Monmouthshire Safeguarding Children Board

Serious Case Review
Child A

Executive Summary Report
May 2011

1. Reason for the Review

1.1 Child A was born on 24th November 2009. She lived with her Mother in a flat in Monmouthshire and was a healthy, well cared for child who was meeting her developmental milestones

1.2 In the early hours of 20th November 2010 Gwent police were telephoned by a person stating they were concerned for the welfare of Child A's mother as she had just spoken to her and she had stated she felt like dying. The caller also stated she had seen Child A's mother earlier that day and that she was concerned about her.

1.3 As a result of the call the Police visited the home and spoke to the mother. Child A was seen and found to be sleeping in a well kept, tidy flat. Mother stated she had trouble sleeping over the previous few nights which had left her feeling emotional and tearful. Avenues for support were discussed and the police left with Mother saying that she intended to retire to bed for the evening and seek advice in the morning. The police were satisfied that no further immediate action was required and made a referral to social services for a follow up assessment.

1.4 At 05.34a.m on the same day a telephone call was received from Mother stating that she had stabbed her baby. Police attended and found Child A deceased with multiple stab wounds. Mother was arrested for murder.

1.5 Monmouthshire Local Safeguarding Children's Board met on 25th November 2010 and agreed that a Serious Case Review would be undertaken.

2. Process of the Review

Serious Case Review Panel

2.1 The Serious Case Review Panel was Chaired by the Head of Children's Services for Blaenau Gwent County Borough Council. He has significant

experience at all professional and managerial levels in children's social services. In addition the Panel members comprised:

- Child Protection Coordinator, Monmouthshire Children's Services
- Named Nurse, Child Protection, Aneurin Bevan Health Board
- Detective Inspector, Heddlu Gwent Police
- Designated Nurse, Child Protection, Public Health Wales

The Panel was administered by the LSCB Administrator for Monmouthshire and Torfaen.

The Overview Report Writer

2.2 Martin Price is a qualified social worker with 35 years experience in statutory children's services. He has worked in different settings and at all staff and managerial levels, in a number of local authorities in Wales; for CAFCASS Cymru; and for CSSIW. Since March 2006 he has worked as an independent social work professional and management consultant. He has experience of undertaking serious case reviews as the Chair of an ACPC, as chair of serious case review panels, as a writer of individual management reports and as a writer of overview reports.

Individual Management Reviews

2.3 The three main agencies involved with Mother and Child A undertook individual reviews and provided reports of the findings. The reports were comprehensive and fully considered issues relevant to respective agencies.

Meeting of the Panel

2.4 The Panel met on the following dates-
2nd December 2010
11th January 2011
3rd March 2011
1st April 2011
6th May 2011

The Panel received very efficient support from the LSCB Administrator.

2.5 The detailed terms of reference of the review are set out in Appendix 1

1. Overview Findings

3.1 Mother's actions in causing the death of Child A were not preceded by any concerns about her ability to safely care for her child. She had experienced difficulties as an adolescent and as a young adult and had been diagnosed as having periodical symptoms of depression but there is no evidence that this undermined her functioning as an adult and a mother.

3.2 Mother's is described as an intelligent, very pleasant, and hard working young woman who had engaged well with the supportive agencies and managed her daily life reasonably well. On two very different occasions Mother and her child had come to the attention of Police and Social Services but neither event raised concerns about the parenting provided to Child A. Mother's episodes of depression that were treated appropriately and she had been offered further help.

3.3 Whilst Child A was clearly the victim of non-accidental injuries which were the immediate cause of her death, there were no prior child protection issues or historical concerns about Mother's care for her child. The Police had called at the house four hours before the fatal incident and the referral they made for a follow up assessment in relation to Child A was appropriate. There was no evidence to suggest they should be concerned for her immediate welfare.

3.4 It is not the purpose of a Serious Case Review to provide a comprehensive overview of formal research linked to the nature or circumstances of the harm suffered by a child. However, cases of filicide like that of Child A are relatively rare and present professionals and the public with a challenge of understanding. For this reason an indicative research view is set out briefly in Appendix 2 below. The contents of the appendix should be viewed as indicative but not of the standard of a research paper nor as a comprehensive overview the issues.

3.5 In conclusion there were no predictive factors known to statutory agencies that suggested that Child A was at risk of harm from her mother. Mother was like many young people who had struggled in adolescence and found themselves managing the responsibilities of parenthood at an early age. Agencies appropriately shared information when there was a need to do so and there was good inter-agency working by professionals involved with the family which did not indicate Child A as being in need of protection.

3.6 It is inevitable that when agencies critically examine their historical involvement with a family, areas of policy, process and / or practice issues are identified as requiring review or improvement. Individual agencies have made recommendations to address these. The issues identified are not linked to the death of Child A. This overview report does not make any further recommendations.

Appendix 1- Terms of Reference

Aim of the Individual Agency Review:

- To look openly and critically at individual and organisational practice to see whether the case indicates that changes in practice and inter agency working could and should be made and if so, to identify how these changes will be brought about.

Specific Terms:

<u>To establish the agency involvement with the child and family by:</u>

Constructing a comprehensive chronology of involvement by the agency and / or professional(s) in contact with the child and family over the period of time specified in these terms of reference. Period of review is from 2nd February 2009 to the time of HR's death.

(This chronology should include decisions reached, services offered and / or provided to the children and family and other action taken)

<u>To analyse the involvement of the agency with the child and family to establish:</u>

a) Whether practitioners were sensitive to the needs of the child in their work and the well being of the mother and about what to do if they had concerns

b) Whether the agency had in place policies and procedures for safeguarding children and acting on concerns about their welfare and whether these were acted upon in this case.

c) Whether key relevant points / opportunities for assessment and decision making in this case, in relation to the child and family were taken.

d) Whether assessments and decisions were reached in an informed, timely and professional way

e) Whether actions were carried out in a timely way and accorded with assessments and decisions made.

f) Whether there was an appropriate level of parental consultation and participation

g) Whether practice was sensitive to the racial, cultural, linguistic and religious identity of the child and family

h) Whether senior managers, or other agencies and professionals, were involved where they should have been

i) Whether the work in this case was consistent with Monmouthshire LSCB's policy and procedures for safeguarding children and wider professional standards

j) Whether appropriate care plans were in place.

Particular issues for this case in relation to the points above are;

- Consider whether agency responses were appropriate to the mothers presenting mental health issues.
- Mother's possible vulnerability and how universal services engaged with her

<u>To identify any lessons learned from the case:</u>

a) Are there lessons to be learned from this case with regard to the way in which the agency works to safeguard children and promote their welfare?

b) Is there good practice to highlight, as well as ways in which practice can be improved?

c) Are there implications for ways of working; training (single and inter – agency); management and supervision; working in partnership with other agencies; resources?

<u>To make recommendations for action in relation to:</u>

a) What action should be taken by whom and by when?

b) What outcomes should these actions bring about?

c) How the agency will review whether the proposed actions have been achieved?

Aim of the LSCB Overview Report:

The overview report should bring together and relate the information and analysis contained in the individual agency reviews and if appropriate the views and experiences of family members. in order to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result and

- Improve inter-agency working and safeguarding children

Specific Terms

In compiling the LSCB overview report, the Author will:

Prepare an introduction that:

i) Summarises the circumstances that led to the review being undertaken
ii) States the Terms of Reference
iii) Lists contributors to the review and the nature of their contributions
iv) Lists the Serious Case Review panel and the Authors of the Agency Reports and the Overview Report

Consider the facts of the case:

i) Prepare a genogram showing membership of family, extended family and household
ii) Compile an integrated chronology of involvement with the children and family on the part of all relevant agencies, professionals and others who have contributed to the review process, noting specifically each occasion when the child was seen
iii) Prepare an overview which summarises what relevant information was known to the agencies and professionals involved, about the parents and the home circumstances of the child.

Provide an analysis of the case that considers:

i) How and why events occurred
ii) The decisions that were made
iii) The actions taken or not taken
iv) Assess whether decisions and actions taken were in line with LSCB policies and procedures
v) What services were provided in relation to decisions and actions in the case
vi) Any reasons /underlying factors, which makes the case a cause for concern
vii) Whether (with the benefit of hindsight) different decisions or actions may have led to an alternative course of events
viii) Any examples of good practice

ix) Any matters of relevance arising from case reviews of a similar nature conducted in other parts of the UK

Provide written conclusions and recommendations that:

i) Summarises what, if any are the lessons to be drawn from the case

ii) Address how lessons may be translated into recommendations for action.

iii) Provide an executive summary and conclusions

Recommendations should:

i) Be focused and specific and capable of being implemented

ii) Highlight, where appropriate, issues for national, as well as local policy and practice.

iii) Include recommendations made within individual agency review reports in addition to those made by the author of the overview report to the LSCB.

Appendix 2 - The Research Context

1. Bourget (2007) discusses the categorisation of filicide and includes a model that describes five major categories: pathological filicide, accidental filicide, retaliating filicide, neonaticide, and paternal filicide. In this model, pathological filicide refers to cases in which the perpetrator most likely has a major psychiatric illness. The filicide probably has psychotic or altruistic motives, and includes homicide-suicide events. Accidental filicide includes death due to various forms of child abuse, including battered-child syndrome and fabricated or induced illness. Retaliating filicide is the murder of a child to punish a spouse, while neonaticide is usually the result of an unwanted pregnancy.

2. In their review of studies Bourget (2007) reports on the numerous reports of an association between filicide and pre-existing psychiatric disorders is compounded by indications that a significant number of homicidal parents come to the attention of psychiatrists or other health professionals before the offence. Two studies indicate that filicidal parents' most frequent reason for contacting agencies was concern over their mental health. One study found that nearly all of the psychotic women in their study were in ongoing psychiatric treatment at the time of the offence, and that significantly more psychotic women compared with non-psychotic women voiced concerns about their children to their family within two weeks before the offence.

3. Friedman (2005) found that women at risk for neonaticide are often young and unmarried, deny or conceal the pregnancy, and lack prenatal care. The factors associated with maternal filicide appear to be nonspecific but seem likely to include past use of psychiatric services and a history of suicidality and depression or psychosis. However, the factors associated with maternal filicide are likely to be different for women who are psychiatrically ill, compared to those who are not psychiatrically ill.

4. Stroud (2008) comments that we know a great deal about the procedures aimed at protecting children but *"the numerous public inquiries into child homicides within families, together with serious case reviews and analyses of these do not afford detailed understanding of child homicide as a phenomenon, nor of those who commit it: instead they offer in-depth information on the specific circumstances of specific cases, focusing on professional failures.* Further, relatively little is known about the lives and pre-offence experiences of individuals who kill a child. Stroud states that it seems justified to conclude *"that we cannot be sure how appropriately the policy focus of procedural requirements addresses the needs of, or risks posed by those who kill a child".* Stroud reports that three main themes emerge in relation to the pre-offence experiences of people who kill or seriously harm a child, namely, the presence, role and effects of psychological difficulties; difficulties in relationships across the lifespan or social isolation; heterogeneity in respect of stressful experiences. However, Stroud concludes that *it is difficult to see current policies, interventions and practices addressing the needs of those who kill a child. Further, given resource constraints on therapeutic interventions, it seems unlikely that such services will be easily accessible in the near future.*

<u>References</u>

i) Bourget, Dominique. Grace, Jennifer. Whitehurst, Laurie (2007). *A Review of Maternal and Paternal Filicide*. The Journal of the American Academy of Psychiatry and the Law 35:74–82

ii) Friedman, Susan Hatters. Horwitz, Sarah McCue. Resnick, Phillip J **(**2005). *Child Murder by Mothers: A Critical Analysis of the Current State of Knowledge and a Research Agenda.* American Journal of Psychiatry 162:1578-1587

iii) Stroud, Julia.(2008) *A psychosocial analysis of child homicide*. Critical Social Policy 28: 482

iv) Yarwood, David J (2004) *"Child Homicide: Review of Statistics and Studies*". Dewar Research