Newport Safeguarding Children Board
Bwrdd Diogelu Plant Casnewydd

Serious Case Review Child 'AB.'

Executive Summary Report

March 2010

1. INTRODUCTION

1.1 On the 19th June 2009, Child 1, aged 4 years, was found dead at the family home. The post mortem indicated that Child 1 had died as a result of suffocation. Mother was arrested by the Police and subsequently charged with murder of Child. Mother has since appeared at the Crown Court, has been detained indefinitely under the Mental Health Act 1983.

1.2 Newport Safeguarding Children Board subsequently initiated a Serious Case Review in line with the guidance contained in *Safeguarding Children: Working Together under the Children Act 2004* (WAG 2006).

2. CASE REVIEW PROCESS

2.1 The Newport Safeguarding Children Board established a Serious Case Review Panel to oversee the case review process and appointed an independent author to prepare an Overview Report of the actions of agencies working with Child 1. The aim of the review was to establish what lessons could be learned about the way local professionals and Agencies worked together in this case and make recommendations accordingly.
The following issues were also considered:

- The needs and risks presented by the family on their arrival in Newport;
- How the information from London was shared and understood by agencies in Newport and used in the assessment of risk;
- The quality of inter-agency information sharing in Newport;
- How the assessment of parenting capacity was undertaken and consideration of Mother's mental health;
- How the needs of the children were assessed;
- The robustness of the Child Protection Conference process.

2.2 The period under review was from October 2006 to June 2009.

2.3 The Review, although primarily concerned with learning any lessons from the circumstances surrounding the death of Child 1, will also examine the circumstances of the sibling.

2.4 The Agencies that contributed to the Serious Case Review were:

- Children & Families, London Borough of Hammersmith & Fulham.
- Children & Families, Newport City Council.
- Newport Health Services.
- Gwent Police.
- Education, Newport City Council.
- Newport Homestart.
- Newport Sure Start.
- Newport Women's Aid.
- Housing Services, Newport City Council.

3. BACKGROUND

Father

3.1 Nothing is known about the father/s of the children.

Mother

3.2 Little is known about Mother's background other than she experienced a difficult childhood which included being sexually abused and as a teenager requested to be looked after. During her early twenties Mother was treated for anxiety and depression with Child 2 being born during this period.

3.3 The relationship with the father of Child 1, that lasted several years, was according to Mother a violent one. As a result they separated during the pregnancy of Child 1 leaving her with certain injuries. Towards the end of the pregnancy, due to Mother's ill-health, Child 2 was looked after for a short period. Mother and her children it is said moved homes at least 20 times in the following years mainly, according to Mother due to poor housing conditions.

4. SUMMARY OF AGENCY INVOLVEMENT

4.1 In October 2006 whilst living in London, concerns by a Health Visitor in regard to neglect issues which led to Child 2 aged 9 taking care of his sister, Mother's feeling of being watched by her ex-partner and bizarre comments i.e. neighbours are against her and will listen to conversations and poor school attendance, led to children's services becoming involved.

4.2 A range of support services were offered but only practical support was accepted. Efforts were made to encourage Mother to have a parenting /

mental health assessment but this was declined. In December 2006 Mother made an allegation against a neighbour of sexual interference on Child 1 on minimal information which led the Police to comment that this could indicate mental health issues for 'entertaining this fantasy on such spurious evidence'. Mother was subsequently seen by her GP in January 2007 who concluded she was not depressed nor required any other assessment. Though Mother was seen as being loving towards her children, there were increasing concerns in respect to Mother's mental health. For example Mother was concerned about the number of paedophiles living between their home and Child 2's school.

4.3 By March 2007 Mother was cutting herself off from her neighbours and refusing offers of help, the curtains were drawn all day and she appeared to be sleeping during the day and awake during the night. Children's Services became increasingly concerned, referred the case to the Community Mental Health Team, and instigated a child protection investigation. Concerns increased when the family could not be contacted or located. Unbeknown to agencies in Hammersmith and Fulham, the family had moved to Newport. The children's names were placed on the local Child Protection Register under the category of Neglect and the system to alert agencies about missing families was instigated.

4.4 Though there is evidence of this action being undertaken, no agency in Newport received such information so it was another two months before Newport Children's Services became aware that the family was residing in the Newport area.

4.5 Mother self-referred herself and the children to Newport Women's Aid on the 21st March 2007, saying that she was fleeing domestic abuse from a violent ex-partner who was Child 1 's father. She was anxious that he would find out where she was living. Mother refused to name her GP, said she had no contact with Social Services. Support was offered in respect of registering for housing, claiming benefits and accessing health services. Education for both children was organised and they settled well into the Refuge. Mother was considered as loving, gentle and calm and 'the last person on earth you would think would harm her child'. The family was re-housed in the Newport area in June 2007. Women's Aid continued to support Mother for several weeks providing practical support. The Women's Aid Aftercare Worker recalls Mother as a loving and 'seemingly over fussy' parent who seemed to worry excessively about minor ailments and illnesses.

4.6 Soon after moving in to the refuge the Health Visiting Service became involved. A Developmental Assessment of Child 1 was undertaken which indicates a sociable cooperative child with age appropriate development. Mother informs the Health Visitor that she does not wish her to contact previous Health Visitor and that her history is complicated. The Refuge staff report no current concerns about the family.

4.7 During this early period in Newport, Housing Services assess the Mother's request for housing and in due course a housing association property is provided in June 2007.

4.8 It is not until 24th May 2007 that Newport Children's Services were informed by the London Borough that they knew the family and that the two children's names were on their Child Protection Register. After visiting the family and making an Initial Assessment, which was based on the information provided by the London Borough, Children's Services arranged a Transfer Conference on the 13th June 2007. The Initial Assessment concluded that a fuller assessment was required.

4.9 The main focus of the Transfer Conference was on the concerns that were identified whilst the family was residing in London. These included the family's many moves, Mother's isolation and lack of engagement with agencies, poor school attendance of Child 2, and Mother's mental health. During this initial period in Newport there was mainly a positive picture in that school attendance had improved and that there had been no concerns over Mother's care of the children. The children's names were placed on Newport's Child Protection Register under the category of Neglect.

4.10 A Child Protection Plan was drawn up though it did not make reference to the need to compete a Core Assessment. In the following three months two Core Groups meetings were held prior to the Review Conferences in September 2007. During this period support services were provided, including for two weeks a childminder to give Mother an opportunity to sort out the house, a male family support worker to engage with Child 2, some social work visits and visits by the Women's Aid After Care Worker. The Health Visitor also visited and monitored the children's health and school attendance. At both Core Groups efforts were made to encourage Mother to undergo a psychological assessment though without success. A referral had also been made to Homestart but after a minimal involvement of a volunteer in November, this was not progressed.

4.11 At the Review Conference held on the 27th September 2007 the unanimous decision was made to de-register both children. This was based on the good health and development of the children, Mother had worked hard to improve the home condition, work was being undertaken with Child 2, Mother was engaging with agencies and it was felt Mother was providing good-enough basic care of the children.

4.12 The Conference agreed to de-registration on the condition that further work on a voluntary basis would be undertaken under the Children in Need process. The Children-in-Need Plan mirrored to a large extent the Child Protection Plan. The Children-in-Need Plan was reviewed on a regular basis until the Spring of 2008, when both Health and Children's Services decided there was no need for their continuing involvement.

4.13 Between October and December 2008 Mother, on her own volition, attended the Sure Start Family Project Group. Mother attended a total of six sessions between 22nd October and 3rd December 2007. During this time Mother completed a Language and Play course which aims to encourage parents to interact with their children. During her period at Sure Start Mother appeared to be wise and knowledgeable who really didn't need Sure Start support, seeming very together, and open and responsive, never appearing stressed or harassed.

4.14 Mother's relationship with the schools was not an easy one as she rarely visited unless there was a problem. The children's attendance fluctuated and from December 2008 onwards Child 2's attendance and lateness was cause of some concern. Efforts by the Education Welfare Service to engage with Mother proved unproductive. A Transition Scheme to assist Child 2 in moving from Primary to Secondary Education was declined by Mother.

4.15 From the Spring of 2008 until the Summer of 2009 the agencies that had contact with the family, i.e. the Education, Primary Health Service, and Housing Association expressed no concerns over the care of the children, apart from school attendance, nor in respect to Mother's mental health. A Housing Officer visited the home in July/August 2008 but had few concerns. Mother accessed Health Services as appropriate. As late as three days before the death of Child 1 in June 2009, Mother, with the two children, visited her GP regarding minor ailments. The GP had no concerns over Mother's behaviour or demeanour.

5. KEY FINDINGS

5.1 The agencies in Hammersmith and Fulham responded appropriately to the concerns identified and offered a wide range of support services. As the concerns increased so it was appropriate that a Child Protection Investigation was instigated, which led to the children's names being placed on the local Child Protection Register. An appropriate referral to the Community Adult Mental Health Services was made, though not able to be followed through, due to the family moving from the area. There is concern that the alert to other authorities regarding the missing family proved in-effective as it took 8 weeks before agencies in Newport were alerted.

5.2 The initial response in Newport was a positive one, with agencies providing a welcoming and supportive environment. Once it was known the children's names were on the London Borough's Child Protection Register, after a little delay, appropriate action was taken to contact the family, make an Initial Assessment and arrange a Transfer Conference.

There was a good level of sharing information between the London Borough and the Newport agencies prior to and at the Transfer Conference.

5.3 Based largely on information provided by Hammersmith and Fulham Children and Families Services the Transfer Conference made an appropriate decision to register the two children under the category of Neglect, and a Child Protection Plan was drawn up. Unfortunately there was no reference to the need to undertake a Core Assessment, a statutory requirement.

5.4 The lack of an in-depth assessment and analysis of the needs of the family meant that the impact of trauma in Mother's early life, coupled with her later life experiences on her parenting capacity / mental health, was never properly explored. It also meant that the true extent of Mother's anxiety over her fears regarding her ex-partner were never fully explored, resulting in no conclusion being reached about whether this was a sign of paranoia or a reasonable response to real threat.

5.5 No Core Assessment and analysis as to the needs of the family meant that the Child Protection Plan was more a list of recommendations and activities as opposed to what was needed to be done to achieve specific outcomes for the children, and what needed to be achieved for the children's names to be removed from the Child Protection Register.

5.6 It was also an oversight that whilst in Newport, no one suggested seeking advice from Community Mental Health Services who might have been able to suggest ways of exploring the true extent of her mental health or assist her to discuss and explore her anxieties.

5.7 The Social Worker allocated the case was inexperienced, had received no Child Protection training, had too a high case load and did not receive the managerial oversight required due to vacancies in the team. At no time was a Core Assessment mentioned to her. The failure not to produce a Core Assessment was more likely attributable to a systemic weakness in Children's Services, as opposed to a failing on one individual, as other members of Children's Services were also involved in the case.

5.8 The decision to de-register the children in September 2007 was premature, though given the absence of a Core Assessment and a Child Protection Plan with clear aims and outcomes and a Children-in-Need Plan that mirrored the Child Protection Plan it probably made little difference. Support Services continued to a good level until the Spring of 2008 when agencies withdrew probably appropriately, given the limited concerns over the care of the children.

5.9 The records kept by the agencies seemed adequate, apart from Children's Services, where poor recording meant that they were unable to fully evidence their involvement and support to the family.

5.10 Though the Overview Report has identified some issues of poor practice, it is important to recognise that there were areas of good practice identified.

- Multi-agency working – there was clear evidence that agencies communicated between one another and generally worked well together;

- Women's Aid had good communication and working relationships with Health Visiting Services and Education;

- Seeking and listening to the views of the children – Women's Aid and Family Support Worker engaged with Child 2 to seek his views and feelings, other agencies also engaged with the children;

- Agencies' commitment to the Child Protection process – agencies regularly attended the various Child Protection and Children In Need meetings;

- In Newport a robust Children-in Need process was in place;

- Sharing reports with Mother – Mother was taken through reports being presented prior to the meetings;

- A good range of preventive/support services were made available to the family in London and Newport;

6. CONCLUSIONS

6.1 Mother was seen as a very anxious person who shared little information about herself, and was difficult to relate to, particularly by those agencies where some conflict existed. Mother was also open to assistance and support as long as it was on her terms. From Spring 2007 onwards, Mother's parenting was seen in a positive light with no one expressing concern that Mother could pose a risk to her children. If anything Mother was seen as being overprotective.

6.2 The longer the family remained in Newport, the concerns over the care of the children and Mother's parenting capacity and mental health significantly reduced from that which existed prior to them moving to the area.

6.3 Within the Child Protection and the Children-in-Need system, agencies worked well together to provide a range of practical support. It can only be

speculation as to whether the completion of a full Core Assessment, which would have required much cooperation from Mother, and consultation with Community Mental Health Services would have resulted in a different outcome.

6.4 Given that Mother has now been diagnosed as suffering from severe paranoid schizophrenia, the concern over her mental health becomes of greater importance. During Mother's stay in London she did not take up the opportunity for a parenting assessment, denying that she was depressed or mentally ill. Her GP was clearly of the view that Mother was not depressed nor required any other mental health assessment.

6.5 The concerns continued partly fuelled by Mother's high level of anxiety and paranoia about her ex-partner finding her. Even so there was only one occasion at the first Core Group in June 2007 when Mother spoke in a way that caused concern i. e. covering house in foil, though this doesn't seem to have been discussed with her.

6.6 As late as three days before the death of Child 1 in June 2009, Mother's GP met the family and had no concerns over Mother's behaviour or demeanour. It has to be acknowledged that the diagnosis of psychosis would be outside the scope of a GP and would require an experienced psychiatrist to detect such an illness.

6.7 In hindsight, it might be thought that Mother may have developed a psychotic disorder around the Autumn of 2006, but at no point was Mother seen by any psychiatric service. If Mother received a full psychiatric assessment at this stage, and a diagnosis of psychosis been made and had appropriate treatment been initiated it is impossible to state in retrospect whether this would have reduced the likelihood of Mother harming her child.

6.8 The Review leads one to conclude that the death of Child 1 would appear to be a sad tragic event, which could not have been predicted or prevented by any specific action or intervention from any of the Agencies.

7. RECOMMENDATIONS FOR ACTION TO THE RESPECTIVE LSCB

London Borough of Hammersmith and Fulham Children and Families Service make the following recommendations:

Recommendation 1:

Early involvement of specialist mental health professionals in families where borderline mental health needs are identified.

Recommendation 2
Increased understanding of the likely impact of past patterns of frequent moves.

Newport Social Services make the following recommendations:

Recommendation 3
That all temporary registration requests are sent to the Child Protection Unit on the day they arrive in Newport.

Recommendation 4
That a caseload management system be introduced within Children's Services in Newport.

Recommendation 5
That Newport Social Services follows the CSSIW guidance 'Making The Most of Social Workers 1st Year in Practice, an Employer's Guide June 2008' for all newly qualified social workers.

Recommendation 6
That all Social Workers and Team Managers receive training on case recording.

Recommendation 7
That Guidance and Training is given on the requirements in relation to Transfer in Conferences to improve the case management and care planning at the conference and make it a more robust process.

Recommendation 8
That the Social Services Department ensure that all front line staff and managers receive training on the requirements for Assessments held within procedures and guidance e.g. Working Together, All Wales Child Protection Procedures.

Recommendation 9
That Newport request from the 'home' Authority the attendance of the Social Worker that best knows the family at Transfer in Conferences, which in some cases will not be the allocated worker.

Recommendation 10
That Social Workers and Team Managers receive training on the essential nature of information sharing and the importance of fully recording what information has been shared, by whom, to whom, when and what is the expected outcome of sharing this information.

Recommendation 11
That Review Child Protection Case Conferences ensure that a Core Assessment has been completed and they have had the opportunity to consider it prior to making a decision re de-registration.

Recommendation 12
That multi agency training around the appropriateness and importance of challenge between professionals and agencies is incorporated as a key element within Child Protection Training

Newport Sure Start make the following recommendations:

Recommendation 13
Parents/carers will be asked for permission to let their Health Visitor know that they are attending a Sure Start group.

Recommendation 14
The Sure Start Project Manager will, from December 2009, ensure that the Sure Start Family Project/Creche registration forms are amended

a) **To ask what other services the family is involved/working with**
b) **Parents' permission sought to share relevant information in line with Newport City Council's Information Sharing Protocol.**

Recommendation 15
Family Project Officers will receive training in the recognition of Mental Health issues.
Arrangements have therefore been made for training for Family Project Officers on a 2 day 'Mental Health First Aid' course (January 2010). This will provide training in how to recognise mental health issues and how/when to signpost.

Recommendation 16
The Sure Start Project Manager will, following completion of this training, ensure that any concerns will be recorded by Family Project Officers in the existing Risk Management 'RRARR' (Report, Record, Assess, Reduce, Review) book, discussed with the Line Manager and reviewed at 1:1 Supervision meetings to agree appropriate action.

The Newport Education Service make the following recommendations:

Recommendation 17
The sharing of information between Social Services and Education in regard to children that are, and have been on the CPR needs to be reviewed.

Recommendation 18
The transfer of sensitive records between schools, to be reviewed and updated.

Recommendation 19
Regular monitoring of the CPR records.

Recommendation 20
To develop procedures for identifying and addressing 'Children Missing Education' This in line with the shortly due WAG Statutory Guidance of the same title

The Gwent Police make the following recommendation:

Recommendation 21
Gwent Police to ensure Police representation at every Initial Conference and to increase attendance rates at Review Conferences.

The Overview Author makes the following recommendation to the Hammersmith and Fulham Safeguarding Children Board:

Recommendation 22
That the system for alerting agencies across the UK of Missing Persons / Families is reviewed

The Overview Author makes the following recommendations to the Newport Safeguarding Children Board:

Recommendation 23
Newport Safeguarding Children Board should develop arrangements with Adult Mental Health Services to enable specialist advice to be made available to Child Protection Case Conferences where this is needed.

Recommendation 24
Newport Safeguarding Children Board should develop a protocol with Housing Services in respect of the exchange of key information in respect of children in need of safeguarding.