless service were also trying to make contact with Olia. They had agreed that Olia could stay in temporary accommodation, that she would be supported to find her own accommodation and they tried calling her and emailing without success. Homeless services were unaware of any other agency's involvement. The homeless service made a referral to the neighbouring authority Health Visiting Service. It has not been possible to find out why they did not contact midwifery services; this is something they usually do. It remains unclear whether they were aware

of her due date and had discussed with her buying what was necessary for the birth of a baby, given the scarcity of the accommodation she had been placed in.

3.24 At the end of May 2018 a Health Visitor (HV1) from the neighbouring authority sent a letter introducing the service and the following week a home visit was attempted. No one answered the door and the house looked closed up. When HV1 returned to the office she contacted the children's Multi Agency Safeguarding Hub (MASH) to ask about any social work involvement. This was good practice. She was informed that Olia and unborn Baby W had been reported missing and all known concerns were shared. The HV provided the new home address. She also contacted the specialist midwife team in the neighbouring authority to share the information. A second home visit was attempted two days later without success.

3.25 The neighbouring authority midwifery liaised with Manchester midwifery services; all information was shared, including the safeguarding care plan and there was a transfer of care at this point.

3.26 On the 13 June 2018 (13:38) the Border Agency contacted Greater Manchester Police to report that Olia would be flying into Manchester airport from Morocco on the 14 June 2018 at 16.00 hours. She had been overseas since the 10 May 2018. This information was shared with the emergency duty team (children's services) at 18.59 and it was agreed that two duty social workers would meet Olia with the airport police; the allocated social worker was not available because she was on leave. The police believed that a strategy discussion would take place, but this did not happen. Children's services made it clear to the police that they had no legal powers regarding the baby and that there was no legal action they could take at this point. A strategy meeting/discussion should have been called, bringing together midwifery staff, the specialist midwife for refugee and asylum-seeking women, the homeless team, neighbouring authority HV1, SW2 and adult social care in recognition of the seriousness of Olia and unborn Baby W's circumstances. Olia was 8 months pregnant, had a history of mental health concerns and neglect of previous children, she had not been seen for any midwifery care since March 2018, she had no birth plan in place, was living in homeless accommodation and no one knew what preparations she had made for the arrival of the baby. An urgent plan of action to consider next steps, how to engage Olia in midwifery and support services should have been formulated.

3.27 Olia was met by airport police officers off the plane; the social workers were not allowed plane side of the airport. She was taken through security to meet the duty social workers. She was seen by them in a coffee shop as there was nowhere private to meet. Minimal information is recorded about this important interview, but SW2 confirmed after the event that Olia's presentation was concerning and that she did not want any social work support and was hostile. It is not clear if the imminent due date for the birth of the baby (in a few weeks' time), her need to develop a birth plan, the suitability of her accommodation for a baby, her ability to make preparations in terms of baby equipment and clothes etc and information about any support networks or churches attended was discussed. These should have been or the absence of this information been a source of concern. Olia said she would take the train back to her accommodation and would be in contact. Given that it was now known that she had previous children removed, and had been reluctant to engage with some professionals (she had kept many of her midwifery appointments) more thought should have been given about how to engage her at this point.

3.28 SW2 contacted the HV1 and reported that Olia had been hostile and had spat at them. The HV tried to organise a joint home visit with a member of the community midwifery team the next day, but was unsuccessful. The HV went to the home but no one answered the door.

3.29 On 18 June 2018 SW2 telephoned Olia to arrange a visit. Olia said she had a maternity hospital appointment that day. There was no record on the hospital appointment system that this was the case; subsequent information has shown that Olia did attend the hospital and was seen by a community midwife, although she did not have an arranged appointment. This attendance was not recorded in her main hospital notes because the community midwife did not think they were available on site. Information was documented within Olia's hand held notes (HHN) which she kept with her throughout the antenatal period.

3.30 On Tuesday 19 June 2018 Olia telephoned GP Practice 2 to request an appointment in two weeks' time as she said she needed further ante-natal care. She refused to give her current address and she challenged why the surgery was concerned, particularly about her history.

3.31 On the 20 June 2018 a new social worker (SW3) was allocated because SW1 was on long term sick leave. Contact was made with the

homeless team to confirm Olia's address. Telephone contact was attempted with Olia but her phone rang out.

3.31 On 22 June 2018 the specialist midwife from the neighbouring authority attempted to visit without success. A card was put through the letterbox with contact details. Olia did make contact by telephone and reported that she had seen a midwife on 18 June 2018 (As documented in 3.29) and that she had a follow up appointment in 2 weeks' time; this was correct. Olia had made an appointment with the GP. Olia denied having any mental health problems and declined any support. Community midwives then attempted a further home visit without success. Manchester children's services were informed of this. It was agreed that the specialist midwife for asylum seekers/refugees in north Manchester would arrange a home visit; Olia did have indefinite leave to remain, but it was thought this might be a way of addressing her cultural context. This home visit was planned, but did not take place in the time frame before Olia and Baby W died.

3.32 On 27 June 2018 the neighbouring authority midwifery team made an appropriate safeguarding referral to Manchester children's services. They were concerned that Olia had not had any antenatal care since March 2018. Manchester children's services agreed a plan of action with midwifery. This included a strategy meeting in the next five days, referral for a legal gateway meeting[15] to initiate legal proceedings, Olia to be visited and all hospitals were alerted. It was agreed a discharge meeting was to take place when Baby W born. The special circumstances form held on Olia's midwifery records was updated. Given that Olia was now 8 months pregnant, it was believed that she had not had any antenatal care since March, she did not have a clinical or professional birth plan in place and no professional had seen where she was living or what preparations she had made for the arrival of the baby, the strategy meeting should have been held immediately. At this stage Baby W was now at risk of significant harm.

3.33 Manchester children's services contacted Manchester PPIU[16] on 2 July 2018 regarding organising the strategy meeting/discussion. They were told to contact the neighbouring authority PPIU because Olia lived in that area. A referral was made to the neighbouring authority PPIU. Again, there seems to have been no sense of urgency, despite the

[16] The Public Protection Investigation Unit (PPIU) is the police department that deals with child protection, domestic abuse and safeguarding vulnerable adults.

seriousness of the circumstances. No strategy meeting was ever convened.

3.34 On 3 July a GP from GP Practice 2 attempted to telephone Olia without success.

3.35 Olia and Baby W were found dead by the police two days later.

Information emerging as a result of the review

3.36 Early Help reported as part of this review that in January 2017 a deliberate car fire was reported to the police. This was at a property (property 4) that Olia gave as her home address to midwifery services, but there is no information about whether she was at the property at the time. The fire service found that the fire had caused heat damage to the entrance of a property where a number of women and children were living and they had no means of getting out. Fire alarms were fitted and the fire service made contact with early help and housing. When Early Help visited with a hub social worker there were concerns that there were a number of women of African heritage living there, all of whom appeared to be pregnant and they had no means to support themselves. There were concerns about possible human trafficking, but no evidence was found and no disclosures made. This information was passed to the community safety team. The Housing Compliance Team was also involved because the housing conditions were so poor and the housing department subsequently issued a Prohibition Notice and all the occupants left.

3.37 In January 2018 the fire service were called again to property 4 in regard to a fire on a cooker hob. There were similar concerns as before about the state of the property and the vulnerability of the occupants. These were shared with the Early Help Hub and a safeguarding referral was also submitted. The social work team confirmed that they were already working with some of the families, but Olia was not one of them and no evidence that she lived there emerged during this investigation.

3.38 It also became known after this review had started that on Monday, 18 June 2018 Olia arrived at hospital asking for an antenatal check without an appointment. She reported that she had been in Africa. The midwife believed that the records for Olia were not available[17] and so saw her without these and therefore did not know that she had been

[17] Following the development of a new hospital Trust (C)MFT in 2009, all hospital records were kept off site and were sent to the hospital in time for hospital outpatient appointments.

reported missing or that there were concerns. This was a missed opportunity as the notes had been available in the Specialist Midwife for Mental Health's office based in the antenatal clinic. The notes had documented the mental health and social care concerns and would have alerted the clinic midwife to ask for specialist input at the unscheduled attendance. The community midwife checked all was well and advised that Olia should see the community midwife in two weeks' time. A month before unborn Baby W was to be born.

4. Findings

4.1 This SAR has looked at the sad and complex circumstances that led to the death of Olia and Baby W. There is no evidence that professionals could have predicted that Olia or her baby would die in the way that they did, but there was a lack of urgency from professionals towards the end of Olia's pregnancy given all the unknowns about her circumstances and her and the baby's vulnerabilities. This SAR has highlighted five findings regarding the professional response to Olia.

- **Finding 1:** Addressing adult vulnerabilities, finding opportunities for engagement and "thinking family";
- **Finding 2:** Delivering culturally competent practice;
- **Finding 3:** The Importance of effective pre-birth processes;
- **Finding 4:** Working with parents who have had previous children removed from their care;
- **Finding 5**: The complexities of information sharing and multi-agency working.

Finding 1: Addressing adult vulnerabilities, finding opportunities for engagement and "thinking family"

"*Every interaction is an intervention" Karen Treisman* (2015)[ii] talking about trauma informed services

4.2 This review has struggled to represent the voice of Olia because there was no one professional who knew her well and there is no information available about family, friends, community contacts or church congregations that she was known to. What we do know is that she wanted to have a baby; for most professionals they were not aware of the historical context that she had her first two children removed in their middle years and her third child at birth. All traumatic and distressing experiences.

4.3 It was possible that Olia was living for some of the time with a group of women (see January 2017) but most of the time she appears to have lived alone. Olia lived an itinerant life, with many moves and struggles with poor housing and hostile landlords; at these times she sought help and the records suggest these struggles with her housing and conflicts were resolved. She was a refugee to this country at a young age and it is unclear the extent to which she had contact with her family. She was poor and likely experienced discrimination and racism. She was known to be religious from her early contact with services in London, but there

is nothing recorded about this in her meetings with professionals in Manchester. Over the period of this review Olia came into contact with a number of professionals who were concerned about her and her baby; she did not see any one consistently and so there was no opportunity to build a relationship and trust. Professionals considered that the concerns about her never met the threshold for statutory action until she was 7 months pregnant. Consequently, when she did seek help each incident was dealt with separately and no picture developed.

4.4 In 2016 Olia saw a GP and asked to be referred for midwifery care. She attended hospital and was found not to be pregnant. Olia reported to the community midwife that she was still pregnant and that the hospital staff were lying to her. This community midwife was concerned about Olia and checked her historical records. She found that although Olia had reported this was her first pregnancy, she had three previous children removed from her care due to neglect and physical abuse which were exacerbated by her poor mental health at the time. The community midwife contacted children's services to express concerns about the three previous children. The children's MASH team clarified that all three previous children were permanently placed with other families in London were all safe and well. No action was discussed about what support Olia might need at this time given the loss of pregnancy and loss of children. Midwifery and children's services were thinking about children, not the adult and not in a think family way.

4.5 In March 2017 Olia saw another GP (trainee) to ask for fertility testing. This GP spent a long time with Olia and was concerned about her. The GP did not know that Olia had previous children removed from her care; the referral made by the midwife a year earlier was not part of her medical records. This referral would have provided further context about Olia's past history and current circumstances. The GP did know that the information that Olia gave about her family circumstances was inconsistent and she seemed muddled and confused. The GP suggested a referral to mental health services, but Olia said she did not have any mental health issues and did not want services. There was an opportunity here to link Olia with community services and to explore her family and friendship networks. This was a busy surgery, but given the concerns a follow up appointment could have been offered to explore her circumstances. At this point Olia left this surgery and registered with a new practice.

4.6 In April 2018 Olia attended her GP surgery. She was 6 months pregnant. The Advanced Nurse Practitioner (ANP) at the surgery noted that Olia had booked her pregnancy care later than would have been expected for a first-time mother. The ANP accessed Olia's records and became aware of the history. The information about the referral made in 2016 was not on file; Olia's concern about pregnancy and the need for fertility testing was part of the emerging picture regarding her needs. Her itinerant lifestyle was not. A referral to children's MASH was made for an urgent pre-birth assessment.

4.7 Children's services decided to carry out an assessment and a social worker was allocated. This was another different professional for Olia to engage with. The social worker spent two weeks trying to contact Olia without success. There were concerns about her and the baby because it appeared that no agency was in contact with her. This was not true. Olia had presented at the homeless team; pregnant and without accommodation. If the homeless team had made contact with midwifery services to ensure that Olia was receiving the right pregnancy support, her address and current circumstances would have been known. Instead the homeless team introduced another worker for Olia to engage with, and this person would change two weeks later.

4.8 Olia then went overseas and as part of the assessment process historical records were sought from the London Borough she had previously lived in. These records provided a lot of information about Olia's circumstances, the trauma she had experienced, her mental health difficulties and the loss of the three children in contested hearings. There was an opportunity here to bring this information together in a partially completed assessment and call a multi-agency meeting to discuss next steps. To plan what needed to happen if and when she returned. Other professionals such as the midwifery service would then have had a better understanding of Olia's circumstances. The lack of this meant when she returned there was an unplanned approach to engaging with her at a critical moment.

4.9 On 13th June 2018 children's services emergency duty team (EDT out of hours service) were informed that Olia would be arriving into Manchester airport the next day at 4.00pm from Morocco. This was picked up by the social work team the next morning. The allocated social worker was on leave and so this was taken on by the duty team. The absence of the written assessment and analysis thus far meant that

these new professionals did not have a full picture of Olia's circumstances immediately to hand. There should have been at the very least a multi-agency planning discussion that morning to consider the best approach to meeting Olia and engaging with her. This did not happen, and she was met initially by the police, and then two social workers. The social workers did not record the content of their discussion, but Olia was said to be hostile. Given the circumstances this was not fully surprising. Consideration should have been given to who would be best to meet Olia at the airport and how to persuade her to link back in with services. The issue of the pre-birth planning processes and working with parents who have had children removed previously is discussed in later findings, but should have been a consideration at this point. This was an opportunity for empathetic care for Olia and the baby. A community midwife might have been better placed to have this first conversation, and someone who knew her and seen her before for routine midwifery care would have helped. If this was not possible there was also a specialist midwife for both refugee communities and mental health whose expertise could have been drawn upon. As it was Olia returned home and children's services were unable to make contact with her.

4.10 She was only seen by a community midwife in the 3-week period before she and Baby W died. This was a critical moment. There were attempts to contact her, but still no meeting convened. The lack of urgency at this time is hard to fathom given the imminent birth of the baby, the lack of health care and past mental health problems.

4.11 Olia came into contact with many different professionals and this meant there was little continuity of care or the opportunity to build a trusting relationship with her. This was in the context of having a history of traumatic experiences and loss; both of her older children, but also of her family and country of origin. Research[iii] suggests that the best approach to engage adults living in complex circumstances with unmet needs and who are reluctant to engage is to take a person-centred approach, based on an understanding of what is known about their circumstances, their wishes, feelings and desired outcomes. A professional response which demonstrates empathy, concern and interest in the person is required. This was complex because so few professionals saw Olia, but a person-centred approach would have been to talk about her circumstances, think about strategies for engaging with her as someone who had experienced a range of

trauma's and devise a strategy. Every interaction with Olia could have been an intervention building towards engagement.

Finding 2: Delivering Culturally Competent Practice

4.12 The first finding for this Safeguarding Adult Review is the importance of Culturally Competent Practice. Insufficient attention was paid to Olia's cultural heritage, understanding whether she had any support networks such as the church or community, or what culturally sensitive support could be provided or signposted. Olia was of African Heritage and had moved to the UK fifteen years before her most recent contact with services. She was Black, poor, lived in temporary housing and likely experienced racism and discrimination. Certainly, there is evidence of this from her landlords with whom there were a number of conflicts requiring police help. This was all important to understand Olia and what might be influencing her response to services.

4.13 Understanding her cultural heritage and its impact and influence on her was important. Olia met directly with a number of ever-changing professionals during the time under review, so the opportunities to ask her about her cultural background, cultural beliefs and relationship with church and community were limited. However, there were opportunities when she saw GPs and the health professionals who provided midwifery care. Olia was asked when she was seen for her first midwifery appointment about mental health, domestic abuse and contact with children services. This could also have been an opportunity to ask about her cultural heritage.

4.14 When her history was known a great deal of information was shared with Manchester children's services by the London Borough she lived in. This included information about Olia attending a church, that she had been very religious and that those religious beliefs had influenced her acceptance of mental health services; she did not believe that she needed them. This was important information that should have helped shape the ongoing response and should have been shared with other agencies to help them to understand Olia's background.

4.15 Children's Services did consider the importance of matching Olia with a social worker of a similar background, home country and knowledge of Olia's first language. This was effective practice. This social worker never met with Olia because agencies did not have her correct address and contact was only ever made by telephone. The first opportunity to meet with Olia was when she returned to the UK and Border Services alerted the police who alerted CSC. The allocated

social worker was on leave, so two duty workers went to meet her. Given the seriousness of the concerns, that she was now 7 months pregnant and the likely anxiety and fear for Olia, who had already experienced one child being removed at birth, CSC could have considered taking someone with them who spoke mother's first language or had knowledge of her culture; this could have provided some reassurance to her at a stressful time.

4.16 Olia was unhappy with discussing issues of mental health and talked to the trainee GP in 2018 about this. Later this reluctance to consider mental health issues and that she might need help was confirmed by information from the London borough who conducted the care proceeding for her three previous children. Research suggests that there are cultural barriers and taboos when talking about mental health difficulties and seeking help which are dominant in the African country where Olia was born. Information provide to this review is that there needs to be cultural sensitivity in the way in which these issues are discussed and this might have enabled Olia to accept support for herself. She refused the two offers of support for her mental health.

4.17 Cultural competence is the ability and confidence of all professionals to explore and ask questions about the cultural context and practices of the children and families that they work with. This includes understanding and addressing racism and discrimination, and recognising that cultural identity will be treated with understanding and respect. It does not mean that professionals can fall back on simplistic notions of culture to avoid making difficult decisions about when and whether to intervene with families or to allow stereotypes and discriminatory attitudes to influence practice.

4.18 Culturally competent professionals recognise every individual as unique and equally worthwhile. Assessments, plans and interventions need to include a discussion of health beliefs, process of immigration, attitudes to professionals and attitude to family relationships. Alongside this it is important to explore a family's experience of racism and discrimination and consider its impact on family life, access to services and opportunities. The culturagram tool[iv] can be a helpful tool in exploring these issues.

4.19 Legislation[v], Guidance[vi] and research[vii] highlight the importance of identifying an individual and families' cultural context and heritage, as well as their experiences of racism and discrimination alongside family strategies to address this. This focus on cultural competence grew out

of historic concerns regarding the professional approach to children and their families from Black and Minority Ethnic communities (BME) which was "colour-blind" (Phillips 2002[viii]) meaning it often lacked a recognition of culture, personal[18] and institutional racism[19]. There remain national concerns regarding many professionals' ability to work proactively in a culturally competent way. Brandon and colleagues (2012) also found in the Biennial reviews of SCRs[ix] that issues of culture and ethnicity were a common theme, which was not adequately explored in safeguarding practice.

4.20 Cultural competence needs to be supported by an organisational framework, which demonstrates the value of working in this way, providing guidance, training and support. There are very few Local Safeguarding Boards that have culturally competent practice guides[x] or frameworks.

Finding 3: The Importance of Effective pre-birth processes.

4.21 This finding is about the importance of effective pre-birth planning processes and multi-agency meetings when there are significant concerns about an unborn child and mother. It is important that all professionals take seriously the vulnerability of an unborn baby; the lack of antenatal care for some time, a mother who had mental health problems and her neglect of previous children should have led to pre-birth multiagency child protection assessment. This would have meant an early sharing of all information and a clearer multi-agency strategy to safeguard the unborn baby and support Olia.

4.22 When Olia first booked her ante-natal care in 2018 she told the GP and midwives that this was her first pregnancy and she indicated no other vulnerabilities. She appeared well when seen. It was only when the Advanced Nurse Practitioner evaluated the discrepancies in the information provided by Olia that agencies became aware of her history.

4.23 This prompted a clear referral to children's services by midwifery in line with the procedures for concerns about unborn babies, their mothers' and the requirement for a pre-birth assessment. Children's services

[18] Prejudice, discrimination, or antagonism directed against someone of a different race based on the belief that one's own race is superior: Oxford University Dictionary

[19] [Institutional racism is] the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people. (Macpherson, 1999b: 6.34)

reviewed the information, but did not know of the previous referral made by a midwife in August 2016 because of an administrative error. Children's Services started an assessment; it is unclear whether this assessment was to be completed using the pre-birth assessment framework[20] as the progress of the whole assessment was hampered by having the wrong address and Olia's reluctance to engage. Midwifery services were also unable to make contact with her at this time.

4.24 The allocated social worker appropriately made contact with the police and reported Olia as a missing person. Information from the GP indicated that Olia might have gone overseas. This would have been an opportune moment to call a multi-agency meeting to discuss Olia and the baby, make plans for when she was found and to consider how best to engage with Olia given her history and experiences.

4.25 Children's services collected information from the London borough where she had previously lived. This provided a lot of historical information, and although the assessment/pre-birth assessment could not be fully completed in Olia's absence an early analysis could have been carried out using the existing knowledge. This would have enabled some thought to be given to what needed to be done if and when she returned.

4.26 6 weeks later Border Control confirmed that Olia was overseas and that she would be returning the next day. At this stage she was 8 months pregnant, appeared to have had no antenatal care since March, did not have a birth plan in place and no one knew whether she had made any practical preparations for the birth of a baby (when Olia and Baby W were found at home there was very little furniture in the house and no baby equipment). There should have been a strategy meeting/discussion in the context of pre-birth processes and would have meant there was a multi-agency plan regarding who should meet Olia at the airport and what this should focus on. A meeting early on could have considered the best way to address current concerns by including the specialist midwife for asylum seekers and refugees or a cultural representative from some of the third sector organisations in the city who could have communicated with Olia in her own

20 https://greatermanchesterscb.proceduresonline.com/chapters/p_pre_birth_assess_app_a.html#assessment_tool

language, and impressed upon her the importance of accessing antenatal care for herself and the baby.

4.27 Olia was reported to be hostile when seen by social workers at the airport and no plan of action was agreed with her. This should have been further point where a multi-agency pre-birth/strategy meeting was convened to discuss the imminence of the due date for the baby, the lack of awareness of the suitability of arrangements and the lack of a birth plan. These should have highlighted the seriousness of the circumstances for Olia and the unborn baby.

4.28 A number of professionals attempted to make contact with Olia over the next three weeks including two social workers, the health visitor, midwifery services and the GP Practice. She was spoken to by telephone. The neighbouring authority midwifery services believed Olia and the baby had not been seen since March and appropriately made a safeguarding referral on the 27th June. This was accepted, and a strategy meeting discussed, but delayed because of confusion about which PPIU team was responsible (see Finding 5). There was still no pre-birth planning meetings or planning. A week later Olia and Baby W were found dead in their home.

4.29 This was a complex set of circumstances, which required a more formal pre-birth child protection response from the very first referral and a coordinated multi-agency response at key decision points. It is not clear why this did not take place or why there was such a lack of urgency. Olia's circumstances highlight the vulnerabilities of babies and their mothers and why formal pre-birth processes are important.

Finding 4: Working with parents who have had previous children removed from their care

4.30 This finding focuses on how to work effectively with parents who have had successive and repeated care proceedings where children have been removed from their care because of harm and are now expecting a new baby. Research[xi] suggests that these circumstances are common and raise concerns about the needs and vulnerabilities of babies and children and how to address the circumstances of parents to stop the repeat cycle. Evidence from an evaluation of the Pause programme[xii], aimed at ending this cycle, is that these multiple proceedings often exacerbate existing parental mental health difficulties, and other vulnerabilities such as instabilities in housing and intense negativity and hostility towards professionals, particularly social

workers. This can impact on future pregnancies and the ability to engage with services to address concerns if left unaddressed.

4.31 The background history of Olia was not known until 6 months into her pregnancy. It then became clear that she had been involved in lengthy and contested care proceedings regarding her two oldest children. Two years later her third child was removed from her care at birth.

4.32 When these circumstances became known, there should have been more discussion about the likely impact of this history on Olia's ability to engage with services, particularly social workers so as to ensure the wellbeing of this unborn baby. Children's services were already discussing the need for a legal planning[21] process and potential removal of the unborn Baby W at birth. Olia would have been aware that this was likely given her previous experiences. It is not unreasonable to think that she was scared and anxious about history repeating itself. This was not part of any professional discussion.

4.33 The evidence was that Olia had disengaged with all services at the time that her history became known. The implications of this were not sufficiently discussed or planned for. A multi-agency meeting (as discussed in Finding 3) would have been an opportunity to consider how to address this issue and how best to address Olia's vulnerabilities. The multi-agency group could have considered the role of any church that Olia was affiliated to or whether there were community resources that could act as a mediator given her likely fears of professionals.

4.34 It is critical that where agencies are working with parents who have had children removed from their care, and are now pregnant, the circumstances of this removal are discussed and the implications for action to be taken agreed. The impact of these traumatic events on parents should also be considered, what support could be provided, and how to enable them to engage with services they are likely frightened of and anxious about. There is no specialist provision in Manchester, such as the Pause programme[22]. This kind of service needs

[21] When social workers decide that the parent's care of their child is not improving enough to protect the child from significant harm, they will call a **legal planning meeting**. This meeting is for social workers and the local authority's lawyers to decide whether it is in the child's best interests for the parent(s) to be given a further period of support to improve their parenting, or to find someone else in the child's wider family to care for the child, or for the child to be removed from their parent's care straight away. The parents (or others with parental responsibility) should be sent a letter setting out the decision made at the meeting.

[22] Pause works with women who have experienced, or are at risk of, repeated pregnancies that result in children needing to be removed from their care. They aim to give women the opportunity to pause and take control of their

to be considered depending on the extent of this issue in Manchester. In the short-term Manchester Safeguarding Partnership (MSP) could issue some good practice guidance for working with parents where there have been previous children removed and there are either new concerns or a new pregnancy.

Finding 5: The complexities of Information Sharing and multi-agency working

4.35 Information sharing is a key finding in most SAR's and Serious Case Review's (SCR). For Olia and Baby W a complex picture emerges of cross boundary issues, information being recorded in different parts of computer systems and then some lack of clarity of what information needed to be shared and with whom:

- In September 2016 Olia visited many different midwives, who worked for different hospitals. It was effective practice that a community midwife from the surgery recognised this, recognised Olia's vulnerability and fully reviewed her records. This led to advice for Olia to visit the GP, but these concerns were not shared with the GP Practice.
- The referral of concern completed by the community midwife and shared with Manchester Children's Services (CSC) was not recorded on the hospital system because Olia was registered with another hospital. The computer system would not accept the recording. This has been now been addressed. This key information was not shared with the hospital with whom Olia was registered for midwifery care because she was not pregnant at the time;
- GP surgery 1 were not aware of the historical information held about the removal of Olia's previous children or the concerns about her poor mental health/diagnosis of schizophrenia. This information was not flagged on this GP Practice records;
- Children's services MASH recorded the concerns under Baby W, and when the next referral came in the following year this was recorded under Olia's name. The two contacts were not connected together. The computerised system has been updated since this time, and a review of progress suggests that this problem no longer exists. This case is a reminder of the importance that any contact or referral for an unborn baby should not be made separately from those of the mother, but if this happens, they are linked;

lives breaking a destructive cycle that causes both them and their children deep trauma. https://www.pause.org.uk/

- When Manchester CSC could not establish Olia's whereabouts in May 2018 they reported her disappearance and the police put out a missing persons alert. This information was communicated to all involved agencies who were asked to alert the police and children's services if Olia made contact with them. This did not go to the homeless team who would have been able to say where she was living. It is unclear why this gap in information sharing existed. Work is needed to ensure good quality information sharing which is in line with information sharing protocols going forward.
- Cross boundary working meant that the strategy meeting agreed did not take place because Manchester PPIU considered that the neighbouring PPIU should convene this because Olia lived in that area. This should have been challenged because all the services and concerns were located in Manchester.
- The homeless service had contact with Olia, but were unaware/did not check whether she was known to other agencies.

Good Practice

4.36 There were three examples of good multi-agency action and practice noted across the review:

- The neighbouring authority HV received a referral from housing and visited immediately. She was concerned that the property looked abandoned and she immediately contacted Manchester to seek information and share the information she had.
- The community midwife in 2016 identified that there were concerns about Olia, reviewed her records and shared her concerns with children's services MASH
- The Advanced Health Practitioner at GP Practice 2 also recognised that there were discrepancies in what Olia was telling professionals about her circumstances and proactively ensured that her GP and midwifery records were reviewed. The discrepancies were shared with the Senior Safeguarding Midwife at MFT who recognised the need for an urgent pre-birth assessment. The Senior Safeguarding Midwife therefore made a good quality referral to children's services.

5. Conclusion

5.1 This review has explored the very sad circumstances in which Olia and her baby (Baby W) died. For much of Olia's pregnancy professionals were unaware of her personal history. When this history became known action was taken, but Olia's time abroad seems to have reduced a sense of urgency and when she returned, 4 weeks before the due date for baby W's birth, despite Olia living in accommodation that was never seen, without a birth plan in place of any sense of whether she had made any preparations, there was no multi-agency meeting held and a lack of appropriate urgency to professional decision making.

5.2 Olia was a Black African woman who experienced much poverty and disadvantage when she came to the UK as a young person and onwards. We know little about her life in Manchester or why she came here after her 3 children were removed from her care. There is sadly no information about friendships, cultural contacts or church attendance; something we now know was important to her. There is no doubt that she was resourceful and managed the many moves she had to make because of the instability of her housing situation.

5.2 We also know nothing of her personal experiences of discrimination, racism or poverty but there is evidence that poverty played a part in her fragile housing situation and led to a number of difficult situations for her. Research highlights the negative effect of all these factors on Black and ethnic minority parents and children's physical and mental health[xiii] and sadly there was no opportunity to explore this further for Olia. Clearly here life experiences had an impact on how she felt about engaging with support services and her three children coming into local authority care will have played a part; she had no contact with these children, and again no professional had any opportunity to talk to her about this.

5.3 It is important to reflect on Olia and Baby W's circumstances in the context the current Black Lives Matter movement. This movement highlights the inequalities and discrimination faced by black and minority ethnic communities, and the impact this has on mental health, housing, employment, health, child welfare services and making and maintaining networks. These were all factors for Olia and Baby W and need to be part of the professional understanding and recognition of the lives of black and minority ethnic groups in the UK.

6. Recommendations

Recommendation 1: The Manchester Safeguarding Partnership should develop practice guidance for culturally competent practice which is then disseminated through briefings and training. This should include a structured process for discussing culture, use of culturagrams where possible and seeking the expertise of the many cultural groups represented within Manchester to ensure effective application. A resource should be developed in partnership with voluntary sector organisations to signpost practitioners to the cultural community groups available in Manchester.

Recommendation 2: MHCC should review the process whereby GP records (Emis records) can flag for historical safeguarding concerns and mental health so that the information is transferred easily from practice to practice.

Recommendation 3: The MSP safeguarding training programme should consider how to address the needs of vulnerable pregnant women and their unborn babies. This training programme should ensure that staff understand best practice in working with adults who are not engaging (potentially self-neglecting) and who may have a history of trauma. This should have a think family focus, consider capacity and be aimed at both children's and adult's practitioners.

Recommendation 4: MSP should conduct a desktop review of services available across the Partnership for parents who have had multiple children removed from their care.

The review should focus on

A. How effective services are in supporting parents to manage avoidance and/or self-harming behaviours.

B. Identify whether there is any evidence of a commissioning gap for specialist services.

Recommendation 5: MSP to consider what Think Family means for Manchester. A joint children and adults Think Family Strategy should be developed, which draws on learning from this and other Manchester adult and child reviews.

7. Changes to practice since the review started

Manchester Homeless service

7.1 Manchester Homeless service have implemented a number of changes to practice within the service. The Our Housing Solutions team (front door service) have changed the questions they ask. They now ask if single females have children, leading to does she have children in other areas of the country, if so, where the children are living. If the applicant presents as pregnant, again she will be asked about any other children she may have.

7.2 If a pregnant woman is offered temporary accommodation, she will be spoken to by a Support Worker who will explore her past experiences and where she has come from. All single pregnant females living in Manchester will be moved to temporary property in Manchester rather than anywhere in Greater Manchester. The service is able to offer more support if they stay in Manchester.

7.3 When placed in a temporary accommodation property, the aim is now to try and allocate all single pregnant females a Support Worker within a week of the team being given the case. In the past this would have taken at least a month. The homeless team do ensure that women are known to midwifery services.

Manchester Foundation Hospital Trust has addressed some of the issues which were raised in the initial scoping review:

7.4 The Trust's safeguarding service have reviewed the letter sent to primary care following a woman's booking of pregnancy to now include a request for primary care to share information regarding safeguarding concerns with maternity services.

7.5 The Trust has now implemented robust processes to ensure that all current maternity records are accessible to maternity staff at all times including for out of hours non-scheduled attendances.

8. Glossary

Advanced Nurse Practitioner (ANP)

Black and Minority Ethnic communities (BME)

Children's Social Care (CSC)

Emergency Duty Team (EDT)

Hand held notes (HHN)

Health Visitor (HV)

Multi-Agency Safeguarding Hub (MASH)

Manchester Foundation Trust (MFT)

Manchester Safeguarding Partnership (MSP)

Manchester Health & Care Commissioning (MHCC)

Public Protection Investigation Unit (PPIU)

Safeguarding Adult Review (SAR)

Safeguarding Adults Board (SAB)

Serious Case Reviews (SCRs)

Social Worker (SW)

Youth Hostel Association (YHA)

9. References

[i] http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

[ii] Treisman, K (2016) Working with Relational and Developmental Trauma in Children and Adolescents. London: Routledge

[iii] NICE (2018) People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services. London: National Institute for Health and Clinical Excellence.

[iv] Cultural Competency Toolkit: Health and Social Care https://www.hackney.gov.uk/Assets/Documents/Cultural-competencies-toolkit.pdf

[iv] http://www.londoncp.co.uk/chapters/B_contents.html#b_two

[iv] DfE (2015) Working Together to Safeguard Children: London https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[iv]National Institute for Health and Clinical Excellence. When to suspect maltreatment. London, 2009. https://www.nice.org.uk/guidance/cg89/chapter/1-Guidance

[iv] http://www.legislation.gov.uk/ukpga/2004/31/section/11

[iv] Woodman J et al (2014). The GP's role in responding to child maltreatment. London: NSPCC.

[v] Children Act 1989 www.legislation.gov.uk/ukpga/1989/41/contents

[vi] DOH (2000) Framework for the assessment of children in need and their families http://webarchive.nationalarchives.gov.uk/20130404002518/https://www.education.gov.uk/publications/eOrderingDownload/Framework%20for%20the%20assessment%20of%20children%20in%20need%20and%20their%20families.pdf

[vi] Thoburn, J et al (2004) Child Welfare Services for Minority Ethnic Families: The Research Reviewed: Jessica Kingsley press

[vii] DfE (2015) Working Together to Safeguard Children: London https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

[viii] Phillips, M. (2002) Issues of ethnicity and culture. In: Wilson, K., James, A. (eds) The Child Protection Handbook (2nd edn.). Edinburgh/London: Ballière Tindall.

[ix] https://www.gov.uk/government/publications/analysis-of-serious-case-reviews-2011-to-2014

[x] Cultural Competency Toolkit: Health and Social Care https://www.hackney.gov.uk/Assets/Documents/Cultural-competencies-toolkit.pdf

[xi] Broadhurst et al (2014) Vulnerable Birth Mothers and Recurrent Care Proceedings: Nuffield https://www.nuffieldfoundation.org/sites/default/files/files/rc-final-summary-report-v1_6.pdf

[xii] https://innovationcsc.co.uk/wp-content/uploads/2017/11/1.2.87-Evaluation_of_Pause.pdf

[xiii] Bernard C (2019) 'Working with Cultural and Religious Diversity' in Howarth J and Platt D (eds) The Child's World 3rd Edition. London: Jessica Kingsley Publishers.