



Ealing Safeguarding Children Partnership

Child Safeguarding Practice Review

Child 'James'

3 January 2010 – 16 August 2020

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Section One

A Picture of the Child

This Child Safeguarding Practice Review report begins by drawing in words a picture of the child who is subject to the review. It is important to understand as much about the child and his lived experience in the months before his death, in order to put him at the centre of the review process (1). For the purposes of the review the child is known as James.

James was a 10-year-old boy who lived at home with his mother (a Russian national) in a ground floor flat in the London Borough of Ealing. His father (an English national) lives in Spain. He was a Year 6 pupil who attended an Ealing Special School. James would go to his mother when she collected him, and they were observed to have a close relationship. The school provides education for children aged 2 to 11 years who have profound and severe learning difficulties. James had a complex range of disorders; autism, significant learning disability, neutropenia (low white blood cell count) and Cohen syndrome. He had a degenerative visual impairment and was registered as severely sight impaired. He also had hearing loss. He wore corrective glasses and adapted special footwear. In 2020, James attended school regularly until March when his mother decided to keep him at home due to the health risks posed by the Covid-19 pandemic.

At school, James was described as a happy, likeable boy who often caused staff to smile. He used Makaton to communicate knowing about 20 signs. He used photos and symbols and was able to differentiate around 50 photos. He used a communication book and speech sounds to ask for things. He had a range of speech sounds and these altered in relation to how he was feeling. James heard English at school; Russian, English and Ukrainian at home. He used big resources in school because of his visual impairment which was deteriorating. It was expected that as a relatively young man he would have lost his sight completely. James was at an early stage of development, he was 'toddler-like'. He had limited functional skills and difficulty retaining information. His body tone was low, as was his fine motor skill level.

James would gain adults' attention by tapping them, he made eye contact and would take adults by the hand and lead them if he wanted something. James enjoyed the company of his peers at school, but he would not initiate contact. James enjoyed being outside, he really liked spinning objects, and focused on wheels on bikes in the playground. He enjoyed books particularly books with sound especially animal sounds and he also liked classical music. James was being encouraged to explore different kinds of play and the school were providing a curriculum for life, supporting his independence. He regularly went out with school staff on visits. There were no behaviour management risk concerns for these visits.

If James became frustrated or did not want to do something, he may have thrown an object, hit out or hit himself. At school, this behaviour was infrequent (no more than weekly). If he was insecure or scared, he would cling to a trusted adult. He sometimes bit his clothes and needed to be reminded to stop. James was able to feed himself, he managed main meals by himself at school and was helped with them at home. He could drink from a normal cup. He wore nappies (day and night), responded well to personal care and was learning to use the toilet. James could pull his trousers up and down when wearing joggers, he was also learning to tolerate having his teeth brushed. James followed simple instructions from adults very well.

(1) This picture is drawn from information provided by the professionals who knew him. James's mother and father felt unable to contribute to the review – see section 3.

Section Two

Background and Context

This Child Safeguarding Practice Review has been commissioned by the Ealing Safeguarding Children Partnership in response to the requirements of statutory guidance issued by HM Government; *“Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children.”* (July 2018).

This guidance recognises that child protection in England is a complex multi-agency system involving many different organisations and individuals. The guidance states that reflecting on how well the system is working is an important part of the collective endeavour to improve the public service response to children and families. The guidance recognises that sometimes a child suffers serious injury or death and that when this occurs it is important to understand what happened and why so that improvements can be made in the public service response to children and their families at both local and national levels. Child Safeguarding Practice Reviews are the means through which this can be achieved.

On receiving the notification from the police of the death of the child known as James the London Borough of Ealing carried out its legal duty to report the incident to the National Child Safeguarding Review Panel (16C (1) of the Children Act 2004 (as amended by the Children and Social Work Act 2017). In accordance with statutory guidance, local safeguarding partners met to hold a Rapid Review Meeting on the 20th August 2020. As required by the guidance, the partners gathered the facts as far as they were known at that point; considered the potential for identifying immediate improvements and whether to hold a practice review. The statutory criteria for undertaking a review were taken into account, namely whether such a review may highlight:

- Improvements needed to safeguard and promote the welfare of children
- Recurrent themes in the safeguarding and promotion of the welfare of children
- Concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children.

It was decided at the Rapid Review meeting that a local child safeguarding practice review should be undertaken. At this point it was known that a severely disabled child had been killed by his mother, and this tragic event took place during the pandemic of Covid-19. It was believed that the criteria for undertaking a review were met in that a review might identify important learning about improvements needed to safeguard and promote the welfare of children. The National Child Safeguarding Panel was notified on the 9th September 2020. Following consideration, the National Panel agreed with the Ealing Safeguarding Children Partnership decision and communicated this in a letter dated 25th September 2020

The Ealing Safeguarding Children Partnership identified an independent person to undertake the review whose professional background met the requirements of statutory guidance. The reviewer has a professional background in social work, well over thirty years' experience of the public sector and a national reputation for partnership working and service improvement. The terms of reference for the review were drawn up from the main findings of the Rapid Review Meeting (Appendix One).

Section Three Methodology

The purpose of the Child Safeguarding Practice Review is to understand for James what happened and why, so that learning can be identified to support future improvements to safeguard and promote the welfare of children, and this includes the identification of good practice. The overall aim is to learn from what happened to prevent or reduce the risk of similar incidents. It is not undertaken to hold individuals or organisations to account.

The methodology adopted for the review is informed by both the statutory guidance contained in Working Together to Safeguard Children (2018) and The Munro Review of Child Protection: Final Report – A Child-centred System (2011) which requires that systems methodology be adopted. This means understanding and analysing the practice in the case through securing the insights of front-line professionals and managers **and** understanding and analysing the context in which the practice occurred.

The methodology used for the review is proportionate to the circumstances and reflective of the guidance. The review has sought to reflect the child's perspective and the family context. It has been shaped to understand and analyse the front-line practice as well as organisational structure and learning. Importantly, it has sought to understand the implications and impact of the Covid-19 pandemic on the family, front-line practice, and organisations.

The information drawn upon for the review has been taken from the agency reports provided to the Rapid Review Meeting on 20 August 2020, and the note of that meeting. The review has not had access to medical assessment reports of James's mother completed after 16 August 2020. Individual discussions have been held with school staff, the community paediatrician, a senior leader for children's social care and the police Senior Investigating Officer. An individual discussion has also been held with a member of the family's local community who helpfully came forward to share their insights.

All the information arising from the written material and individual discussions were considered and analysed and emerging themes were explored at a Practice Insight Event. This event engaged front line practitioners and leaders in an in-depth exploration of those themes. The practice insights and overall learning have been considered and analysed. Conclusions are drawn from the analysis and recommendations made.

The child's mother and father have been approached individually and invited to contribute to the review on two occasions. They have declined to contribute, and it is appreciated that both parents are grieving the loss of their child. There is no doubt that their contributions would be beneficial to the review and of great value to the learning that could be achieved.

Section Four Participating Agencies

The following agencies participated in the Child Safeguarding Practice Review:

Central London Community Health Care NHS Trust

James's and his mother's GP practice

Great Ormond Street Hospital

London Borough of Ealing Council

An Ealing Special School

Metropolitan Police Service

London Ambulance Service

NHS Ealing CCG

London North West University Health Care NHS Trust

West London NHS Trust

Section Five

Summary of the Case

A summary of the child's development and service response has been collated to begin to understand the practice in this case. This supports the understanding of what happened. It begins by describing the circumstances of James's death as it is these circumstances that have resulted in the review being undertaken, and then relays the case history. A summary has been drawn up of what was known about mother's mental health prior to James's death.

The child's death

James died on the evening of the 15 August 2020. His mother gave him an excess dose of Melatonin (a medication prescribed to help him settle at night). She put him into bed with his toys and placed a sponge in his mouth, he died because of restricted airways. James's mother then called a friend (the person who had been providing care under the Direct Payments system), for help and who came to the family home. Both adults subsequently walked to Acton Police Station in the early hours of 16 August 2020 where James's mother reported to police that she had "killed her son". Police attended the home and found James unresponsive; officers attempted to resuscitate him and paramedics were called. James was pronounced dead at the scene. James's mother pleaded guilty to manslaughter with diminished responsibility on 25 January 2021, this plea was accepted by the Crown Prosecution Service. She was sentenced to an indeterminate hospital order on 11 February 2021. A Coroner's Inquiry is ongoing.

The child's history

James was born on the third of January 2010. He was the first and only child of his parents, and they shared legal parental responsibility for him. No problems were detected at his birth. However, by October, James's parents had concerns and his development was identified as delayed by his health visitor. Referrals were made to the Child Development Team (CDT) and Physiotherapy, a service which he received throughout his life. From this point onwards James and his family were in receipt of additional and specialist health services.

A home portage service was provided to James and his parents; this is an early years' service for children with special educational needs and it focuses on play, communication, and relationships. In December 2010, at eleven months old he was seen by the CDT for floppiness (a condition caused by neuromuscular and central nervous system disorders) and microcephaly (a condition where a baby's head is much smaller than expected). James's mother was known to be understandably anxious about her son's progress and she carried out her own internet research. She believed he had Cohen Syndrome and he was subsequently investigated by the geneticist at Great Ormond Street Hospital for Cohen Syndrome. Testing at this point did not find this to be the case. Cohen is a rare syndrome, and it is not usually detected in children under the age of 5 years. In 2011, James had occupational therapy services and this service continued to support him for the rest of his life. He also started to receive speech and language therapy, and this continued until 2015.

In 2011, at the age of eighteen months James was referred by his health visitor for additional needs childcare funding. Ealing Borough Council Early Years Services reviewed this request, and he was allocated a place at the local Children's Centre and nursery. He started to attend the following year in February 2012 at the age of two years. As this age, he was showing signs of autistic features and had been diagnosed with optic atrophy and retinal dystrophy (this can be progressive, leading to blindness). James attended the visual clinic at

Great Ormond Street Hospital and remained under their care for the rest of his life. He was also found to have intermittent neutropenia (reduced white blood cells) which meant that he may be more susceptible to infection. James was now receiving speech and language therapy services, occupational therapy services, as well as physiotherapy services and childcare services to support his development. From 2012 onwards he received the continual care of the same community paediatrician. James received audiology support during 2012 and 2013. In 2012 James's mother told community paediatric services that she and James's father were divorcing.

In 2013, after his third birthday James was privately diagnosed at Great Ormond Street Hospital as having autistic spectrum disorder. He continued to attend nursery taking up around 80% of allocated time until December 2012 when he travelled to Russia with his mother for an extended holiday to visit relatives. He returned to nursery in March 2013. Thereafter his attendance was low and by August 2013 at the age of three years seven months, James's mother stopped taking him to nursery altogether, choosing to support his education at home. During 2013 (July) she contacted Ealing Council for support, and this led to a recommendation for multi-agency support which was given. This came through a multi-agency service run by the NHS and Ealing Council that gives both families and professionals a single point of contact for information, referrals, assessments and help for children and young people with special educational needs and disabilities living in the London Borough of Ealing.

In February 2014, when James was four, his mother contacted Ealing Council's Children with Disabilities Service (CWDS) and asked for a social work assessment for home support. She later decided not to go ahead with this request. In the same year James was registered as severely sight impaired and he had a statutory assessment of his educational needs which resulted in a statutory Statement of Educational Needs. The Statement was later transferred to an Education Health and Care Plan (EHCP) following the implementation of the Children and Families Act 2014 and this Plan was subject to annual review. The Special School was identified as an appropriate placement to meet his needs and James started attending in February 2015 just after his fifth birthday. He attended this school until his death and staff there along with the whole school community knew him very well.

In October 2015, over 18 months after her first request, James's mother once again contacted Ealing Council's CWDS and asked for a social work assessment for home support. On this occasion she did not withdraw her request and an assessment was completed. This led to an agreement with James's mother to support him as a Child in Need (The Children Act, 1989) and a support plan was drawn up which largely focussed on service co-ordination. From this point onwards James and his mother were in receipt of practical support from Ealing Council Children's Services and this support continued until James's death.

In July 2016 at the age of six years and six months James was confirmed genetically as having Cohen Syndrome. A few months later in December, at his mother's request, the help she received from Ealing Council CWDS transferred from being provided under the Children Act to the Chronically Sick and Disabled Persons Act, 1970 (CSDPA). A Resource Panel decision was made to support the family with holiday provision (12 hours a week), after school provision (7 hours a week in term time) and home care support (6 hours a week). This meant that James and his mother received practical support without social work support and co-ordination, as James's mother did not want James to be treated as a child in need.

James's mother subsequently declined the agency-provided home care support, having refused the services of a care worker on faith grounds.

During 2017, when James was seven years old there were several missed hospital outpatient appointments between June and November. These all related to concerns that his mother had raised about his middle ear and nasal congestion. Although it was mother's concern that resulted in appointments being made for her son, she did not take him, and he was subsequently discharged. James's parents' divorce was finalised in 2017, and at some point, in this year his father moved to live in Barcelona, Spain.

In January 2018, James's mother and James moved from a large house in Acton to their flat, initially the flat was rented and then it was purchased. Later in 2018, James's mother decided to manage his home care package herself through the Direct Payments system. This meant that she was able to make decisions about who to employ to provide care and when that care would be provided. James's mother directly employed the carer, and the funding was provided by Ealing Council. In October 2018 James's mother contacted CWDS and said she had found her own carer and had been paying them for 12 hours a week since March 2018. At this point the agreed package included 6 hours of home care support a week. Support was provided with the completion of the necessary administration requirements, the additional home care hours that James's mother had put in place were agreed, and funding provided from 19 October backdated to March 2018. At this point the family were again offered support from a social worker, and this was once again declined. Ealing Council continued to support the family under CSDPA.

In May 2019, at James's mother's request the support package was again revised as she reported that she was under considerable pressure, suffering headaches and depression. Two weekly sessions at The Log Cabin (an out of school Specialist Centre) were agreed and Direct Payments to fund 12 hours care a week continued. She told the social worker that she was receiving less support from James's father. The nature of the reduction in support is not known.

The events of 2020

In January 2020, James was ten years old. In the same month, a review of the CSDPA support package was completed at a meeting in the family home. The care package remained in place and James's mother was once again offered support through the Child in Need services and this again was declined. In January, James's mother asked her GP for more bespoke care, the practice linked her to another parent of a disabled child for peer support. It is not known if she followed this up. In March 2020, the CSDPA support package was revised following completion of a child and family assessment and further review. By agreement, the two weekly sessions at Log Cabin were increased to three weekly sessions (although this support had not previously been taken up) and home care support through Direct Payments was increased from 12 to 16 hours a week.

In March 2020, and before the government's decision to close schools and place the country into lockdown in response to the Covid-19 pandemic, James's mother contacted her GP and asked for him to be included on the shielding list, and this was agreed. James had not been originally included on the list because he had not been a child deemed to be at risk. Although James had no significant history of physical illness, his mother was concerned about the potential for him to be immunocompromised because of Cohen Syndrome. She decided that James should not attend school because of the risk and he never resumed attendance. Schools closed in March, remaining open for the children of key workers and

vulnerable children where attendance at school could be safely managed. There was weekly contact from the school following the closure of schools in March. This contact was initially between the class teacher and James's mother and was mainly by telephone as this is what James's mother said she preferred.

In March, James's mother also contacted Ealing Children with Disabilities Service to discuss support. She asked for help with the costs of outdoor play equipment and an iPad that she had purchased. On a separate occasion in March, she asked for support with shopping and other practical support for single parents. She also talked with social care staff what would happen to James if she became ill and respite care was discussed. The following day James's mother was linked to 'Ealing Together' for practical support, this is a collaborative support network set up by Ealing Council and local voluntary organisations in response to Covid-19. In the third week in March, the direct payment carer had to self-isolate and his mother was managing James's care alone, although the direct payments continued. After the carer completed the period of self-isolation and was able to resume caring for James, his mother asked her not to come because she was concerned about the risk of infection.

From April, there was weekly direct contact between the teacher and James. It is known from school contact and neighbour reports that mother and James went out regularly to play in the garden of their home and to visit the park. In April, the GP contacted James's mother as a Covid-19 response to see how she was. James's mother described herself as 'coping' to the GP. She was also contacted by a CWDS manager to see how she was doing (6 April). James's mother said she was managing okay; she was on the government list for priority on-line food shopping. She told the CWDS manager that she would only be using her carer in emergencies and discussed an additional request for funding toys and equipment.

In the same month (17 April) James's mother contacted Ealing Children's Integrated Response Service with a health concern about her knee which she felt was exacerbated by caring for James. She had consulted her GP. She asked for financial support to help make adaptations to her kitchen to fit a dishwasher. The service asked about support from the carer and James's mother said that she had asked her not to visit due to Covid concerns. The service passed the request to CWDS who contacted her the same day. James's mother's concerns about shielding and support from the carer were discussed, the use of personal protective equipment (PPE) was raised. James's mother also mentioned making the home care support package more attractive to the carer by increasing the hours. A few days later (20 April) James's mother was again contacted by CWDS to see how she was doing, James's mother was upbeat, not wanting to increase the care package and she asked for the school to be contacted for the teacher to telephone James, and this was done.

In the third week of April (21 April), the community paediatrician contacted James's mother, also as part of the Covid-19 response, to discuss the balance of shielding and attending school. The safety of receiving support from the direct payment carer was discussed and it was agreed that the family should receive support from the carer if personal protective equipment (PPE) was worn. It is not clear exactly when the support of the carer was reinstated by James's mother, but it is known that from 26 May the carer was providing support 30 hours a week and that this care was continually in place until James died.

In early May (05), James's mother asked the OT (who had contacted her to discuss a report for James's annual EHCP review) to borrow a scooter and tricycle from school. The OT arranged this for two days later and James's mother collected them from her in the school car park.

Towards the end of May and into June the family had building work completed in the kitchen to fit a dishwasher which was stressful. The works resulted in a difficult dispute with a neighbour for which mother sought legal advice. In May (half-term) a planned holiday (James and mother) in Spain to visit father did not go ahead: there are two alternate reasons put forward for this: one is the impact of the pandemic on travel and a second is that James did not have enough time on his passport before it expired - six months is required. Mother told school at the end of term in July that she and James were going to Spain. School thought James was in Spain with his mother and father over the summer until they heard that he had died in London. It is not known what level of contact James had with his father during 2020 and by what means.

James's mother made a request for James to return to school towards the end of May. she wanted James to be taught in a room on his own with his teacher wearing full PPE. This was not in line with national guidance issued to schools. The school could not provide education for James in the isolated conditions that mother requested. An offer was made that he could have attended a small class. James's mother's request was discussed with her and she decided to continue shielding at home with support from school. Mother emphasised her view that James needed training, Applied Behaviour Analysis (ABA) work sessions or a member of staff to come into the home to teach James. School staff did not believe that ABA (an approach sometimes used for teaching children with autism) was appropriate for James and they were unable to provide home tuition.

At the end of June (26 June), James's mother contacted CWDS by email and described ongoing stress and asked for financial support from children's social care for expenditure incurred for toys, the increase in carer support that she had put in place and the kitchen refurbishment. On 03 July CWDS contacted James's mother by email; the request for help with toys was declined, but mother had received some equipment from school on loan, the request for support with additional care was being progressed and advice was being sought over help with the kitchen. On the same day James's mother contacted her GP about James's ear; he was seen on the same day. In the consultation James's mother said she needed more support managing James as she was exhausted because of disturbed nights. The GP wrote to CWDS on the same day and his letter was immediately acknowledged.

On 06 July, the social worker from CWDS telephoned James's mother to say that a review of the support package would be undertaken. On 07 July, the manager from CWDS telephoned James's mother and confirmed that a review would be held under CSDPA. James's mother said that she was under significant pressure and so stressed that she was not functioning mentally. She wanted funding for the additional hours that she had put in place. On the 08 July, the social worker updated James's mother about the review, the request for the increase in hours would be presented to the Resource Panel for a decision by the 08 August.

On 10 July, the Community Paediatrician telephoned mother to see how she was doing. James's mother said that she was struggling. The Community Paediatrician offered to end the shielding status and resume James's attendance at school. This was turned down by mother who felt that the end of the school year was near. James's mother was aware that the school was running a three-week play scheme over the summer; she did not take up the offer. The next contact was planned for 25 August to help James to return to school in September. The Community Paediatrician followed up with CWDS the request for financial support for care on the same day.

On 07 August, James's mother contacted the GP about James's teeth, the GP asked how James's mother was doing and she reported that she is 'surprisingly fine'. She said that she has not heard about her request for support from children's social care for the care package and this was followed up by the GP on the same day.

On the 10 August James's mother met a neighbour in the communal garden of their home, they had a friendly conversation in which they shared a joke and laugh together. James's mother said James had not gone to Spain for the summer as he had for the past two years because he had insufficient time on his passport before it expired.

Mother's mental health

In the autumn before James's birth (during the ante-natal period in 2009) his mother consulted her GP and said she was concerned about stress which related to finances. She said that she was receiving private counselling and the following month when reviewed by the GP, no concerns were raised about mental health. Following James's birth his mother reported to her GP that she felt empowered, she was sleeping and eating well. She spoke about the private treatment she had received for depression and mood swings. Post-natal depression was discussed. A month later she declined the health visitor's offer of a maternal mood assessment. In May (three months later) her mood was assessed on the low side and she was referred to psychotherapeutic services for cognitive behaviour therapy which she did not take up.

In July 2011, James's mother consulted her GP with stress related problems, she was again referred to psychotherapeutic services and it is understood that she attended and was assessed on this occasion. In March 2012, the GP records show that James's mother was receiving cognitive behaviour therapy privately. The following month (April 2012) the GP records show that James's mother has been prescribed an anti-depressant by a private physician with follow up in the private sector. There are no further references to mental health care until January 2018.

In January 2018, The GP notes record that James's mother was stressed having recently divorced from James's father. She was referred to a specialist to follow up a physical health condition and that specialist recorded that she was stressed, and she was advised about sources of support. In the following August (2018) in a GP consultation for a physical health concern, James's mother reported she was under a specialist in Spain for her mental health and had been prescribed medication. The GP assessed James's mother's mental health and diagnosed depression. An alternative medication was prescribed in line with the GP prescribing practice. James's mother was directed to support networks through psychotherapeutic services. There was a review in September 2018 when James's mother reported that she was in a much better place and the prescription dosage was decreased.

In February 2019 there was a further review, James's mother reported that her mental health was stable, that her stresses would not go away and that she was coping. She questioned whether she still needed medication and was advised to continue with it. From August 2019 this was prescribed at three monthly intervals, the latest being July 2020 at which point the prescription was further reduced.

It is understood from information reported at the practitioner insight session that in the days just before James's death, his mother had suffered a severe depressive episode with acute psychotic symptoms. Sleep deprivation and stress have been identified as factors contributing to the onset of this episode of mental illness.

Section Six Key Issues and Practice Episodes

The review has adopted a systemic approach to achieve a comprehensive understanding of what happened and why with the aim of reflecting on how well the system worked, to identify learning and recommendations for any improvements to the public service response to children and families. The previous section helps with the understanding of what happened in this case, and the question of why remains. A review of the material provided, and individual discussions led to the identification of key issues and practice episodes for further enquiry to develop an understanding of why James died.

In summary the key issues and practice episodes are:

1. The Covid-19 pandemic and timeline

It is important to consider the context in which the family were living and in which multi-agency front line practice occurred. The timeline of the national response to the pandemic is important as this affected both the family's experience and the agency response.

2. The picture of James in 2020

It is important to place James at the heart of this review and to understand what life was like for him in the months before his death. He died during the pandemic of Covid-19, an exceptional time for the family as it was for everyone living in England. The factor of Covid-19 is an integral part of the family's experience of life during 2020 and cannot be separated out. It is important to consider the implications of this.

3. The support provided to the family in 2020

It is important to understand the support received by James and his mother during 2020 and to consider how responsive the front-line practice was to identified need, and the potential for learning. It is equally important to be curious and consider whether with the benefit of hindsight there were indications of additional need, and the potential for learning. The factor of Covid-19 also applies to organisations and the support that was provided to the family.

4. Mental health care of mother

It is now known that mother's mental illness was a very significant factor in James's death. It is important to review what was known about mother's mental health by practitioners and consider how responsive the practice was to identified need. Here too, it is important to be curious and consider whether with the benefit of hindsight there were indications of additional need, and the potential for learning. Mother received a mix of NHS and private provision and the implications of this need to be understood.

5. Offers of Children in Need Support

Support was offered to support James and his mother through the Children in Need process. His mother rejected this service on three occasions. It is important to consider why she made these decisions, how this service might have benefited James and his mother. Alongside this it is important to consider whether there are implications arising from the way in which his mother chose to manage the care package, namely through the Direct Payments system. Again, the purpose of this consideration is to identify the potential for learning.

6. Missed appointments in 2017

There were several missed hospital appointments in 2017. It is important to understand this as a practice episode, to consider whether there was a missed opportunity to support James and his mother, to identify learning.

7. Engagement of fathers

James's father shared parental responsibility for him with his mother. The combined chronology illustrates that there was little to no direct communication between education, health and care agencies and James's father. It is important to understand why this was the case, what the implications of this were for the family and what can be learned.

These issues were considered in depth at a well-attended Practice Insight Event. A combined chronology and outline picture of the child were drawn up to support the event. The approach of practitioners, managers and service leaders was one of reflective and open enquiry with the aim of identifying areas of learning and the potential for practice improvement.

1. The Covid-19 pandemic and timeline

By March 2020 England was in the throes of the national and global Covid-19 pandemic, infection rates were rising as were the rates of hospitalisation and death. Schools were closed on Friday 20 March but remained open for vulnerable children and the children of key workers, where they could be safely educated. A 'national lockdown' was announced on 23 March 2020. The following day the prime minister referred to a 'moment of national emergency'. All non-essential shops and services closed on 26 March 2020. All non-essential travel was banned, citizens were required to work at home unless they were key workers and the nature of their work required working outside the home. Citizens were asked to go out for 'one form of exercise a day', to shop only for 'basic necessities'. The public were told to stay at home, support the NHS and save lives. Life completely changed for families across the country.

Lockdown began to ease on 15 June 2020 with the opening of non-essential shops, parks, and zoos. The national alert level reduced from four to three on 19 June. On 4 July, cafes and restaurants re-opened with social distancing rules and with this the lockdown ended. Restrictions on citizens behaviour remained in place with requirements to socially distance, wear face masks on public transport and maintain handwashing hygiene. The country was opening up again, but home working continued. James died after the first 'national lockdown' ended.

Schools in Ealing remained open throughout the lockdown period. They actively engaged with parents who were key workers and with parents of vulnerable children to continue to offer education safely.

2. The picture of James in 2020

The Practice Insight Event considered the implications of the pandemic for James, and his mother and concluded it meant a significant change in routine. It is known that the family had a limited close friendship network, no extended family living close by, and James's father was abroad. There was regular social contact with residents of the other four flats in the converted house where the family's flat was located, and there were offers of support from neighbours. In addition, James's mother had the support of Ealing Together who dropped food parcels. James's mother had decided earlier in March to keep James at home from school. She was concerned that he was more susceptible to infection because of Cohen Syndrome and wanted to keep him safe. The desire to keep children safe from the pandemic

and reduce infection rates prompted the government's decision to close schools a week or so later when all parents were asked to keep children at home if they could possibly do so.

Practice Insights

"James's mother was a powerful advocate for him, she was always concerned to do her best for him. Her decision to keep him at home and stop attending school was the action of a "good and concerned parent."

"All children find a change in routine difficult; this is more so for children with autism. It is likely that the change in routine was frustrating for James. As a child he was less emotional and affectionate. He was close to his mother but not physically close."

James's mother was the sole carer for him from the third week in March (when the carer had to self-isolate) until the end of May, and this must have been a challenging time. James's routine was disrupted, and it is likely that he found this difficult. His mother was managing all the practical aspects of his care. This meant helping him to wash, dress, eat, play, and learn and to settle at night. It also meant attending to his personal care at night and disrupted sleep for them both. Disrupted nights were nothing new but there were no breaks for James's mother during the day as James was no longer attending school. His learning at home was supported by school and there was weekly contact.

Despite the challenges this situation must have presented, James's mother took a decision not to allow the carer to resume care following the required period of self-isolation, this decision was motivated by her concern to keep James and herself safe from infection. This decision meant that she cared for James without the support of the carer for a period of about ten weeks until 26 May.

Following contact from health professionals James's mother decided to accept the support of the carer once again at the end of May. From this point she had the help of a carer for 30 hours a week. She took the decision herself to increase the hours of support from 16 hours a week. She was directly managing the care package and could make decisions about when and what care was provided. The pressures of caring for James would have eased. A month later she contacted CWDS to ask for support with equipment and the increased cost of the care she had commissioned.

In May around half term time (25 – 29 May) James and his mother were due to go to Spain on holiday. This was cancelled and although the reasons are not completely clear it was felt by practitioners that foreign travel did not accord with James's mother's decision to keep him at home from school. UK residents were officially welcomed back to Spain by the Spanish Government on 26 June 2020. The cancelled holiday meant that James's mother and James missed a break and direct contact with his father. It is known that there was ongoing contact with his father, and that James's mother shared with him how difficult things were for her. James's father knew that James's mother was in regular contact with health and care agencies.

At the end of May, James's mother re-considered her decision not to let James attend school and having discussed the options with school staff, she decided to continue to keep him at home. She commissioned building work to her kitchen which was started in May and ended in June, so a dishwasher could be fitted. The work was largely completed by a builder who was also a flat tenant in her 'block'. This is proved to be stressful and resulted in a dispute with a neighbour, a source of further stress.

It is evident that James's mother sought to enrich James's experience at home with the purchase and loan of play equipment and that she asked for help with this. It is known that she and James regularly went out to play in the communal garden of their home and they went to the park. She and James were often seen by her neighbours in the garden and James played alongside other children. After the easing of lockdown on 15 June with the opening of non-essential shops, they went shopping regularly. James's mother received Ealing Together food parcels every few weeks and shared food surplus to her requirements with neighbours, this provided another source of social contact. She also bought groceries on-line which were delivered, she was on the priority list as her child was being shielded. James's mother continued to keep James at home from school and term ended on the 24 July 2020.

In the two previous years (2018 and 2019) James had spent the long school summer holiday in Spain. It is understood that James's mother took him to Spain, returned home to take a break and then collected him. This did not happen in 2020 because there was insufficient time on James's passport before it expired. As a result, James missed the opportunity to see his father and James's mother did not have the opportunity for an extended break. It is not known whether James's father considered coming to London.

3. The support provided to the family

The family benefited from continuity of support from James's school, their GP and community paediatrician, and children's social care over many years. The family had regular contact with them, and these professionals knew them well. There were no pre-existing concerns about James's care or his safety.

Education

At school, James's teacher had known him since the start of his school life, and he benefitted from 1-2-1 support from a teaching assistant. His mother's powerful advocacy ensured that his needs were being met as far as the school was able. The School remained open to small numbers of children during lockdown and contact was maintained with all pupils and their families whether children were attending school or not. The nature and frequency of contact was agreed with parents. James's mother decided to keep James at home, he could have attended along with a small group of children from April, but this arrangement was not acceptable to James's mother who wanted him to be educated in a room on his own by a teacher wearing full PPE. This was neither an appropriate education environment for a child nor was it practically achievable. The school supported his learning through the provision of learning plans and tools as well as the loan of equipment. He had at least weekly telephone contact with his teacher and the school maintained frequent contact with James's mother through email, in line with her wishes. The school operates a three-week play scheme over the summer which mother was aware of. She did not approach school for a place following the cancelled August holiday in Spain. Mother saw school as a place for learning, not play. Throughout the contact the school had with James and his mother there were no indications of additional need, and school staff had no concerns about James's welfare.

Practice Insights

“James’s mother challenged school staff over the years about the progress James was making. She was frustrated about this and put it down to of a lack of teaching skill rather than her child’s ability. She had unrealistic expectations of James and what his development would be. More recently she had been more accepting of who James was. School staff felt they were working more in partnership with her.”

“James’s mother saw school as a place of learning not play or learning through play. Her non-acceptance of the school’s summer play scheme for him needs to be seen in this light.”

Health Care

From March to August there were 11 separate contacts with health professionals. Some were initiated by James’s mother; some were initiated by health professionals concerned to support the family during the challenges of the pandemic. Health care was provided to the family as needed. The GP responded to James’s mother’s concerns about James’s susceptibility to infection and he was placed on the shielding list. There were two proactive discussions initiated by the community paediatrician which supported James’s mother to think firstly about the safe use of carer support, and on a second occasion about school attendance. There was a planned further contact about school attendance to take place at the end of August. There was also regular contact with the school nurse and contact with the OT. It is evident that a regular line of communication was open and in use. On some occasions James’s mother reported that she was stressed and on others she said that she was coping. Health practitioners did not feel with the benefit of hindsight that the reports of stress were unusual or in any way different to the levels of stress of families in similar circumstances. There was nothing that made the family stand out.

Children’s Social Care (CWDS)

The latest child and family assessment was completed under CSDPA in March 2020 and the package of care increased in line with need. James’s mother managed James’s care herself, through the Direct Payments System and employed her own carer. During the lockdown period CWDS maintained contact with and responded to requests for support from James’s mother; there were 14 separate contacts. Practical and financial support was discussed, James’s mother was linked to community sources of support and on two occasions she had the opportunity to talk through what would happen to James if she became ill. One decision was outstanding, that relating to funding the additional hours of care that James’s mother had already put in place. Again, it is evident that a regular line of communication was open and in use. On some occasions James’s mother reported that she was coping on others she reported that she was stressed. She did not make requests for more support than the 30 hours of home care that she had put in place. There were no indications of additional need.

Multi-agency practice

In addition to the regular and open communication to and from health professionals, school staff, CWDS, and James’s mother, there was regular contact and exchange of information between professionals from different agencies. There was a multi-agency discussion in May

about the possibility of a return to school for James. The potential to have missed risk factors was explored at the Practice Insight Event. In all this contact it was known that as a single parent caring for a severely disabled child not attending school (in the context of a national pandemic) the family would be under pressure. As stated at different times James's mother reported being stressed and she also reported that she was coping. She was clear about the support that she needed and communicated appropriately across the children's education, health, and care system. James's mother made clear decisions and managed the family's care package.

Practice Insight

Practitioners thought very carefully and deeply about whether any signs of potential risk of harm were missed and concluded that they were not. "There were no Red Flags, this was not the case with all children and families in Ealing during this time, some children needed child safeguarding services."

There were no concerns raised about James and his care, and professionals were both extremely surprised and deeply shocked when they learned of his death.

4. Mental health care of mother

James's mother was known to have depression which was managed through the care of her GP and subject to regular review. Whilst treating James's mother there was no indication of a more severe level of need that would have required more specialist care via a referral for consultation with a psychiatrist. This conclusion held with the scrutiny that the benefit of hindsight brings. The picture that her GP had about James's mother's mental health history was incomplete. She was known to have had care for her mental health whilst abroad in both Russia and Spain. Difficulties arising from the use of private alongside NHS resources was explored at the Practice Insight Event.

Practice Insight

"It is not uncommon for patient to take up a 'mix of treatment'. Ealing has a diverse community, and many residents take up medical care whilst travelling abroad. Health practitioners are alert to the implications of this. Private health practitioners are required under regulating body rules to report any safeguarding concerns, this does not apply to medics practising abroad".

"There were no signs of symptoms of mental ill health that raised a red flag."

The reports James's mother made about feeling stressed were considered in a discussion about her mental health. The presentation of stress did not suggest that any change was needed to treatment and nor was this requested by James's mother. There were no signs or symptoms of the severe depressive illness and psychosis that she subsequently experienced.

5. Offers of Children in Need Support

Offers to support the family through the child in need process were rejected by James's mother on three separate occasions, the most recent offer and rejection being in March 2020. This meant that there was not a child in need plan in place that focussed on meeting

the needs of James and the family did not benefit from a key worker role. A key worker is a professional who can support the co-ordination of other professionals providing services within a plan agreed with the parent. The Practice Insight Event reflected on this. James's mother was very proactive, she acted as James's champion wanting the best for him.

Practice Insight

James's mother needed to feel in control of the support she received, and she did not see any value in the children in need service. This is why when she realised that she could have the package of care without the children in need service, she transferred to accessing support through CSDPA and then to the Direct Payments (DP) system. She wanted the flexibility and autonomy that the DP system brings. She acted as her own co-ordinator. Parents of disabled children have the right to manage their own care through the Direct Payments system, this is a national government policy initiative. His mother chose to manage James's care directly and in effect act as his key worker.

"Children in Need services are voluntary and James's mother had the right as his parent to refuse this support if she did not want it. No professional ever identified a concern about James and/or his mother's care that could have led to the imposition of the non-voluntary child protection process. On the contrary, James was observed to be a well-loved and well cared for child."

There was also consideration of whether James's mother's nationality, class and culture impacted on her decision not to accept a child in need support service at the Practice Insight Event. As children in need services were rejected these issues were never explored and assessed. It has not been possible to pursue this line of enquiry with James's mother during this review.

6. Missed appointments in 2017

There were a number of historical missed hospital appointments for James. These were originally instigated by concerns that James's mother had about his middle ear and nasal congestion. The appointments were in 2017, the year in which James's mother and father were divorced. The hospital's response to the missed appointments was to discharge James following several unsuccessful attempts to contact his mother.

Practice Insight

Ealing Safeguarding Partners now have a "Was Not Brought" policy in place. The events of 2017 pre-date this. However, James's health and wellbeing were overseen by ESCAN and he remained under the care of the community paediatrician with regular oversight of ESCAN health services. He did not become a forgotten child following the hospital appointment non-attendances.

Current child safeguarding practice is to regard events where a child did not attend a medical appointment as an event where a child "Was not Brought". The professional response needs to be based on both an understanding that children cannot take themselves

to hospital appointments, and a consideration of whether non-attendance gives rise to a concern for the health and welfare of the child. The continual care James received from ESCAN services meant that there was no missed opportunity to intervene and support him; that support was already in place. A clinical decision was made not to pursue his mother's concerns about James's middle ear and nasal congestion further at that point in time.

7. Engagement of fathers

There was minimal engagement between agencies and James's father following his birth, and no engagement following his move to Spain in 2017. James's father did not seek information directly from agencies about James and neither was he provided with any. This meant that all the information James's father received about James' health and his progress was from James's mother. As his legal guardian, James's father was entitled to receive reports from the annual review of his son's Education, Health and Care Plan, attend health appointments, engage in discussions about diagnoses, and be involved in the child and family assessments and reviews that were completed under CSDPA. The fact that he was not, means that agencies have no clear information about the support he provided to James's mother and James nor did they have the opportunity to engage him in discussions about the support he might offer in the present and in the future, as James grew older and his needs changed alongside both his development and the physical conditions he had progressed.

It is often, but not exclusively, the case that agencies delivering services to disabled children and their families engage only with the main care provider, and this is often the child's mother. In the experience of front-line practitioners, it is mothers who bring children to medical appointments and mothers who engage in assessments and reviews of children's needs, fathers rarely attend appointments.

Practice Insight

"Men, fathers, men disappear from professional view. This is likely to be the case when they work and is certainly the case where they live abroad."

Section Seven

Overall Learning

The Practice Insight Event identified several learning points. Firstly, that there was a significant level of contact between the family and agencies from March onwards, services were maintained and there was multi-agency oversight. The nature of contact was different because of public health safety requirements arising from the pandemic. James did not attend school because his mother did not believe it was safe for him to do so. The school supported James at home and there was regular contact with both James and James's mother. Services had no mandate to insist James went to school and to override his mother's wishes.

Secondly, during this contact James's mother was inconsistent in her presentation. She said different things to professionals at different times. In March, the family were in receipt of home care support which was assessed at 16 hours a week. When care resumed at the end of May James's mother independently commissioned 30 hours a week and wanted reimbursing for this increased level of care through the direct payments system. There were a number of contacts in which James's mother reported stress alongside a request for financial support for the increase in hours. At the last contact with professionals before James's death, James's mother said that "Despite all that is going on in the world I am surprisingly fine."

Thirdly, James's mother refused offers of support through Children in Need services. She was entitled to do so, just as she was entitled to receive support for home care through the Direct Payment System. There would have been an opportunity through child in need services to have support with co-ordination of the agencies supporting James, and there were many of these, and to receive support as a parent. Parents caring for disabled children can benefit from the opportunity to express their feelings; to think through the support they and their child need, and how the services they receive support their child and family to live a good life. Children in need services are accepted by parents on a voluntary basis, they cannot be imposed on families. There were never any concerns about James wellbeing or safety that would have warranted compulsory intervention.

Fourthly, there was no contact between agencies and James's father. This meant that he missed out on receiving direct information about the progress his son was making, diagnosis and the prognosis of his health conditions over time. It was James's mother who engaged with agencies about James's education, health, and care needs. James's father lived abroad, and he did not have a daily presence in James's life.

Section Eight

The Analysis

James was a ten-year-old boy with severe learning disabilities and a complex range of disorders. From an early age he received a wide range of health, education, and care services. For the last few years of his life, he was in the sole care of his mother and they had a close relationship, it is understood he had limited contact with his father. James's mother was a powerful advocate and champion for him; school had regular contact with her on all aspects of his education and care, including discussion on issues that she had researched. The school was confident that his needs were met with the appropriate level of service provision.

James's mother was an experienced and effective navigator of the children's health and welfare system. She evidently understood the contribution individual agencies could make to James's life and to supporting her and James as a family. It is clear that she knew where and how to request services and how to seek support from professionals for the help she felt that James and she needed. It is also clear that she knew which services she did not want to accept; for example, children in need services and agency-provided home care.

Unlike most cases that are the subject of Child Safeguarding Practice Reviews, in this case no concern was ever raised about the nature of James's mother's relationship with her son and no concern was ever raised about the nature of her care of James. There were no 'red flags' that triggered a professional discussion based on a concern about James's welfare in the care of his mother, nor about any potential risk of harm. There was no history of severe depression or psychosis. The family were well within the 'line of sight of agencies' and there was no information that would have given rise to concerns about James's mother's mental health and prior to James's death there was never any question that her mental health or level of stress impacted on her ability to care for James or placed him at risk.

This continued to be the case when the family's life changed because of the pandemic. James's mother took a number of decisions in response to the pandemic that were motivated by her concern for James's safety; she decided that he would not attend school and that she would not accept the services of the home support carer for a period of about 10 weeks. James's mother decided that home care would resume at the end of May, James's mother had been under more pressure than usual and was tired. It is also likely that this motivated her decision to increase the hours of care from 16 to 30 each week.

There was a high level of multi-agency contact with James and his mother throughout his life and this continued to be the case during the Covid-19 pandemic although the method of contact was different. The family benefitted from the fact that professionals providing education, health and care services knew them well, they remained well within the 'line of sight'.

This is the case despite the fact that the Covid-19 pandemic meant that education, health, and care agencies across the country were operating under extraordinary and unprecedented conditions. There was significant national guidance and services were frequently adapting their approaches to deliver services safely. This meant that working practices changed, there was less physical interpersonal contact, services were generally provided through digital means. The pandemic also meant that organisational resilience was affected as staff attendance reduced because of illness, caring responsibilities, and requirements to self-isolate. Over time this affected both professional and personal resilience. Supply of important equipment (PPE) was restricted and working practices were adjusted and readjusted in response to progressively developing government guidance and

shifting priorities. Organisations and their workforce were operating within a national climate of grave concern as the number of hospitalisations and deaths rose.

Education, health, and care agencies in Ealing identified those citizens who might need support and worked hard to maintain contact with them despite reduced resilience. The Council worked with local voluntary organisations to establish a network of support. Set against this context, the level of multi-agency contacts with James and particularly his mother from March to August was significant and good practice.

One request for support from James's mother did not result in a decision before James died. This relates to the request for financial support for the additional care hours that she had commissioned independently. The request was under review and a decision was due by the 8 August and this was delayed. This needs to be seen in the context of organisational pressure because of the pandemic. It is notable here, that at the end of April James's mother had said that she would only use the home care support in an emergency, that she did not want to increase the home care support package and mentioned that an increase in the care hours might make the role more attractive to a carer. A month later James's mother had both re-instated the care and increased the hours that the carer was working from 16 to 30 hours each week, and this level of support was in place when James died. A further month later (at the end of June) she asked for financial support for this increase. Evidently, the care James's mother felt she needed was in place, she had previous experience in 2018 of deciding to increase home care hours and securing retrospective agreement from Ealing Council to fund these hours. This cannot therefore be regarded as a contributory factor to James's death.

James's mother received direct payments to manage the family's home care needs, and she was entitled to do so. This meant that she managed the employment and tasking of the carer herself. In contrast to home care workers who are employed by care agencies, direct payment carers are isolated and have no wider organisational support, access to advice and guidance. If direct payment carers have concerns, and it is not known whether this was the case here, it may be more difficult for them to know how to raise them. Following James's death, it emerged that James's mother had employed a carer with whom she had previously had a personal relationship. The Direct Payment guidance requires that carers who are family members and do not live in the family's home can be employed with the agreement of the funding body (in this case Ealing Council). Whilst the carer was not a family member, this situation presented a sensitivity that Ealing Council should have been made aware of and could only have been aware of if James's mother had told them. However, whilst this is a learning point this cannot be regarded as a contributory factor in James's death.

Child in need services were offered to James's mother on three occasions, she had received the service from October 2015 to December 2016. Thereafter she chose to receive services through CSDPA and then to manage care herself through direct payments. She was entitled to make this choice. Children in need services are provided on a voluntary basis and they are accepted by parents where they feel they add value. They provide an opportunity to place the child at the heart of assessment and planning to ensure their welfare is promoted through appropriate support. In so doing they give parents an opportunity to think through their child's needs and support in a more holistic way and this includes impact of caring. James's mother evidently did not find the child in need service helpful in 2016, and whilst this is a learning point it was not a contributory factor in James's death.

James's father lived abroad and did not have frequent personal contact with his son as a result. The information he received about James's progress and wellbeing came from

James's mother. He did not have direct contact with the education, health and care services that were so involved with James and his mother. The information that James's father had about his son was limited as a result. For James, this meant he had one parent rather than two parents acting as his advocate and making fully informed parental responses to his needs. Whilst this is a learning point, it cannot be seen as a contributory factor in James's death.

James and his mother were due to go to Spain over the half term break in May because of the risks associated with the pandemic and James did not spend the long summer holiday with his father in Spain as he had done over the previous two years. This was because he did not have sufficient time left on his passport before it expired. This meant that James didn't get to spend time with his father, James's mother did not benefit from a break and the pressure that she was under did not ease. However, the fact that a holiday did not take place cannot be seen as a contributory factor in James's death and this is not a learning point for the public service response to children and families.

Section Nine Conclusions

The review adopted systems methodology and as a result has clearly identified the multi-agency practice in this case. It has helped to understand from a multi-agency perspective, what this practice was and why. Questions remain however, about why James died. The factors that precipitated the rapid onset of a severe depressive illness with an associated psychosis that was so acute a loving mother killed her son, are not known to those engaged in the review, with any level of certainty.

What is certain is that there was regular contact with this family from all the agencies involved in James's life. The method of contact was different because of the Covid-19 pandemic, it was generally not in person and through digital means. Nevertheless, the levels of contact were significant, services were in place in August 2020, and there was timely and appropriate information sharing between professionals. In all this contact, there were no indications that James was at risk of harm. It was known that his mother was stressed, but the level of stress was not new.

Given the context of the Covid-19 pandemic, the conclusion is drawn that the child welfare system worked well in this case. It is appreciated that this is a conclusion that may be difficult to receive in a case where a child has been killed by his mother. Society looks to the child welfare system to work effectively to keep children safe and prevent tragic events such as the death of James. However, service providers could not know what was not there to know; they could not know the unknown. There were no signs that James's mother was suffering a severe mental illness in the GP contact on 07 August 2020 and the observation that there was nothing unusual in her behaviour, was shared by a member of her local community who met her a few days later on 10 August 2020. There were therefore no failings in this case.

Agencies could not have predicted that James's mother was going to suffer an episode of mental illness so severe that it led to killing her son, and they could not therefore have prevented her from doing so.

Section Ten

Recommendations

The overall purpose of a Child Safeguarding Practice Review is to identify areas of improvement in the public service response to children and their families at both local and national levels. This review has identified three areas of improvement for the Ealing Safeguarding Children Partnership.

1. Child in Need Services – collaborate and co-produce with disabled children and young people and the parents of children with disabilities, information about and service delivery of child in need services.
2. Direct Payment Carers – review the information provided to parents about the Direct Payment System which helps them to make good choices about who to employ and of their responsibilities to inform funders of situations where family members or partners are employed.
3. Engagement of fathers – review the approach to engagement of fathers as single agencies and as a partnership.

Appendix 1



Terms of Reference for a Local Child Safeguarding Practice Review in respect of James

Background

James was a ten-year-old boy with disabilities who resided with his mother in the Borough of Ealing. On the 16th August his mother attended a local police station and stated that she had murdered her son who was found at the family home. Despite attempt to resuscitate he was pronounced dead at the scene. James's mother has subsequently been charged with murder. A Rapid Review has been completed.

This incident occurred during the national Covid Pandemic.

We are concerned to understand a number of issues and to ensure that any learning is effectively embedded in the local system for safeguarding. We are also concerned to identify any good practice and to ensure that this is consolidated. We seek to understand the following

- The circumstances and lived experience of James immediately prior to his death
- The support afforded to the family, including care and financial support sourced and paid for by James's mother and his father, alongside support paid for by local services including health and the LA
- The impact of James's disability on all family members
- The impact of the pandemic on all family members
- Missed opportunities to intervene

The period to be covered

We are keen to understand the engagement of all agencies in this case. We are keen to understand the period immediately following James's birth and, in the involvement, up to the point of his death. We are of the view that this gives a good sense of the lived experience of the family and will help us to understand the issues and challenges they faced.

Methodology

In accordance with the arrangements in Working Together 2018, we seek to use this review as an opportunity not to apportion blame but to support learning any lessons. The LCSPR will include the following elements

1. An opportunity for all agencies to share the reports completed for the Rapid Review and Joint Agency Response meeting and to engage in structured dialogue with the Review author

2. The data and material gathered from individual agencies will be collated into a single report highlighting a number of learning points and or hypotheses to be explored further in discussion
3. At this stage we anticipate two learning sessions will be conducted to discuss the case-based shared material. This will include:
 - A discussion with some front-line practitioners
 - A discussion with key managers and other interested staff members nominated by agencies.
4. A discussion with family members, including James's mother and his father to ascertain their view and contribution to this learning exercise (subject to their agreement and cooperation and in line with the views of their advisors)
5. An overview report will be drafted to include the information gleaned from the above
6. A recall session with practitioners to share learning
7. Production of a final report to be agreed with the Ealing Independent Person. With discussion to include issues relating to potential anonymised publication and the response to the national panel.
8. We aim to complete all activities by 31st January 2021; and publish the final report thereafter.

Information Sharing

This report is being produced in accordance with Working Together 2018. The information supplied in respect of James and his family, is shared for the purposes of safeguarding. It is to assist the agencies in Ealing to learn and to ensure that practitioners have the necessary skills, knowledge and experience to operate safely.

Appendix 2



Footnote, added 27th April 2021, after completion of the report:

At the point of the report being shared with James's father and the solicitors acting for James's mother, James's father apprised the Chair of the ESCP of the correct facts relating to the passport issue – referred to on pages 10, 11, 15 & 23 above:

Although professionals may have been of the view that there was insufficient time left on James's passport, in fact the passport had expired. Mr Freeman sought to make the Passport Office aware of the circumstances, and was in discussion with them, however, a new passport was not granted, with the result that James was unable to travel.