HM Coroner's Office
HM Coroner's Court – Manchester North
Floors 2 & 3, Newgate House
Newgate
Rochdale
OL16 1AT

30th January 2024

[redacted]

Dear Sirs,

Bury Council apologise for the significant delay in responding to the Regulation 28: Report to Prevent Future Deaths, dated 17th January 2020. The delay has been caused by changes in leaders within both the Children's Service Department and the Safeguarding Partnership Business Unit.

Bury Council have reviewed the 'Ruling' of the Coroner, Edward Morgan, dated 24th August 2018, in relation to the death of Shneur Zalman Kaye (dob 16/09/03) and had completed a Serious Case Review (SCR). An action plan, in response to the SCR was created by the Bury Safeguarding Children's Partnership, who monitored the actions for the partnership.

Matters of concern to the Coroner

1. The decision to close a referral without prior contact with parents (where there is no safeguarding or legal reason why such contact should not be made) potentially deprives the Social Worker of the opportunity to contextualise the event or concern which has triggered the referral, and of forming an informed view of the welfare of the child to whom the referral relates;

2. The evidence received by the Court indicates that the closure of the safeguarding referral marks an end to social services involvement. Despite this no attempt is made to share the fact of the referral or the reasons for it with any third party, service or agency. This may have the unintended result of depriving third parties (including parents) and agencies already participating in the care and welfare of a child from being alerted to the concern and taking appropriate action (including accessing other services) in response to it. The submission made on behalf of the council indicate these practices are driven by considerations of data protection compliance. The practice imperils the precedence to be given to the paramountcy principle and has the potential to undermine the protection of children who are subject of referral.

Bury's response to the matters of concern raised by the Coroner

In early 2022, Bury's Multi Agency Safeguarding Hub (MASH) went through a systematic service review, which reviewed practice, operating principles, and practice standards. Our vision, underpinned by practice principles states that "all partners are committed to providing support to children and their families at the earliest opportunity and work with them at the lowest point of intervention in line with our children's continuum of need, this reflects our Bury LETS strategy of offering services locally, seeking Enterprising solutions with families to support change, a commitment to Working Together in partnership with families, doing with them, not to them and building on family strengths to support change". Strength based practice within the MASH, working alongside of parents/carers and seeing them as an expert in their own right is standard practice and unless there is a safeguarding or legal reason not to, it is an expectation that parents/carers are spoken with as part of the process.

In addition, the MASH consults with referrers to discuss concerns, clarify information and provide them with an outcome to their referral or to consider alternative support pathways should the recommendation not be a referral to Childrens Social Care.

I hope that this letter provides some clarity to the steps that Bury have taken as a result of the tragic death of Shneur.

Yours sincerely

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Interim Director of Social Care and Early Help