**Surrey Safeguarding Children Board**

# Serious Case Review

# Overview Report

# Executive Summary

**in respect of**

**Child J & Child K**

**Report Author:**

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## 1 INTRODUCTION

1.1 This serious case review was carried out as a result of the deaths of two children, Child J aged three and Child K aged two. Their Mother was subsequently convicted of their murder. At the time of their deaths, Child J and Child K were living with their Mother in Surrey but had previously lived with their Mother and Father in East Sussex. Mother's previous husband (known in this report as Partner 1) with whom she had two children (Half-brothers 1 and 2) also lived in East Sussex. Since the children were officially resident in Surrey at the time of their deaths this review has been led by Surrey Safeguarding Children Board working in partnership with the relevant agencies in East Sussex.

1.2 The decision to conduct a serious case review was made by the Chair of Surrey Safeguarding Children Board three weeks after the deaths of the children. The reason for the review was that two children had died and abuse or neglect was known or suspected to be a factor in their deaths. In these circumstances, a local safeguarding children board should **always** conduct a serious case review into the involvement of organisations and professionals in the lives of the children and family.[1]

1.3 A panel was appointed to oversee the review chaired by Paul Kerswell, independent consultant. Members of the panel were:

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| Safeguarding Board Manager | Surrey Safeguarding Children Board |
| Head of Safeguarding | Surrey Children's Services |
| Designated Nurse | NHS Surrey |
| Local Education Officer | Schools and Learning |
| Detective Inspector | Surrey Police |
| Principal Solicitor | Surrey Legal Service |
| Head of Safeguarding | East Sussex Children's Services |
| Child Protection and Safeguarding Manager | Sussex Police |
| Head of Service | CAFCASS |

[1] HM Government (2010) *Working Together to Safeguard Children* London DCSF

1.4 The overview report was prepared by Jane Wonnacott, Independent Consultant, and Director, In-Trac Training and Consultancy Ltd.

**Terms of reference and scope of the review**

1.5 The terms of reference set for the review were agreed by the serious case review panel. These required the individual management reviews and overview report to consider:

- The level and extent of agency engagement and intervention and whether this was appropriate to the assessment of the parents' ability to provide adequate care and supervision of Child J and Child K.
- The recognition of safeguarding issues by all agencies and how these were addressed.
- The quality of assessments on which decisions and actions were taken.
- The level and extent of domestic abuse, whether this was known and whether the impact/risk to Child J and Child K had been adequately assessed and responded to.
- The existence of any mental health issues which may have impacted on parenting capacity.
- Whether there are any factors in the history of any adults that indicated that they may pose a risk to children.
- Whether race, religion, language or culture was a factor in this case and had been considered fully.
- The extent and quality of partnership working among key agencies and across county borders.
- The effectiveness of working arrangements (including information sharing and communication), between all professionals in all organisations across borders and whether this could have been improved.
- The existence of any factors in relation to the "capacity and climate" within agencies, which may have impacted on practice in this case.
- In addition to the above, the review should consider learning both for the individual agency and for how agencies work together through the Surrey Safeguarding Children Board (SSCB).

**The serious case review process**

1.6 The serious case review began at a time when Mother had been charged with murder and criminal proceedings were underway. At this stage it was not possible to interview key members of staff who may have been witnesses at the trial, or to involve family members. The decision was therefore made to conduct the review in two stages. During the first stage individual management review reports were prepared and action taken to address any immediate practice issues. An interim overview report was accepted by both Surrey and East Sussex Safeguarding Children Boards with an overarching action plan put in place. Approximately one year later following the conclusion of the trial, further staff interviews took place, family members were given the opportunity to contribute to the review and a final overview report prepared and presented to the relevant Safeguarding Children Boards.

1.7 Individual management reviews were prepared by:

- Surrey Children's Services, in respect of Surrey County Council Contact Centre.
- East Sussex Children's Services.
- East Sussex PCT.
- Surrey Police.
- Sussex Police.
- Sussex Nursery.
- CAFCASS
- Surrey Schools.
- Surrey Early Years.
- East Sussex Schools.
- GPs – Surrey.
- GPs - East Sussex.
- Surrey Community Health.
- East Sussex Hospitals Trust.
- Kent PCT.
- Surrey Health Overview – NHS Surrey.
- Sussex Health Overview – NHS Sussex.

1.8 A letter was received from SE Ambulance Service outlining their minimal involvement and this was considered sufficient. In addition a letter was received from Maidstone and Tunbridge Wells NHS Trust, noting that their contact was historic and minimal and any issues would be incorporated into the Sussex Health overview report. The panel agreed that there was no need for a full individual management review from this organisation.

1.9 During the first stage of the review, Sussex Police re-investigated the circumstances of the death of Mother and Father's first child (Baby 1). At the time this had been deemed to be a sudden unexplained infant death. The re-investigation resulted in Mother being charged with the baby's murder although, following a special court hearing, a judge directed that the charge should be dismissed as there was insufficient evidence to support it. Consideration of the Police response at the time of Baby 1's death formed part of the stage 2 Sussex Police individual management review.

1.10 Following the trial and Mother's sentencing, the serious case review panel was reconvened and updated individual management review reports were requested (to take account of additional staff interviews) from:

- Sussex Nursery.
- East Sussex Community Health.
- Sussex Police.

1.11 In addition, the panel explored the possibility of obtaining Crown Prosecution Service notes and/or a transcript of the judge's summing up, in order to verify information obtained from Father and Partner 1 and understand whether any issues had emerged at the trial that might have a bearing on lessons learnt. However due to the cost and the time it would take to obtain the documents, the panel agreed that the delay to the process and the cost involved was not justified in this case.

**Family Involvement**

1.12 Following conclusion of the criminal proceedings, Father and Partner 1 both expressed a wish to contribute to the review. They were seen by the overview author, notes were taken of both meetings and a letter sent to the relevant family

member, in order to confirm the content of the conversation. Information from these discussions has been included throughout the review and informed the analysis. The overview author and panel would like to thank both Father and Partner 1 for their time and the contribution they made by providing information about day to day life in the family home.

1.13 Partner 1 reported that his sons did not wish to contribute formally to the review. Mother was also written to directly and asked whether she would like to meet with the overview author. No reply was received.

## 2 FAMILY CONTEXT AND PROFESSIONAL INVOLVEMENT

2.1 Child J and K were the second and third children of Mother and Father, their first child (Baby 1) having died as a result of a Sudden Unexplained Infant Death. Until four months before their deaths Child J and K lived in the East Sussex area, received the appropriate universal services and attended a private nursery. Four months before they died Mother left Father and moved to Surrey taking Child J and K with her. Child J started attending a Surrey preschool and Child K was placed on a waiting list. Mother and the children registered with a Surrey GP practice and records were requested from East Sussex in respect of GP and health visiting services. There was some GP contact with Mother and one contact between Child J with the out-of-hours service for a non serious illness. There was no face to face contact with the health visiting service although prompt telephone contact was made to offer a service should this have been required.

2.2 At the point that Mother moved to Surrey, Father contacted Sussex Police to express concern for the welfare of the children. There was a series of contacts between East Sussex and Surrey Police Contact Centres and the Surrey County Council Contact Centre with a focus on ensuring the safety and wellbeing of the children. Sussex Police requested that Surrey Police undertook welfare checks: the first of these took place at a police station and the second at the family home. Mother made various allegations to police officers in both Counties as well as Surrey County Council Contact Centre staff about domestic abuse

perpetrated by Father. These allegations were taken at face value by all professionals and risk assessments were completed at various points by both Surrey and Sussex Police. Since there appeared no reason to disbelieve Mother appropriate advice was given, including Surrey Police advising how to apply for a non-molestation order. In addition, just prior to the deaths of the children Father was arrested by Sussex police following one such allegation of violent behaviour towards Mother. These contacts with both police forces can be understood as indicative of organisations that take domestic violence seriously and act promptly in the face of a high number of such allegations. However, there are also indications that a more questioning approach by both Surrey County Council Contact Centre staff and police officers may have revealed inconsistencies and contradictions in the information being given to them.

2.3 In addition to Child J and K, Mother had two older children from her marriage to Partner 1 (Half-brothers 1 and 2). Both half brothers lived with Mother with weekend contact with their father. Partner 1 became dissatisfied with Mother's commitment to these contact arrangements and made an application to the court for Contact. There was some limited involvement with Cafcass but because there was no resulting request for a report the records were not kept in line with Cafcass policy at that time.

2.4 Both half brothers attended schools in East Sussex before moving with Mother to Surrey. The younger half-brother remained only briefly in Surrey and returned to East Sussex to live with Partner 1, resuming education an East Sussex school. The older half-brother decided to remain with Mother in Surrey and enrolled at a Surrey college.

2.5 Mother was unhappy about Half-brother 2's desire to return to East Sussex and there are reports of inappropriate behaviour on the part of Mother which resulted in considerable distress to Half-brother 2. In a series of e-mails to the head of year at the East Sussex school Partner 1 expressed a view that Mother's behaviour was emotionally abusive. The head of year was concerned about the content of the e-mail exchange as well as e-mails received from Mother but did not discuss this concern with either the appropriate line manager or the child protection lead within the school..

2.6 Following Half-brother 2's return to East Sussex, Partner 1 made an application for Residence and a Prohibited Steps Order which was heard in a Kent court. There was further Cafcass involvement with checks being made with Sussex Police, East Sussex and Surrey Children's Services in respect of Mother, Partner 1 and Partner 1's new partner. The Cafcass request to East Sussex Children's Services was for information pertaining to Half -brother 2 only and when the information was received it did not reveal any concerns. The request for information from Surrey was not responded to. Processes have since been put in place to remedy this and ensure prompt response in the future.

2.7 In the weeks immediately prior to the deaths of the children Mother appeared to be making plans to return to East Sussex. She requested places for Child J and K at their original nursery and also saw an East Sussex health visitor in the family home, saying she hoped to return to East Sussex once the house was sold. At this visit Mother alleged domestic violence from Father and as well as informing the health visitor that Father had smacked Child J. These allegations were taken at face value by the health visitor who did not believe that any further action was warranted at that time as Mother had always seemed competent and was taking appropriate action to protect herself and the children.

2.8 The day prior to the deaths of Child J and K, Mother threw a brick through the window of the family home. Sussex Police attended and Mother was not arrested since she had damaged property that she jointly owned. This was the last face to face contact with any family member prior to the deaths of the children.

2.9 At the point that Mother enrolled both children at their original nursery she gave the address of the family home in Sussex as their place of residence. The nursery proprietor therefore assumed that Mother and Father had reconciled although subsequent information from Father given to the nursery proprietor, including information about the above incident, made it clear that this was not this case. This contradiction was not picked up on at the time.

## 3. LESSONS LEARNT

3.1 The main lessons that have emerged from this review relate to:

- Ensuring that where parents are separating and there are concerns about the children, information is collated about all children within the family by all relevant agencies.
- The need to remember that child abuse crosses all class boundaries and professionals need to consider the potential impact of bias on their evaluation of information. This relates to gender as well as class.
- The importance of robust child protection knowledge and safeguarding practice in early years settings, including effective systems for advice and consultation.
- The importance of record keeping within schools when any concerns are raised about a child and ensuring that records about a child are kept at a central point.
- The need for all teaching staff to use advice and consultation mechanisms. This is particularly important when they are feeling overwhelmed by the issues being presented to them.
- The need to ensure that where allegations of domestic violence are made to professionals, such as health visitors, the information is verified in order to inform next steps.
- The need for clarity of roles across professional boundaries, most particularly in relation to police welfare checks.
- The importance of establishing processes, management and supervision within Surrey County Council Contact Centre, which ensure that sufficient information is gathered and analysed in order to make an informed judgement about next steps.
- The need to develop systems within Sussex Police whereby relevant information about children is managed in such a way that all relevant information is immediately available to Sussex Police staff and for dissemination to other agencies.
- The challenges of identifying where parental separation is adversely affecting children and in particular the significance of rapidly deteriorating behaviours or relationships in either the adults or children involved.

3.2 Individual management review recommendations and action plans have addressed many of the above issues and progress had been made in the time between the interim report and the final overview.

## 4 CONCLUSION

4.1 This review relates to an extremely tragic event and it is important to consider whether it could have been predicted or prevented on the basis of the information available at the time. The conclusion of this review has to be that although there are lessons to be learnt regarding some individual areas of practice, at no point could anyone have predicted that Mother would seriously harm or kill her children. There is no information to suggest that such an extreme act of violence was likely.

4.2 There are points where there was an opportunity to consider more carefully the impact of situation on the children and question the truthfulness of the information that was being given by Mother. However, there is nothing to suggest that, had this happened, the level of concern would have resulted in action to remove the children from Mother's care and prevent the abuse occurring. At the current time, the lessons that have emerged relate to ways in which practices can be improved to enhance services to a wide range of children, rather than specifically prevent such deaths occurring in the future.

## 5. OVERVIEW REPORT RECOMMENDATIONS

5.1 Surrey and East Sussex Safeguarding Children Boards should require partner agencies to:

- Explain how professional curiosity is promoted within their organisation.
- Explore the barriers to this occurring and how these barriers can be overcome.

5.2 Surrey and East Sussex Safeguarding Children Board should provide a synopsis of learning for professional use, which should be disseminated to relevant front line managers in all agencies. This should include the narrative of this case and

encourage reflection on the need to test allegations and assumptions, particularly where factors such as class and gender may be influencing responses.

5.3 Surrey and East Sussex Safeguarding Children Boards should request a review of the advice, support, supervision and reporting arrangements for staff working in early years settings, in order to ensure they provide sufficient opportunity for reflection on issues of concern. This is particularly important for proprietors and managers of such settings.

5.4 In relation to response to domestic abuse, Surrey and Sussex Safeguarding Children Boards should :

- Develop a strategy for supporting front line professionals to work effectively across agency boundaries in situations of domestic abuse, including how to maintain professional curiosity and identify significant information whilst working with a high volume of information.
- Commence a multi-agency debate regarding the best way to develop an effective multi-agency response.

5.5 Surrey and East Sussex Safeguarding Children Boards should ensure that Social Care staff are aware of the meaning of a Police welfare check and understand that it is not a substitute for an initial assessment.

5.6 Surrey Safeguarding Children Board should write to the Department for Education, to request that any future research into lessons from serious case reviews should explore the relationship between parental separation, risks to children and appropriate professional responses.

5.7 East Sussex Safeguarding Children Board should require East Sussex Community Health to work in conjunction with Children's Social Care to review their understanding of the threshold for referral to Children's Social Care where there has been an allegation of domestic abuse and associated harm to a child.

5.8 Surrey Safeguarding Children Board should write to East Sussex Safeguarding Children Board to bring to their attention the learning and recommendations from

the final report.

## 6. SUSSEX HEALTH OVERVIEW RECOMMENDATIONS

6.1 ESHT should undertake a retrospective file audit of children under two years of age who have died suddenly or unexpectedly to examine whether practice is in line with the Sussex Unexplained Death Procedure.

## 7. SURREY HEALTH OVERVIEW RECOMMENDATIONS

7.1 NHS Surrey to ensure mechanisms are in place to monitor timely transfer of records between acute and community health providers when families move within Surrey and across health boundaries.

7.2 NHS Surrey to ensure that a robust Sudden Untoward Incident (SUI) reporting process exists which complies with National Guidance.

7.3 NHS Surrey to have mechanisms in place to disseminate lessons that become evident following completion of Serious Case Review/IMR's through the Health Economy and have mechanisms in place to monitor progress of actions implemented.

## 8. INDIVIDUAL MANAGEMENT REVIEW RECOMMENDATIONS

### Cafcass

8.1 Cafcass needs to review its guidance about screening checks and case closure, to ensure that some outline timescales are included during the work to First Hearing and afterwards.

8.2 Cafcass will review the process for checking with children's services to ensure that all known children in the household are referred to.

8.3 Kent Cafcass need to consider the findings of this review at the next service improvement meeting and put in place any necessary action to ensure full compliance with the requirement to interview parties separately at first. The

outcome should be monitored by the head of service (QI) and reported back to the operational director at the next service improvement meeting.

8.4 Kent Cafcass to consider the noted learning points in this review and consider looking at amending the local preliminary hearing form if still used, so that the assessment of individual parties can be recorded, encompassing the child's needs, parenting capacity and relevant diversity issues. The outcomes should be monitored by the head of service (QI) and reported back to the operational director at the next service improvement meeting.

8.5 Kent Cafcass need to consider the findings of this review at the next service improvement meeting and put in place any necessary action to ensure that when the new procedures are in place, letters to court in advance of First Hearing in private law applications contain the full information. The outcomes should be monitored by the head of service (QI) and reported back to the operational director at the next service improvement meeting.

8.6 Cafcass should bring to the attention of ACPO the learning from this serious case review, with a view to improving the implementation of the protocol at local level. Cafcass in Kent should make local representations to the LSCB.

**East Sussex Children's Services**

8.7 That Children's Social Services request that East Sussex LSCB reviews the Sussex child protection and safeguarding procedures and if necessary amend them, to ensure that when a child dies unexpectedly, all children living in the household are assessed.

8.8 That training provided in the new procedures for responding to child deaths highlights the importance of considering all children in the household, when assessing what support should be provided to a family following the unexpected death of a child.

8.9 Social work staff to be reminded to take copies of forms returned to agencies requesting information, so that a record is kept of information provided. Staff to be reminded of the need to include in their recording, the rationale for decisions

reached as well as the facts of the decision.

**East Sussex Community Health**

8.10 No recommendations

**East Sussex Hospitals NHS Trust**

8.11 No recommendations

**East Sussex Education**

8.12 To explore with the head of safeguarding within East Sussex, how senior school staff i.e. heads of year / pastoral leaders can develop their awareness of split families and how this may affect a young person. To consider the training already on offer to schools and whether this area is discussed sufficiently. To consider within the training, how staff can be up skilled in their observations relating to possible indicators of emotional harm. This should take place by December 2010.

8.13 Discussions to take place with E Business regarding general record keeping within schools using the electronic school information management system and whether the system provider CAPITA could provide a communication log for staff members on each pupil profile, ensuring an accurate record of communication is maintained between schools and parents. This should take place by December 2010.

8.14 To explore with the head of safeguarding within East Sussex, how independent schools can be encouraged through joint working, to develop a protocol to share pastoral information relating to young people who move into local authority schooling, particularly where safeguarding and welfare concerns have been identified. This will enable the receiving schools to build a support plan around the young person to keep them in focus. This should take place by December 2010.

8.15 A specific action for the senior school to revisit their child protection procedures and ensure all staff are up skilled in child protection matters through whole school training. To take place by the end of October 2010.

**Sussex Nursery**

**Nursery**

8.16 Nursery should, with immediate effect, update its child protection and safeguarding policy and practice so that:

- Staff are fully informed about roles, responsibilities and duties consistent with the East Sussex Safeguarding Children Board handbook.
- Advice and guidance is sought from children's social care, with or without identifying the child or children in question in the first instance, whenever changes in circumstances or events could be considered to signify a potential risk to safety.
- All staff undergo regular updates in child protection training so that all staff have received training in the last three years by December 2010, and the proprietor completes level 2 accreditation by July 2010.

8.17 Nursery should, with immediate effect, improve procedures for ascertaining and recording children's home circumstances and internal communication of this information within the nursery so that:

- There is always a secure understanding of children's home circumstances, including where they are living at all times and access arrangements.

- All supervisors working with children are fully informed about children's circumstances.

8.18 Nursery should improve procedures for the exchange of information when children move between Nursery and other settings, by being proactive in making contact and requesting or offering records.

8.19 Nursery should improve procedures for recording attendance and absences so that:

- Registers are better organised, dated with day, month and year, so that it is easier to see patterns of attendance which might alert staff to concerns.

- Reasons for absences are recorded.
- Records are never altered, so that the original entries are obscured.

**Surrey Children's Services**

8.20 Management action to be taken regarding the application of eligibility criteria and processes for transfer of cases to ensure those of complex circumstances are appropriately dealt with.

8.21 Training programme and opportunities for staff dealing with initial contacts from the public and professionals to be identified with specific attention to the requirements of Working Together and linked with Safeguarding Board and Children's Services procedures

8.22 The process for tracking progress of new cases within the contact centre be reviewed by Contact Centre Management with a view to preventing avoidable delays in implementing agreed actions.

8.23 All 'case files' should have an easily accessible chronology identifying important contact information that will provide both an at a glance picture of causes for concern and signpost additional significant information to aid efficient review of and planning for cases.

8.24 Recording systems must allow for the sequential recording of contacts and action plans and fuller, detailed information when required. The paper recording of Duty Manager's reasons for closing cases must be incorporated into the electronic record system allowing for evidence based clarity as well as brevity.

8.25 Ensure contacts are followed up, e.g. Police notifications will all be seen within the required 24 hour response timescale, all are acknowledged and where required, further enquiries are made or clarification is sought, to improve the quality of information for assessments and decisions.

**Surrey Community Health**

8.26 No recommendations

**Surrey Early Years**

8.27 Surrey EYCS extends its current work around transitions to include more focus on sharing information between multiple settings that a child attends and also when a child leaves one early years setting to attend another. The focus currently is around transition from early years setting to school.

8.28 Review the quality of information collected from parents / carers on an initial enrolment / application form to include whether the child attends or has attended other early years settings. Also include in this, permission to contact other named settings. It is down to the individual setting to produce their own forms, but some further guidance around this would be useful. **Note**: Surrey pre-school have already updated their registration form to reflect this collection of information and to have permission from parents to contact other early years providers where the child has attended.

8.29 Settings to have in place a policy around non-attendance by children when no contact has been made and to ensure that reason for non-attendance is recorded. Settings should have a process to follow if parents / carers do not contact the setting to say why the child is absent after a reasonable length of time. If the child is of concern to the setting or it is monitoring a child's attendance as part of an agreed plan, then the relevant agency should be contacted. As part of this, if a child is known to social services and has a named social worker or family support worker, then the pre-school should be notified of this so joint working can be more effective.

8.30 Ensure that staff keep their safeguarding training up to date and relevant to their individual role within the pre-school / early years setting. **Note:** Surrey pre-school have now had delivered in house, 'What to do if Safeguarding Training**'** for all their staff on Thursday 17th June 2010. Staff who need additional training have been signposted to Surrey safeguarding training to book further modules; JK and PT have been identified as required to attend further modules.

**Surrey Education**

8.31 No recommendations

**Surrey Police**

8.32 The head of public protection should consider issuing a reminder (reinforcement), to all police officers of their safeguarding responsibilities when attending incidents where children are present or suspected to be present. This should be in the form of a global email, an entry on routine orders and should be reinforced on team training days.

**Sussex GP**

8.33 Continue the rollout of both CAF and contact point to improve communication between agencies.

**Sussex Police**

8.34 Specialist Investigations Branch (SIB) are conducting a review of the complete structure and working practices of Sussex Police in relation to safeguarding children.

The review will specifically address the following:

- Whether the paper family file system is best vehicle for recording and sharing child protection information.
- Whether the MOGP/1 protocol is the best method of identifying police incidents impacting upon children's safeguarding.
- How, and in what circumstances and format, we should share and refer child protection information.
- How we can accurately record and risk assess referrals from other agencies.
- How we can improve the depth and quality of research undertaken in relation to children's safeguarding
- Whether centralised management of child protection resources will enhance the efficacy of those teams.

8.35 The above review will also address the following recommendations of two

previous individual management reviews:

1. SIB to address an organisational culture in which dealing with children is perceived as the responsibility of specialists, by reminding staff of the statutory responsibilities of everyone in the organisation.
2. SIB to include within current revisions to the force child protection policy, a mechanism and standard for the review of repeat child protection referrals/incidents.
3. SIB to continue work to review the structure and process of specialist investigations units as a whole, in order to address identified shortcomings in the current systems of referral management, intelligence collation and development, and the recording of child protection information.