SERIOUS CASE REVIEW

Executive Summary

Child CS- DoB 29.10.01
Child AS -DoB 15.11.02

Date of Death 5.11.06

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1. Introduction

Child CS and Child AS, who lived in Denbighshire, were killed on 5th November 2006 by their father, PS. PS has been described by his family and by professionals familiar with him as a "loving and doting father". PS had a well documented history of mental illness and received extensive services for a number of years.

The authors' conclusions are that the deaths could not have been predicted or prevented, but that there are lessons to be learnt.

2. Purpose of a Serious Case Review

Under section 32(2) of the Children Act 2004, a Local Safeguarding children Board is to have such functions as the Assembly may prescribe by regulations, which may in particular include functions of review and investigation. The Local Safeguarding Children Boards (Wales) Regulations 2005 require that where abuse or neglect of a child is known or suspected and:

- a child dies; or
- a child sustains a potentially life-threatening injury or serious and permanent impairment of health or development, this may include cases where a child has been subjected to particularly serious sexual abuse.

The Local Safeguarding Children Board for the area must conduct a serious case review.

Additionally, LSCBs should always undertake a serious case review where:

- a child has committed suicide; or
- the child has been killed by a parent with a mental illness.

The purpose of serious case reviews carried out under this guidance is to identify steps that might be taken to prevent a similar death or harm occurring and in so doing, 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 as a consequence;
- improve inter-agency working an better safeguard children; and
- identify examples of good practice.

3. The story in brief

The children's mother SG and PS had been together for a number of years. Both SG and PS came from caring and supportive families. PS had regular contact with his mother, his sister, and his brother and his wife. The children had regular contact with these family members and SG's mother. The relationship between SG and PS began to break down in 2005 and they separated but by late 2006 PS and SG were again living together with the children. On the night of 5th November 2006 SG left the children with PS. He smothered them the same evening.

4. The review process

The review is based upon single agency reports, a joint chronology, a series of interviews with staff and family members and three serious case review panel meetings. It has been overseen by the Denbighshire Safeguarding Children's Board.

5. Professional involvement

There were a number of professionals involved with the family. Two GPs, Health Visitors and, near the end of their lives, teachers, working with SG and the children; and Psychiatrists, CPNs and nurses working with PS. The involvement of the mental health professionals was intense but only one, a CPN, included the children and the mother in her work. Communication between the mental health professionals was good as was communication between children's professionals. However there was very little contact between adult and children's professionals.

Adult professionals saw their responsibility towards the children as being limited to a consideration of whether the children were at risk of significant harm, or not, rather than thinking about their general needs. The authors concluded that the children were not at risk of significant harm, until immediately before their deaths, but that there is research and evidence to show that children living with a parent with a severe mental illness will face some difficulties. The authors have therefore concluded that children's needs should be included in the reviews of parents who have severe mental illness problems and that there should have been more contact between adult professionals and health workers.

The authors were concerned that despite the fact that a protocol existed about communication between adult mental health and children's professionals the local team were unaware of its existence. The authors were also concerned that the protocol was flawed in some areas.

After the children were murdered contact between the adult mental health professionals and the family stopped. This caused added distress to the family. The authors will be producing a draft protocol for use in these situations.

The authors concluded that the work carried out with the adult members of the family was, by and large, thoughtful, sensitive and caring.

6. Analysis

Identifying parents who may kill their children is probably beyond our present knowledge. From a literature review, commissioned by the authors and completed by Jim Wild, from Nottingham Trent University, it is clear that PS fitted some of the criteria for men who might kill; his devotion to the children, his lack of social contacts, his comments that he "lives for his children", could all, with hindsight, be seen as pointers to the eventual tragedy. And yet, if every parent who showed these characteristics was considered a risk, social services departments would be overwhelmed with referrals.

All the professionals and family members involved accept that PS had difficulty in expressing his feelings about his illness, and that he was sometimes in denial and "hard to engage". He did not express any thoughts about harming his children to his family, and it seems unlikely therefore that he would have said anything to professionals.

7. Conclusion

A serious case review can be a distressing experience for everyone, but especially the family involved. We have tried to involve all relevant family members in the review, and have gone back to them to check our understanding of events. Many points of detail would not have emerged without their help, and in turn we hope that we have answered their questions. We have tried to investigate their areas of concern as well as the questions raised by the single agency reports.

We hold no individual to blame for the deaths of the children. We believe the responsibility for their deaths lies wholly with PS, although we recognise that his illness and his intense feelings towards the children contributed to his actions.

We hope and believe the recommendations in this report will be implemented and will improve the lives of other children living with parents with severe mental illness. But we must face the fact that the lives of Child CS and Child AS would probably not have been saved even if the practices that we now recommend had already been in place.

8. Recommendations

	Recommendation	Who responsible	Timeline
1.	Introduce the domains from the Assessment Framework to assessments for the Community Mental Health Team. ▪ Redraft assessment framework ▪ Implement in team	Reconstruct Reconstruct Julie Mountford	June 2008 June 2008 December 2008
2.	Redraft the existing North Wales Multi-agency Protocol for working with children and families experiencing serious mental health illness, reducing it's length and including information on consent and the assessment framework. This to be issued across North Wales	Reconstruct North Wales Safeguarding children Forum	June 2008 September 2008
3.	Devise a procedure and a guide for writing a letter, to ensure that there is sympathetic contact between helping agencies and families in the event of a death	Reconstruct	June 2008
4.	Ensure that reports and case notes in the Community Mental Health Team are typed	Julie Mountford	December 2008
5.	A member of the Conwy & Denbighshire LSCB will be designated as the nominated (reciprocal) link with the Conwy & Denbighshire Adult Mental Health Partnership	Nicola Francis and Neil Ayling	June 2008
6.	Each agency to review their training strategy in the light of this review and to submit to the Conwy & Denbighshire LSCB	Each agency:- North Wales Police Denbighshire Children's Services Denbighshire Education Service Conwy &	December 2008

		Denbighshire NHS Trust (including Adult Mental Health Partnership) North Wales Probation	
7.	The Welsh Assembly Government to issue guidance in respect of the independent investigation of adverse events in mental health services concerning the death of a child to relevant agencies. Working Together under the Children Act 2004 to be revised accordingly.	Welsh Assembly Government	As soon as practicable

9. The Authors

Reconstruct is a company providing consultancy, training and children's services. It was commissioned to complete the inquiry and produce this report. The process followed was as recommended in *Safeguarding Children: Working Together Under the Children Act 2004* (WAG 2006) – hereafter *Working Together*. The work began in August 2007 and was completed in March 2008.