Barnet Safeguarding Children Board

SERIOUS CASE REVIEW: EXECUTIVE SUMMARY

Child S

Born 10.04.06
Died 26.10.07

1. The Serious Case Review (SCR) Process

1.1 Barnet Safeguarding Children Board commenced a SCR at the beginning of November, 2007, following S's death a few days before. The Review was undertaken in line with Government guidelines in Chapter 8 of *Working Together to Safeguard Children,* 2006.

1.2 The Board's SCR Sub-Committee met in a timely way, and established Terms of Reference for the Individual Management Reviews (IMRs) and the Overview Report. The SCR was to focus on a period beginning during mother's pregnancy with S (December 2005), and ending shortly after his death. However, agencies with relevant background information were invited to include this in their reports.

1.3 The IMRs were asked to address the following issues:

- The decision to de-register from Barnet's Child Protection Register (CPR)
- The decision to close the Children's Service's involvement with the family in September 2006
- Did these decisions balance historical concerns with the recent perceived improvements?
- The communication between professionals in Hemel Hempstead and Barnet
- Mental Health and Substance Misuse services received
- Multi-Agency Public Protection Arrangements (MAPPA) involvement.

1.4 The independent Overview Report author was given leave to include other aspects of the case which might contribute to learning for individual agencies and for the inter-agency network. A number of additional themes were covered, the chief of which dealt with:

- Pre-birth referral, Core Assessment, and Initial Child Protection (CP) Conference
- Sharing information – who knew what/when?

The Overview Report also examined whether procedures were followed, and commented on "What worked well".

2. Criteria for conducting the review

2.1 From the outset, it was accepted (and was later confirmed at his inquest) that S had been killed by his mother, who also killed herself.

S became the subject of official concern, once it was known that his mother was pregnant; she had been a violent offender, and was regarded as posing a potential risk of harm to a child. S's name was placed on Barnet's Child Protection (CP) Register pre-birth, until he was two months old. He had therefore been the subject of an inter-agency CP Plan, and thereafter, briefly, a Child in Need Plan.

2.2 A number of child care and adult agencies were involved with S and his parents, largely in Barnet but also in Hertfordshire (Herts.). Throughout his short life, no further questions were raised by these agencies about S's care, and certainly none had predicted that serious harm would come to him.

2.3 It was therefore agreed that an SCR should be carried out, to help agencies understand what might have gone wrong in this case, and, where possible, to improve safeguarding practice in future.

3. Case Summary

3.1 S was a white British boy, the only child of his parents. When he died, aged 18 months, he was living with his mother; father, who lived elsewhere, had been closely involved with his son and partner.

3.2 S was said to be a much-wanted and much-loved child. His parents' manifold problems (see below) appeared to be in abeyance once they became parents. S was a healthy child, meeting his developmental milestones, and giving no cause for concern. (His post-mortem examination found no other signs of abuse or neglect.)

3.3 S's parents were apparently committed to parenting him jointly, despite not living together. However, in late September 2007, it is believed that his father "broke up" with his mother. About two weeks later, father committed suicide by hanging in his flat. This tragic event was entirely unexpected both by his family and by agencies.

3.4 Mother was said to be distraught at this loss. Two weeks later, she killed S by smothering him, and herself by hanging. Her suicide note stated that she wanted them to be together as a family.

4. Family background

4.1 Mother was born in 1977. Her childhood was marked by a number of losses, the most traumatic being her father's suicide when she was aged eight. Her relationship with her own mother was apparently problematic, and she became beyond her "care and control" at a young age (though never "accommodated" or placed under a Care Order by the local authority).

4.2 Her recorded history of severely disturbed and self-abusive behaviour began aged 12, and continued until she was in her mid-20s. This included chronic alcohol abuse, drug abuse, numerous self-harming and more serious suicide attempts, and violence towards others, including a knife attack on another young person, for which she served a 2-year sentence in a Young Offenders Institution.

4.3 As a young adult, mother's psychiatric symptoms persisted and appeared to worsen, and she was eventually diagnosed as having a Borderline Personality Disorder.

4.4 Father was born in 1971. His background was much less known to agencies. He appears to have had a close relationship with his mother and sister, with whom he lived for part of his adult life. He (self-reportedly) abused alcohol from a similar age as his partner, and poorly attended secondary school. As a young adult, he experienced symptoms of agoraphobia.

4.5 The parents, both clearly on a downward path, met in an alcohol rehab unit in 1999. Later that year, they were homeless (living in a squat) and drinking heavily, when they committed the manslaughter of a man in a drunken argument. They both served a prison sentence for this offence, mother's being a life sentence because of her previous violent conviction. Father's offending history had been relatively minor, compared to mother's.

4.6 The couple's reunion following release from prison (April 2004) was initially troubled, but within a few months, they were apparently together as a couple (though never living together) and coping better than before. Neither gave their respective Probation Services cause for concern from late 2004. The risk of their further offending was linked with alcohol abuse, both by them and their Probation Officers, and there were no known signs of this for either mother or father.

5. Agencies involved

5.1 Both parents had regular involvement with their respective Probation Services (though father's licence ended in March 2007). The fact that their supervision on licence was provided within two separate Probation Areas raised some issues of communication across boundaries.

5.2 Mother had been involved with Mental Health (MH) services over many years. Historically, services were regularly and appropriately offered to her, but not taken up. There were no MH referrals for mother during her pregnancy or during S's life.

5.3 Barnet Children's Service became involved during mother's pregnancy with S, under CP procedures, and then as a "Child in Need" case following S's de-registration in June 2006. The case was closed in September 2006, after a referral of the family to a local family centre (poorly used by mother).

5.4 The Barnet PCT Children and Families Team provided a service to S, with the same Health Visitor involved throughout.

5.5 Mother had a housing support worker who offered both practical and emotional support over several critical months (before and after pregnancy).

5.6 None of the agencies' IMRs commented on contextual issues in providing services to the family, apart from the effect of there being two Probation Services involved with the couple. No resource implications were suggested in the IMRs, or inferred by the Overview Report author.

5.7 By the time of the parents' and child's deaths, few of the agencies mentioned above were still engaged with the family. Apart from universal services (HV and GPs), only the London Probation Officer was involved with mother.

5.8 Reflecting on the different models used in the IMRs, the Overview Report recommends to London Safeguarding Children Board that: **A template for IMRs, including chronologies, should be agreed, consistent with Ofsted guidance.**

6. Key themes and lessons learnt

6.1 The IMRs made twenty-three recommendations for their agencies. The Overview Report endorsed these, and added a further twelve

recommendations. Included here are those with the broadest application, addressing the main themes in this case.

6.2 **Risk Assessment**: This emerged as the principal area for learning from this case. Within this, the single most important lesson was the fundamental importance of the personal history of parents (or parents-to-be). Critical points (to be addressed in inter-agency Risk Assessment Training) include:

- Beginning pre-birth assessments as early as possible
- Reviewing previous agency records, especially key documents and chronologies
- Obtaining and analysing psycho-social histories from each parent, as a means of understanding their past, present and future needs, and the risk they may pose to a child.
- Understanding (using evidence) the significance of clustered risk factors, in particular MH problems, alcohol abuse, and violence.
- The need for challenge (from CP Conference Chairs and Supervisors) to partial or over-optimistic views held by individuals or the professional network as a whole.

Overview Recommendations to address this crucial area of practice include the following:

- **Inter-agency Risk Assessment training should be offered regularly to staff and supervisors; this should reflect upon the key themes and lessons in this case.**
- **For all cases reaching the CP threshold, the analytic use of psycho-social histories should be developed across agencies. Training should be provided for undertaking this area of work.**
- **Front-line staff and their supervisors in Children's, Adult MH, and Child and Adolescent MH Services should train together about their respective services and roles in relation to CP.**
- **In signing off a Core Assessment or Risk Assessment, the Team manager should record the following:**
  a) Is there a need for a psychiatric assessment?
  b) If the parent/parent-to-be has previously had such an assessment, has the local authority sought an updated MH assessment?

  (Where this is possible, the same psychiatrist should be asked to re-evaluate the adult, addressing questions about what has changed, giving evidence for change, and offering a view about risk now and in the future.)

- **New-born babies subject to a formal CP Plan should continue to have such a plan for sufficient time post-birth, to ensure good bonding and parenting patterns before removal of the CP Plan. Following the removal of the CP Plan, all children should be subject to a Child in Need Plan for six months before case closure is considered.**
  (The aim of these measures is to improve the safeguarding of children at highest risk. Barnet Safeguarding Children Board should review the impact of these measures after one year.)

6.3 **Information-sharing:** This was the other main area of practice highlighted in the Overview Report. Critical points include:

- Ensuring that key professionals can and do attend key meetings (e.g., the Initial CP Conference) – those who have background information and those with a current picture of the parents/family.
- Establishing effective systems for sharing CP records across different hospital departments.
- Clarifying the expected levels of communication across separate Probation Service areas (where clients are linked as this couple was)

Recommendations to address the second bullet point have been made by the Hospital NHS Trust, and the Overview Report adopted these. The Overview Recommendations for the National Offender Management Service (NOMS) are as follows:

- **Guidelines should be established for communication in cases of co-defendants or couples being dealt with across separate Probation Services.**
- **Where substance misuse has been a major concern in relation to re-offending, verification of abstinence should always be sought.**