Executive Summary

REPORT TO

DERBYSHIRE SAFEGUARDING CHILDREN BOARD CONCERNING

Child K

In order to preserve anonymity substitute initials have been used in this summary.

Date: July 2008

EXECUTIVE SUMMARY

IN RESPECT OF CHILD K

1 Reason for the Report

This report provides a summary of the overview report commissioned by Derbyshire SCB and was conducted in line with guidance provided in Working Together to Safeguard Children (2006).

2 Summary of the Case and Background to the Report

This Serious Case Review was commissioned in August 2007 by Derbyshire Safeguarding Children Board following the death of a young child at the family home.

The Serious Case Review was conducted in line with guidance set out in Working Together to Safeguard Children (2006). The criterion was met on the grounds that the child's death was suspicious and subject to a homicide investigation by Derbyshire Police. His mother has since been found guilty of causing his death.

During the majority of his first four years, this child and his family were resident in another authority and this increased the challenge of collating the evidence from a large number of agencies and completing the dialogue necessary for a thorough understanding of the facts in the case.

The Review concerns a child who was born in 2002 in Southern England, the fourth child of his mother, but the first of her relationship with his father. He resided in Southern England, before moving to Derbyshire with mother and half-siblings, and resided there until his death.

Immediately following the child's death his half-siblings were placed in the care of the local authority whilst his mother was placed in a Mental Health Hospital, and later remanded in custody. Mother is currently serving a prison sentence for the above offence.

The child and his siblings appeared to be functioning well throughout their lives and although there were issues, which this report brings to light, around improvements needed in multi-disciplinary and multi-agency interventions, there was no evidence that any intervention or absence of intervention would have impacted on the sad outcome for this child. The mother displayed an ambiguous relationship with Health and Public Services, contacting services for support, but being unavailable when services attempted to engage. This makes assessment of personal and parenting needs challenging to the agencies involved in the family's care. When the parent's relationship

broke down mother seemed to develop an irrational fear of father's contact with the child that ultimately led to his death and mother's apparent suicide attempt. In the year prior to the child's death mother was identified as suffering from Mental Health problems, but these were not of a nature that would indicate deliberate harm to the child. The fear of attending a Court Hearing, focused on father requesting contact, seemed to be the catalyst for mothers actions.

3 Lessons to be Learned/Assessment of Risk

Mother's assurance that she would not do anything to harm her children was not a protective factor in the risk she posed to her son and herself. The welfare of the children should be assessed separately where a primary carer is reporting suicidal ideation.

Where threshold for initial assessment is reached it is important that this is completed in a thorough and timely manner. Parents, who have anxiety, whether rational or irrational, may display patterns of non-engagement that can only be identified through good information-sharing practice. Opportunities for constructive joint working and assessment should be built into multi-agency practice.

The medication which was involved in this child's death was an anti-depressant prescribed to mother. The Medication Code needs to consider risk as well as capacity when considering the disposal of medication, although this particular medication did not have a history of fatal toxicity.

4 Recommendations

National Recommendations

This death was an unforeseen tragedy. Although there are cases of homicide of children where parental suicidal behavior is a feature, this is extremely unusual in the case of the maternal parent. Suicidality is increased by access to means and in this case the prescribed medication is used in a suicide/parasuicide attempt and is an identified causal factor in the child's death.

1 Consideration should be given by the Department of Health to examine the evidence of the use of prescribed medication in suicide and parasuicide, and in addition any listing of such medication being administered to children, with a view to considering whether there is a need to offer guidance to Health Trusts in reviewing their Medicine's Code for the disposal of medication where the patient has expressed suicidal or homicidal ideation.

2 In addition, this Serious Case Review should be highlighted in the National Care Services Improvement

Partnership (CSIP) programme on Parental Mental Health and Safeguarding Children.

Recommendations to Children's Social Care (Original authority)

1 The organisation should undertake an audit of initial assessment, to determine:

a If thresholds for Initial Assessment and Section 47 investigations are being consistently adhered to;
b How many of these cases incur a delay in meeting the 7 day timescale for completion;
c What is the quality of these assessments. Are all other agency checks undertaken and clear analysis provided of the information?
d The Government's expectations around ICS ensures that consistent decisions in relation to interventions and closures by managers are demonstrated within case records. The audit should reflect progress in this area;
e Where concerns are raised around children 'home alone' then an assessment should be undertaken around the safety of the children, including liaison with the Police where appropriate.

2 If there are consistent themes the Local Safeguarding Children Board needs to consider what action the Local Authority need to take to address service provision.

3 When a worker is absent, managers need to review the allocation of the worker's cases, ensuring the child's welfare is checked through duty arrangements in the interim. This should be conducted within two weeks of the case workers first day of absence and consideration given to re-allocation if the absence is likely to be more longer term.

4 Consultation with all parties who hold Parental Responsibility (PR) should be undertaken as part of the Initial Assessment (IA) process. Where a biological parent is identified but does not hold PR, consideration should be given to consulting with this parent – the IA pays attention to issues of identity for the child and account of this should be evidenced.

5 Family non-engagement with the assessment process should be viewed as a risk factor and a case should not be closed due to non-compliance unless the child's welfare is assured. The case audit outlined above needs

to take account of this and the threshold for case closure reviewed.

Recommendations to Health Services

Recommendations – Original Health Authority

1 The health visiting service should review current working arrangements for staff. This must include supervision arrangements, access to support mechanisms available to all staff in the PCT and reviewing the policy and capacity of the service when cover arrangements are required.

2 The PCT should review training in line with national guidelines regarding record-keeping and the uptake of training is monitored; and to ensure that recommendations from the local health visiting Service Records Audit have been implemented, and that the audit includes ensuring that evidence of appropriate information-sharing when concerns are identified, are documented.

3 Accident and Emergency Services should audit record-keeping and information sharing practices and procedures.

4 Develop or identify audit that ensures Health Visiting practice is compliant with current Health Visiting Service policies and procedures, including the transfer of Health Visiting records within the PCT and between their own and other areas policy; considering how historical information can most appropriately be shared, and auditing the current use of the Priority Index System to ensure that it is now more firmly embedded in practice and to implement any recommendations.

Recommendations for Derbyshire Health (including Mental Health)

1 A development of DNA's policy between Primary and Secondary care should consider the potential of developing joint assessment between Primary Care Services and Secondary Services such as Mental Health Trusts. In particular consideration could be given as whether a CPN could engage with a GP in assessing mental health needs where there is resistance to referral-on to Mental Health Services or Counseling Services.

2 The potential for the development of joint assessment between Health Visitors, CPNs, Social Workers or other primary health workers should be considered further. The use of the Common Assessment Framework as a tool for agreeing the needs of children of parents with mental health problems should be developed.

3 Where parents are expressing suicidal ideation assessment of risk to children should be considered. Training should be improved on this subject relative to not considering children as a protective factor for parents who feel suicidal. Trusts need to reinforce the message that children should not be considered a protective factor even when parents convey messages such as they would do nothing to hurt or distress their children. Development of training in this area should be led by the DSCB and Mental Health Trust.

4 Information should be shared within the Primary Healthcare Team about parental mental health issues where children are involved, to ensure that relevant professionals can give full consideration to the child's welfare.

5 Mental Health Trust - The Mental Health Trust should review the Trust's Procedures regarding the responsibility for the disposing of prescribed medication for those expressing suicidal or self-harm ideation in the light of this Serious Case Review.

6 Training improvements relative to parental mental health for the development and discussion locally and within the local Safeguarding Children Board, as per the Trust Work and Development Plan for the Mental Health Trust 2006/08.

7 A protocol for schools to inform the School Community Nursing team when a young person is registered in the school should be developed, so that children and young people receive the School Health Questionnaire about their health with a view to contributing to the Be Healthy Outcomes Agenda.

Recommendation –Women's Aid

1 The relevant Women's Aid office to review whether the use of the café for the meeting in July 2007 was appropriate and whether a more secure environment might have helped to gain further information from mother regarding support at the High Court in August 2007. The

evidence from other contacts suggests that she was unlikely to access the support offered.

Recommendation - Education

1 Education should develop a protocol for schools to inform School Health Nursing Service of all new registrants within the school system.

Recommendations - CAFCASS

1 CAFCASS should raise this Serious Case Review with the Family Justice Council to consider what actions the Justice System could initiate to reduce the anxieties of avoidant parents.

2 CAFCASS to audit its own compliance with its Safeguarding Policy in respect of initial checks and screening processes including engaging with children in assessments.

3 To ensure that new models of practice are developed and clear guidance exists in respect of what role practitioners play when "Finding of Fact Hearings" are listed, either at the outset or during CAFCASS involvement