Kingston Local Safeguarding Children Board
In Collaboration with Surrey Local Safeguarding Board

SERIOUS CASE REVIEW

In respect of Child A and B

EXECUTIVE REPORT

January 2008

Contents of Executive Summary

	Page Number
Introduction	3
Background	3
Serious Case Review Process	4
Summary Findings	4
General Recommendations	8
Single Service Recommendations	10

1. Introduction

This Serious Case Review (SCR) was commissioned by the Kingston Local Safeguarding Children Board (KLSCB) in collaboration with Surrey Local Safeguarding Children Board (SLSCB) to consider the circumstances surrounding the serious and potentially fatal harm to Child A and Child B by their father in Surrey in April 2007. The decision for Kingston to lead the SCR was arrived at due to the family living in the Royal Borough of Kingston at the time of the incident. The family had been living in Surrey prior to moving to the borough.

In August 2007 the Chair of KLSCB commissioned an Independent Chair for the SCR Panel commencing in October when Management Reviews were obtained. The two LSCB's have worked together throughout the SCR.

2. Background

2.1 In April 2007 Police Child Protection Officers were called to an incident in Surrey after a member of the public had reported that a man had assaulted two young boys with what appeared to be a car jack. The man was the father of the two boys. Child A had sustained a severe injury to his head and both boys T-shirts were soaked with diesel fuel. The father, whose clothes were also exposed to the fuel was arrested at the scene. He is currently on remand facing two charges of attempted murder.

2.2 Child A (7 years old) and Child B (6 years old) were taken to Hospital and the mother was taken to the hospital to be with her sons. Paediatric staff at the hospital carried out examinations on both boys. Child A and Child B were both washed down and cleaned of accelerant and Child A was noted to have several lacerations to the back and top of his head and to both his hands and forearms. No visible injuries could be seen on Child B. The boys were admitted to the hospital overnight. On admission Child A was diagnosed with a major head injury, bruising on arms and minor fracture to the right hand. Child A had a CT scan, his head was sutured in theatre and he was prescribed antibiotics for infection. Child A was discharged on 2 days after the incident.

2.3 The family had moved from Surrey to the Royal Borough of Kingston (RBK) in February 2007. While living in Surrey the County Council and other agencies had significant historic involvement with the boys and the mother. Both boys have autism and the mother had mental health problems. Child A and Child B had continued to attend school in Surrey following the move to Kingston. Both boys have been placed in foster care by RBK and were under an interim care order at the time of this Review.

3. Serious Case Review Process

The review methodology complied with “Working Together to Safeguard Children 2006” Guidelines. The period of time under review was from the birth of the older child in 2000 to April 2007. The review also considered whether Child Protection procedures were adequate and adhered to during that period.

A panel of representatives from agencies in both Local Authority areas who had involvement with the boys and parents was drawn together with an Independent Chairperson. All agencies were required to produce Chronologies and Individual Management Reviews of the services. Individual Management Reviews were required to look openly and critically at individual and organisational practice to see whether the case indicated that changes could and should be made, and if so, identify how those changes would be brought about. The Chair of the Panel then analysed the reviews, obtained further clarification and drew conclusions and recommendations for improvement. The Chairperson interviewed the mother of Child A and B, but not the father due to the legal proceedings. The agencies agreed Action Plans for implementation of the Recommendations.

4. Summary Findings

4.1.1 The overall conclusion is that, while there were failings in the support provided to the family, and agencies could have anticipated some level of family breakdown, the seriousness of the incident could not have been predicted and it is therefore not possible to conclude that it could have been prevented.

4.1.2 Although there were some examples of good practice, the general picture is of failed joint working with poor follow through or liaison between Surrey Children’s Services, Central Surrey Health Trust and Surrey and Borders Partnership Trust, leaving the two children vulnerable. There was therefore a weakness in the implementation of ‘Every Child Matters’ between those agencies.

4.1.3 The following findings explain this overall conclusion.

4.2 Better Focus on the Needs of the Children

4.2.1 The case was complex, with multi family member difficulties. There was a lack of focus that appropriately embraced ALL family members, including carers and the voice of the child. There was a need for an appropriate multi-agency/service management structure to facilitate this which clearly identified who had lead responsibility for arranging Network and Planning Meetings and coordinating action so that the case could not be closed without an appropriate ‘safety net’.

4.2.2 The focus of attention was on the mother’s mental health problems (which were complex), leading to assumptions that the difficulties with

the children were due to her poor parenting. This may have been partially true, but events reveal that the children's disabilities were also contributory. The mother felt wholly criticised for poor parenting with no positive encouragement, leading her into further mental health problems due to sense of inadequacy and loss of identity.

4.2.3 The complexity of needs may well have caused a cocktail of 'nature and nurture' but the Voice of the Child was lost in the focus on the mother.

4.2.4 When the children's problems and disabilities were recognized (which were also complex), the focus was on their educational needs, not the family situation. The focus does not ever appear to have been on the FAMILY and the complex needs within it, and how that could impact on the main carer. Rather, there appears to have been repeated assumptions that all was well. The boys diagnoses should have been opportunities to recognize the multi family member complexity of the case that needed to be monitored and appropriately supported.

4.2.5 There are few references to the needs of the boys until the referral of each child with communication difficulties, eventually leading to diagnosis of ASD, and thereafter few references to the children being at risk, despite the mother's mental health problems and both parents difficulties coping with the boys behavioural problems. A more child focussed response by all agencies may have better identified the risks from both parents due to strain.

4.3 Improvements to Practice in Relation to the Assessment Framework

4.3.1 Several assumptions were made by various agencies, despite there being accumulating evidence that previously proposed 'solutions' did not work, and which led to a continued 'sticking plaster' approach.

4.3.2 Assumptions:

That the parents were capable of being receptive to the support being offered

That the mother was capable of following up support leads on her own

That the father did not need help

That the mother, family or children would meet another services' criteria. In some instances the case was closed without ensuring that referral was picked up by other services which is dangerous practice, implying a lack of ownership or desire to pass the problem on too quickly

That 'the other service' would monitor take up of support

That the parents would/could comply with a written agreement

That the services being offered were able to cope with the children's behaviour. But many were not - highlighting the difficulties the parents faced.

There was a need for better quality assessments, outcomes and monitoring based on information, not assumptions, and these needed to focus on the view of the children.

4.3.3 The information available to agencies and services did not detect a potential risk posed by the father to the boys. Gradually, one by one, services closed active involvement in the case for various reasons – which in some cases should have alerted cause for concern (e.g. mother's non-attendance) about potential risk to the boys – eventually leaving the family without support. With the benefit of hindsight it can be seen that some 'events' could have triggered a different response which may have provided a greater insight into the father's state of mind.

4.3.4 While School Services were involved in some professionals meetings, they were not involved in any Child Protection related planning meetings.

4.3.5 Better quality assessments (initial or core) and better multi-agency sharing of information and strategic planning could have led to more appropriately targeted services being put in place for the children at a much earlier stage. Eligibility decisions should have complied with the intention of 'Safeguarding Children' and the Surrey Child Protection Procedures (Key Principles and Values), based on a holistic view of the boys needs within the family rather than assessment against individual service criteria for a narrow one-off outcome (e.g. funds for a carers break). Whilst there is no guarantee that these would have mitigated the risk, they may well have led to successful outcomes which could have prevented the life threatening incident in April 2007.

4.3.6 Professionals could have anticipated potential strain on the father and devised a more tailored solution that would have addressed needs. The father was the main carer of a wife with mental health problems, and also the main carer to not just one but 2 children with severe behavioural problems, and unbeknown to most agencies, also had history of suicide/depression. He gave up work to care for the family and tried to maintain a façade of coping. The personal, financial and accommodation problems exacerbated the pressures on the family. The whole family appear to have been subject to intolerable strain due to this 'cocktail' of problems. The father was caught in a cycle:

4.3.7 At first nobody noticed that the boys had problems that were not due to poor parenting skill, as a result the children (and professionals response) made the mother feel inadequate

4.3.8 The mother felt she had caused the children's problems which exacerbated her mental health problems

4.3.9 Her mental health problems reportedly made her feel violent/aggressive towards the children. The father intervened and was perceived (by all professionals) as more successful in caring for the children, which makes the mother feel more inadequate, thus exacerbating mental health problems.

4.3.10 The cause of the father's behaviour in the incident is not known, but it is easy to speculate that the burden of caring, relationship tensions, a feeling that no-one was listening and lack of any useful support, may have contributed to a disturbed state of mind and inability to cope.

4.4 Improvements to Lead Professional and Strategic Working Together

4.4.1 The Management Reports revealed a disjointed picture with no comprehensive information sharing between all relevant services (adult, children, or family services across agencies), and therefore no effective multi-agency strategic planning or decision-making to protect the children from the damaging relationship that appears to have developed within the family. There were no meetings of all multi-agency adult and children service professionals. There was no coordinating lead professional able to maintain an overview of actions by each agency.

4.4.2 There were several significant events that could have alerted practitioners to the need for multi-agency strategic management of the case, and although some professionals repeatedly attempted to draw attention to the potential risk (e.g. Risk assessments of the family/children were requested by agencies but do not appear to have been completed), there was a lack of appropriate response. It is therefore possible that a more pro-active response might have at least mitigated the risk from the father, including more frequent and holistic Carers Assessments.

4.4.3 There was a lack of recognition of a 'Child in Need' (CN) when closing cases and turning down referral to the CWD Team on grounds of eligibility. On each occasion there could have been CN Multi-Agency meetings (of Adult and Child services/agencies) with recognition that there were cumulative needs even though these may not have neatly complied with a specific service criteria. The closures and non-referrals exposed the family to risk, and indicate poor supervision of Child Protection issues with focus purely on individual service criteria.

4.4.4 The family had complex needs that did not respond well to mainstream services. The lack of information sharing between all relevant (adult, child, family) services meant a failure to notice or respond to the patterns of behaviour (i.e. deterioration of mothers mental health, crisis, help offered, improvement, then failure to follow up or cease to attend support) and just repeatedly offered the same failed support time and time again. There was a need for a strategic multi-service approach to problem-solving that would offer more creative and long term stable solutions.

4.4.5 Absence of coordinator/lead professional may have contributed to the family going 'off radar' i.e. disappearing from agency contact at the time of the incident, due to moving a short distance, but into another borough. Management Reports have little information for the period from February 2007 (when the family moved to Kingston). GP records identify only that

psychiatrist appointments continued to be made for the mother, and her minor health problems. It is known that the boys continued to attend the same School in Surrey, and that school and RBK school transport service would have known of the new address. Had there been appropriate tracking/flagging of Children in Need, this could have prompted pro-active response from RBK Children's Services.

4.5 Quality of Supervision Arrangements

4.5.1 Case management by SCC Children's Services and Central Surrey Health Visitor services generally appear to have poor continuity within their agencies, or in joint work with others. The Chair of the SCR has concerns about the quality of assessments and competence of trainee staff allocated to such a complex case. Poor quality assessment and staff competency was exacerbated by poor record-keeping, and worrying discrepancies between agency records/actions.

5. Recommendations

5.1 General Recommendations

The two Safeguarding Boards should ensure implementation of the following recommendations:

a) **The two Safeguarding Boards should ensure there is a clear plan setting out agency responsibilities**.
Each agency (e.g. SCC, SABP - CMHT and CAMHS, Central Surrey - Health Visitor and Surrey Primary Care Trust) should have clearly identified lead professionals who understand their role of advising and supporting multi-agency working and information sharing. (see d. below)
Safeguarding Boards should ensure Frontline staff understand their agency's responsibilities to involve relevant partners in planning at the earliest opportunity.
Schools/Schools Nurses should be involved in CAF related planning meetings at the earliest opportunity.
Safeguarding Boards should satisfy themselves that cases can not fail to be 'held open' where a child may not satisfy individual service eligibility criteria, yet may have complex needs or is clearly vulnerable. (see i. below)

b) **Cross-boundary working:** The two Safeguarding Boards should develop protocols to ensure pro-active communication across Borough/County boundaries where vulnerable children move from one area to another. Safeguarding Boards should hold responsibility to ensure that information relating to *any child who has been the subject of a CAF* is shared as soon as any agency becomes aware that a CAF related child has moved out of the area to a known other Borough/County Safeguarding Board.

c) **The Safeguarding Boards need to promote joint working:** SCC, SABP (CMHT and CAMHS), Central Surrey (Health Visitor) and Surrey Primary Care Trust services need to promote multi-agency frameworks that enable information sharing and inter-professional relationship development for

improved joint working and effective management of risk. This should include a framework for joint working *across adult and children services, including Joint Assessments* where relevant. The framework should ensure multi-agency planning meetings are arranged at the earliest opportunity where there are concerns about risk to a child. In cases where mental health of parents is a factor, the success of interventions needs to be monitored more closely, in a structured way across those agencies/services.

d) **Agency review of procedures to ensure focus on the voice of the child**: SCC, SABP (CMHT and CAMHS), Central Surrey (Health Visitor) and Surrey Primary Care Trust should ensure professionals who hold lead responsibility for coordinating inter-agency working, maintain the focus on the Children's Voice within the whole family situation. Models for good practice co-ordination exist in other LA's.

e) **Preventing inappropriate closure:** SCC, SABP (CMHT and CAMHS), Central Surrey (Health Visitor) and Surrey Primary Care Trust need to ensure a procedure review and development of a multi-agency protocol/framework that prevents cases of children that may be at risk from being closed prior to confirmation that the case is being held by another service. This should also include clarification of who the lead agency is in joint monitoring approaches, how the case will be managed if the case is closed, and ensure standards for notification of closure to other agencies (adult or child services) e.g. 'x' working days.

f) **Safeguarding supervision arrangements**: SCC, SABP CAMHS, and Central Surrey (Public Health Nurses) and Surrey Primary Care Trust GP services need to review their Safeguarding Supervision arrangements to ensure that all children at risk/families that need to be supervised are identified and information shared appropriately with other agencies by practitioners, and that there is appropriate monitoring to ensure that information *is* shared and responded to appropriately.

g) **Safeguarding Board responsibility for overview in complex cases**: The Safeguarding Boards should ensure effective structures and protocols exist for identification and dealing with complex family needs which don't necessarily meet individual service criteria but where the totality of need falls within the Safeguarding Values and Principles. This should include cases where children may not have a diagnosis (yet obviously have problems) so may have difficulty being identified as needing extra help *over and above mainstream services*. Safeguarding Boards should ensure frontline staff are made aware of the arrangements.

h) **Unique and tailored solutions**: The Safeguarding Boards should review commissioning arrangements to ensure that there is an appropriately flexible structure for devising unique child/person/family-centred support solutions in non-mainstream cases. There should be a whole systems framework approach which includes Children's Trusts. Arrangements should promote strategically planned multi-agency support (pooled budgets?) for creative and long term solutions that are offered pro-actively where mainstream solutions

fail. Such commissioning arrangements should be easily accessed e.g. a panel for advice and guidance, and have clearly defined and accessible criteria which are made known to all relevant frontline staff. Staff should be able to refer cases of complex needs or where ‘normal’ solutions fail.

i) **Eligibility Criteria:** The Safeguarding Boards should acknowledge the difference between Surrey CC and RBK eligibility criteria for services to children with disability. RBK criteria includes Autism (as defined in ‘Valuing People’) but SCC does not. Surrey CC should be encouraged to adopt the same criteria as RBK.

j) **Training:** Multi-agency training should be provided to staff in RBK and Kingston Primary Care Trust, and SCC, SABP (CMHT and CAMHS), Central Surrey (Health Visitor) and Surrey Primary Care Trust to ensure awareness and support implementation of the above recommendations and improve joint working. This should include clarity about responsibility to ensure cross-borough liaison for tracking to prevent a family going ‘off radar’ and consequent breakdown of safety net.

j) **Monitor and review:** Implementation of new frameworks should be monitored and reviewed annually by the Safeguarding Boards to ensure effectiveness in protecting children.

k) **Staff Competence:** CC and Central Surrey Health Trust should ensure that, where a family has complex multi family member difficulties, cases should be managed, supervised and guided by suitably qualified and experienced staff and not be delegated to inexperienced/unqualified staff.

5.2 Single Service Recommendations

Surrey County Council Children’s Services

a) Procedures and practice in risk assessment should be reviewed to ensure managers, supervisors and frontline staff comprehend its purpose and record it appropriately.

b) SCC should not delegate responsibility for multi-agency professionals meetings or planning meetings to unqualified and inexperienced staff (e.g. student SW).

c) Promote greater awareness of Children’s Advocacy services with frontline staff.

d) Ensure team managers/supervisors signpost staff to training or guidance for early recognition of autistic spectrum disorder, including closer working with the Children with Disability Team.

e) SCC should promote the use of Carers Assessments and provide training to frontline staff for assessing broad needs, to determine potential for crises and avoid assumptions, particularly where the family has a ‘cocktail’ of problems which could all exacerbate each other and cause intolerable strain on carers e.g. both adult mental health and child behaviour/disability.

f) SCC should review supervision arrangements, quality and structure to ensure they are appropriate to safeguarding requirements.

g) SCC and Central Surrey should ensure file records are improved and contain all relevant information documentation (e.g. names of those present, assessment forms).

Royal Borough of Kingston

a) RBK should ensure that staff from Hospital Trusts are included in the planning of Multi-agency Planning Meetings following critical incidents to ensure comprehensive contribution of all the known facts.

Surrey Primary Care Trust

a) Surrey Primary Care Trust should ensure access to GP records of family history is possible at the earliest opportunity in cases where a family has complex needs, to ensure all information is known at an early stage.

Surrey and Borders Partnership Trust (SABP)

a) Professionals (CMHT/CAMHS)should ensure follow through of referrals where there is risk to a child and liaise in multi-agency planning/ professionals meetings.

b) CAMHS should regularly monitor the quality of records to ensure improvements are made and sustained.

c) The Trust should promote the use of Carers Assessments to male carer/fathers and provide training to frontline staff for assessing broad needs, to determine potential for crises and avoid assumptions.

d) The Trust should monitor CPA to ensure Carers Assessments are being used.

Central Surrey Health Trust

a) CSH should implement training for staff in record keeping.

b) The new model of supervision recently introduced should be monitored to ensure it delivers the required improvement to safeguarding supervision.

c) CSH should develop a system that will ensure practitioners identify and record all families who require safeguarding supervision.

d) CSH should introduce a system for assessment of parenting capacity of fathers/carers of children in complex cases.