Leicester Safeguarding Children Board

SERIOUS CASE REVIEW

(under Chapter 8, Working Together to Safeguard Children 2010)

In respect of deaths of the

children known as Child 1 and Child 2

Case "A"

Executive Summary

Report by: Anne Binney, Independent Author

Accepted by Independent Chair of Leicester Safeguarding Children Board on 9 September 2011

1. Introduction

1.1 In the early part of 2011, police discovered the bodies of two pre-school aged children and that of their mother in their home. The deaths were treated as suspicious. A note in another language had been found the day before with a body of a man found hanging in a local park. This was discovered to be the father of the two children and he is believed to have committed suicide. The note led the police to the mother's home. Inquests into all the deaths have been opened and adjourned and enquiries are ongoing. No other suspect is being sought for the deaths of the two children and their mother. Cause of death has not as yet been ascertained.

1.2 Prior to their deaths, the children had been assessed by agencies as meeting all their developmental milestones, although many health appointments had been missed. The children had been observed as having a warm relationship with both parents. They were described as lively and vocal children.

1.3 On 17 March 2011, David Jones, the Independent Chair of the Leicester Safeguarding Children Board (LSCB) decided to hold a Serious Case Review (SCR) in respect of the two children. Statutory guidance, Working Together to Safeguard Children (2010) stipulates that where a child dies and abuse or neglect is known or suspected to be a factor, then a Serious Case Review should be held into the involvement of organisations and professionals into the lives of the children and the family.

1.4 This family were known to many local agencies and the children had been subject to child protection plans in the past and were still being supported by a multi-agency family support plan at the time of their deaths. It was also known that domestic abuse and harassment had been a feature within this family and the Independent Chair of the LSCB therefore concluded that a Serious Case Review should be held so that any learning from these tragic circumstances could be quickly identified and acted upon.

1.5 Serious Case Reviews are designed to establish what lessons are to be learned from the case about the way in which local professionals worked individually and together to safeguard and promote the welfare of children. They are not inquiries into how the children died, or into who was culpable. These are matters for the Coroner and criminal courts.

1.6 An independent person was appointed to chair an SCR Panel comprised of senior managers who had not had any direct involvement with the case. They were from a range of agencies. An independent overview author was also appointed to produce a report which analysed the findings from individual reports provided by agencies involved and from a health overview report

which considered the actions, conclusions and recommendations of the health agencies involved. The review period analysed was from 2003 until 2011.

1.7 For the purposes of this report, the two children who died will be known as Subject Child 1 and Subject Child 2. Their parents will be identified as Mother and Birth Father 2. Mother's former husband will be identified as Birth Father 1 and his son as the half-sibling. This is to protect the identity of the family and prevent further intrusion into the grief of surviving relatives. The only information about the half-sibling included in the published report is material that is directly relevant to the two subject children. Other information has been redacted to preserve confidentiality for a child who is not the subject of this Review.

2. Process for this Serious Case Review (SCR) and parallel processes

2.1 The Independent Overview Author and Independent SCR Panel Chair were commissioned by the Local Safeguarding Children Board in April 2011. A briefing was subsequently held on 13 May 2011for authors who would be providing reports for the relevant agencies involved. The SCR Panel met on 7 occasions between April and August 2011. Panel membership was as follows:

Independent Chair: Chris Nerini, Head of Safeguarding for Leicestershire County Council
Detective Chief Inspector, Leicestershire Constabulary
Director, Safer and Stronger Communities, Leicester City Council
Head of Service, Children's Social Care and Safeguarding, Leicester City Council
Head of Service, Early Prevention, Leicester City Council
Associate Director of Quality, NHS Leicester City
Director of Performance and Business Development, Leicestershire and Rutland Probation Trust
Assistant Director, UK Border Agency
Head of Safeguarding, Action for Children
LSCB Manager

The Independent Overview Author, Anne Binney, attended all panel meetings except the first one held just prior to her involvement. The Health Overview Author attended some meetings, as did the LSCB policy officer.

The Panel also received confidential briefings from the Police in relation to the ongoing enquiries and from an experienced practitioner in relation to domestic violence issues.

2.2 Eleven individual management reports and chronologies were received from local agencies. Reports critically evaluated the involvement of individual agencies with the children and family and identified actions which would ensure that learning from this case was embedded in future practice. In addition, there was one information report and chronology and another two chronologies outlining very brief agency involvement. Involvement of the three health agencies in this case was reviewed within a health overview report and that author also made some additional recommendations arising from identified learning. Agencies providing reports were as follows:

Leicestershire Constabulary
Children's Social Care Services, Leicester City Council
Education Services, Leicester City Council
Access, Inclusion and Participation, Leicester City Council
Action for Children
Housing Services, Leicester City Council
UK Border Agency
University Hospitals, Leicester
Leicestershire Partnership NHS Trust (health visiting)
Leicestershire Partnership NHS Trust (G.P. and community paediatrician involvement)
Leicestershire and Rutland Probation Trust

2.3 Chronologies were received from CAFCASS and East Midlands Ambulance Trust and an information report was received from NHS Direct all outlining very brief involvement.

2.4 Liaison was undertaken with H.M. Coroner whose enquiries were ongoing. Inquests into the deaths of all four family members had been opened and adjourned. The Coroner and the police gave permission for contact to be made with family members to assist in the review process, without compromising other enquiries.

2.5 The Independent Police Complaints Commission was also undertaking a review of police involvement with the family at the time this SCR was undertaken.

2.6 The Leicestershire and Rutland Probation Trust submitted a report for a Serious Further Offences Review. This was graded as "good" by the National Offender Management Service.

2.7 In April 2011 the Government issued statutory guidance for completion of Domestic Homicide Reviews. The deaths of these children and their mother predated this guidance but attention was given in the SCR to the requirements of that guidance.

3. Involvement of the family

3.1 With the agreement of the Coroner, the SCR Panel made contact with the former husband of the mother who was also the father of her oldest child, resident with him. He provided permission for details and records about himself and his child to be included as it related to the Serious Case Review. He did not, however, wish to discuss matters with the Independent Panel Chair and Independent Overview Author who visited by appointment. He considered it was too painful a reminder of events for his son. Alternative arrangements were offered for a meeting but were not taken up.

3.2 An SCR Panel member and the Independent Overview Author visited the maternal grandfather by appointment and the Panel was very grateful for his involvement, especially in such difficult circumstances. Letters inviting participation were also sent to the former foster carers of the mother, to the maternal grandmother and to the cousin of the children's father. No response had been received at the time of preparing this report. It was discovered that the address for the former foster carers was not the current address but efforts to identify this were unsuccessful.

3.3 The SCR Panel is very grateful to family members for their responses during an extremely sad and difficult time.

4. About the author and independent SCR Panel Chair

4.1 Anne Binney was appointed as the independent overview author by Leicester Safeguarding Children Board in April 2011. She has over 40 years' experience in children's social care services, having retired in 2010 as Assistant Director responsible for children's social care in a county council. Anne is a registered social worker and holds an advanced certificate in child protection studies along with a Masters degree in Manager and Organisation Development. She has previously chaired an Area Child Protection Committee and a Local Safeguarding Children Board and sub groups. She has worked as an independent consultant since 2010, mostly writing overview reports or chairing SCR Panels.

4.2 Chris Nerini is Head of Safeguarding for Leicestershire County Council. There was agreement by her employer to Chris being provided with time to chair this SCR as she was able to provide relevant experience alongside the necessary independence of the case and of any of the agencies involved. Chris has over 30 years' experience of working in the children's social care sector and holds an MA in social work and an MBA. She has held many senior management roles in a number of East Midland authorities mainly focusing on safeguarding services. Chris has previous experience of chairing serious case reviews, panel arrangements and LSCB sub groups.

5. Synopsis of this case

5.1 Mother was 17 years old and a care leaver supported by another local authority when she moved to Leicester to be with Birth Father 1. He was an asylum seeker and of Asian (other) ethnicity and of Islamic faith. He had been granted 4 years exceptional leave to remain in the UK as it was unsafe for him to return to his country of origin. Mother was White British. The couple married and the half-sibling was born in 2003. Mother was recognised as a vulnerable pregnant teenager and referred to a specialist midwife for support.

5.2 By early 2004, Mother was reporting a lack of support from Birth Father 1 and she was tearful and low in mood. Police were involved on 3 occasions when verbal arguments were reported between Mother and Birth Father 1. The half-sibling sustained a fractured arm, aged 15 months, but this was deemed an accident.

5.3 Mother and Birth Father 1 separated in 2005 and in January 2006 a child protection enquiry was undertaken in respect of a number of injuries noted on the half-sibling. He was placed in foster care and Mother was charged with 4 counts of actual bodily harm. She admitted she had been struggling to cope and was prescribed anti-depressants by her G.P. who referred for counselling. Mother subsequently failed to attend two appointments with the practice therapist .

5.4 The half-sibling was placed on the Child Protection Register under the category of physical abuse and remained in foster care while a parenting assessment was carried out.

5.5 Mother was convicted of the injuries caused to the half-sibling and was sentenced to custody, suspended for two years, with 24 months' supervision and a curfew of 17 weeks. She saw offender managers at the Probation Trust very regularly for the two years, only missing one appointment.

5.6 In 2005, Birth Father 2 had made application for asylum in this country. His ethnicity was Asian (Other) but he was from a different country to Birth Father 1, although was also of Islamic faith. His application was refused and it was noted that he had claimed asylum in a third country so it was intended that he should be removed to that country. Arrangements were made to detain him for this purpose. He avoided this by absconding.

5.7 In early 2006, Birth Father 2 made a second application for asylum in this country, using a different name, details and date of birth. This was recognised as a multiple application and it was refused. An enforcement visit was planned to detain him but he again absconded from accommodation

provided. He made application instead to voluntarily return to his country of origin but this did not take place.

5.8 In May 2006, Birth Father 2 was placed in accommodation for asylum seekers in Leicester. The National Asylum Support Service did not recognise that he was being sought for return to a third country. By the time it was recognised, the statutory timescale for effecting return had run out.

5.9 In June 2006, it was decided to return the half-sibling to Mother's care as she had shown sound behaviour management strategies. He remained on the Child Protection Register at that time.

5.10 At a home visit by the health visitor in June 2006, the child was back in Mother's care and noted to be responding well to her and to her new partner. This was Birth Father 2. Social Care services undertook a check of the police national computer but the earlier caution given by the police for possession of cannabis did not show as he had used the different name provided to the UK Border Agency. He subsequently used both names and dates of birth at different times.

5.11 In July 2006, Mother finally saw the practice therapist. More appointments were offered, but Mother failed to attend.

5.12 In August 2006 Mother advised the health visitor that she was pregnant. In September 2006 police were called by neighbours who said they could hear banging and a woman screaming for help. The half-sibling was present. All was calm when police arrived and it was concluded the noise may have emanated from a television. No further action was taken and no injuries were seen. The next day Mother presented at Nursery with bruising which she acknowledged was from a fight the previous day with her partner, which could have occurred after the police had left. The Nursery informed children's social care services who in turn advised the health visitor but no further action was taken. Mother states she would ask Birth Father 2 to leave if any further incident occurred. Mother advised her offender manager that she was in receipt of counselling via the G.P. practice but in fact she had failed to attend appointments.

5.13 In December 2006, the half-sibling ceased to be subject to a child protection plan, replacing it with a family support plan. All agencies were positive about progress. A month later, Mother asked for him to be placed in foster care as she was not coping. At a family support meeting Birth Father 2 was said to be angry and unsettled until an interpreter arrived who could help him express his concerns. There was acknowledgement of difficulties in his relationship with Mother and it was noted that cultural and language issues were impacting. Two weeks later, the social worker recorded that the couple

had “sorted out” their communication problems and another rehabilitation plan was made for the half-sibling.

5.14 Subject Child 1 was born shortly after this and Mother required 2 blood transfusions following the birth. The hospital midwives were unaware of social care involvement until they overheard a conversation. There had been no formal pre-birth conference in respect of the new baby and it appears that conversations with the community midwife by the health visitor and social worker had not been on records. In addition, the hospital midwives could not access previous birth records and relied on Mother to self-report any concerns. She had not told them of the problems in her care of the half-sibling.

5.15 The half-sibling was returned to Mother’s care just over a week following the birth of Subject Child 1. Subsequent reports noted both Mother and Birth Father 2 interacting warmly with the children although the offender manager noted in supervision that she was concerned at the father’s controlling relationship with Mother. The health visitor suggests to the G.P. that a mental health assessment may be beneficial for Mother but there is no further mention of this. 6 weeks after the return of the half-sibling to Mother’s care Mother expresses concern for her capacity to care for him. The possibility of him being cared for permanently by Birth Father 1 was raised but a few weeks later Birth Father 2 took the half-sibling to nursery insisting he be placed immediately in the care of Birth Father 1. Mother advised the offender manager that she had been “shocked” by this but it followed an incident in which the half-sibling is said to have pulled Subject Child 1 from a chair. Subject Child 1 was taken by the parents to the hospital but no injuries were found. Mother stated that Birth Father 2 had threatened to throw the social worker through the window if there were further home visits as he now saw no need with the half-sibling having moved. Birth Father 1 subsequently obtained a Residence Order in respect of the half-sibling.

5.16 Between June 2007 and June 2008, Mother wrote 13 letters to the U.K. Border Agency, plus telephone contact in support of Birth Father 2’s asylum application. She discussed with her offender manager the financial pressures as he was unable to work.

5.17 In September 2007 police were called by Mother to a second domestic violence incident. Birth Father 2 is said to have reacted by punching and kicking Mother when she shouted at Subject Child 1, aged 7 months. Both parents ran out of the house during the incident, leaving the baby alone. There was injury to Mother’s neck and forehead but no medical attention was required. Birth Father 2 was arrested and charged with assault, later changed to battery and was given a Conditional Discharge. The Probation Trust involved with Mother was not advised that she was the victim and she did not

share this information with her offender manager. The police checked with the U.K. Border Agency whether Birth Father 2 could be removed. They advised that no removal could be made from this country while an application was pending. Shortly after this incident and immediately back with Birth Father 2, Mother advised that she was pregnant. This was the second domestic violence incident while she was pregnant.

5.18 The following month, Birth Father 2 made the first of three visits to his G.P. Practice to tell of his concerns about "feeling angry all the time". He revealed he had suffered trauma in his own country and that his family were upset at his relationship with Mother. He had wanted to be a doctor or teacher prior to joining the army in his home country and now felt frustrated at not being able to work. He also felt guilty about a road traffic accident. He told the G.P. about the domestic violence incident and he was provided with information on domestic violence and post-traumatic stress disorder. Anger management and counselling was suggested and he was prescribed some tranquilisers. Birth Father 2 failed to attend his next G.P. appointment but the G.P. provided in the post some information about Assist, a health agency offering support for asylum seekers. The G.P. recorded that the child was "safe" but with no explanation about this judgment. No other professional was told of Birth Father 2's own concerns about his behaviour.

5.19 In March 2008, a domestic violence incident was reported by Birth Father 2 to the police when he was bitten by Mother. She claimed it was in response to his pulling her hair. No action was pursued in respect of the incident but the police officer did return to check on the child, recognising potential risk from the case history. The officer informed the Child Abuse Investigation Unit who in turn informed children's social care services.

5.20 Mother attended nearly all ante-natal appointments as she had done with her previous two births and Subject Child 2 was born in 2008. Good progress was noted and Mother spoke of "good support" from Birth Father 2. Birth Father 2 was granted permission to work in July 2008.

5.21 In late 2008, after missed immunisation appointments for Subject Child 2, Mother told her G.P. she was depressed and could not cope. She had financial worries, her partner was not supportive and she was worried the children would be removed. She was prescribed anti-depressants and advised to see the practice therapist but there is no evidence the health visitor was made aware of this. Just after this, Birth Father 2 was granted 3 years' discretionary leave to remain in the U.K. because of his right to family life with his partner and two children. Mother failed to attend 2 further G.P. appointments booked.

5.22 In spring 2009, Subject Child 1 attended hospital with a spiral fracture to his leg, said to have got stuck in a slide. He was just over 2 years old. This was deemed to be an accident although this was a second fracture to a young child in this family which is unusual.

5.23 In April 2009 the health visitor undertook an assessment of Subject Child 1 and noted all three children were present and that both parents (Mother and Birth Father 2) engaged warmly with all the children.

5.24 The G.P. was advised of many failed appointments for Subject Child 1 with the renal (kidney) clinic. A potential problem had been diagnosed prior to his birth which should have been monitored regularly. The Clinic had not seen the child for two years. Shortly afterwards, Mother brought the child to the G.P. on the advice of NHS Direct as he had mouth ulcers and was not eating. The G.P referred him to hospital because of recurrent urinary tract infections and weight loss. He was admitted and found to be anaemic.

5.25 Police were again called to the family home in July 2009 and referred to children's social care as there were "constant verbal arguments in front of the children". Children's social care tried and failed to contact Mother and after checking with the health visitor, they closed the case with no further action.

5.26 In August 2009, there was another domestic violence incident involving the police. It was alleged that Birth Father 2 had poured lighter fuel on Mother. In the subsequent Child Protection Conference it was stated that he had threatened to set it alight and had also broken a mirror near to the children when Mother tried to escape with them. The incident was assessed by police as a "standard" risk but an enhanced risk assessment was requested. The incident was reviewed as per procedure by the Domestic Abuse Investigation Officer who upgraded the risk to "medium" and children's social care were later contacted and they began an investigation.

5.27 Mother initially minimised the incident and did not want social care involvement, stating that Birth Father 2 was now living elsewhere. She told the social worker that Birth Father 2 had been arrested after making sexual comments to a young woman and that although she was in telephone contact with Birth Father 2, he had not seen the children.

5.28 The police did not pursue the incident with the young woman after she refused to make a complaint and witnesses stated she had been abusive.

5.29 There followed a period of non-co-operation by both parents. Both refused to meet with the social worker and did not attend the Child Protection Conference in October 2009 in which both subject children were made subject to child protection plans under the category of risk of physical abuse. There was to be assessment of parenting capacity, parental relationships, Birth

Father 2's use of cannabis and domestic violence. Legal advice was to be sought if co-operation was not forthcoming.

5.30 Planned visits by the social worker did not immediately begin owing to capacity issues for that worker but a police safe and well check was undertaken. They encouraged Mother to co-operate with the plans and in December 2009 she attended a Core Group Meeting, called to consider progress in meeting the child protection plans.

5.31 In January 2010, Birth Father 2 was arrested but not charged for a road rage incident.

5.32 Also in that month, Mother said she was considering a move to the north of England to be near her birth father. She changed her mind about this on several occasions.

5.33 In March 2010 Mother was reported to be low and tearful, feeling isolated and lonely. Later that month, she reported numerous text messages from Birth Father 2 in which he was threatening to kill himself. Around that time he was charged with burglary of a shop premises and was later reported for intimidating a shop keeper. The latter incident was dealt with by restorative justice but in November 2010 he was sentenced to an unpaid work requirement for the first offence.

5.34 In April 2010, Mother saw her G.P. and reported feeling weepy, lonely and low. She was prescribed anti-depressants but failed her next appointment. In this period there were also missed health appointments for both children.

5.35 Three weeks later, Mother attended the Review Child Protection Conference. The social worker had intended to recommend continuation of the child protection plans on the two subject children as there was still outstanding work to be done. However, Mother was able to convince conference members that she was well able to protect her children and described what she would do if Birth Father 2 tried to gain access. The Conference was unaware of her earlier visit to the G.P. and was not aware of the missed health appointments for the children. The child protection plans were replaced by family support plans and mother was to be referred to the Freedom Programme which is aimed at support of survivors of domestic violence.

5.36 In May 2010, Mother called police as Birth Father 2 was outside her home wanting his belongings. No offences were disclosed but Mother revealed that she had been taking the children to see him at his request. This was less than 2 weeks after the Child Protection Conference. Children's social care services were not informed.

5.37 In June 2010 Mother reported that Birth Father 2 was constantly texting her and wanted to resume the relationship, leaving gifts outside her home. She advised the social worker that she had accidentally met Birth Father 2 in town and gone for a meal with him and the children. His mother and sister were also said to be texting her on his behalf. A week later, she told police that he was threatening to remove the children "within the hour" to his home country. Police attended but Birth Father 2 did not arrive. Mother was stating she believed he just wanted contact with his children and did not seem distressed. The incident was assessed as "medium" risk, markers were placed on the property and children's social care was informed.

5.38 At the end of that month, Mother reported her suspicion that Birth Father 2 had attempted to burgle her home. Although forensic evidence led to his elimination as a suspect, Birth Father 2 was given a harassment warning. This was because his attempts to contact Mother were seen as a one-off incident rather than a course of events which would have led to an arrest. The incident was assessed as "high risk" but not referred to the Independent Domestic Violence Advisors. Police procedures require a mandatory referral for cases assessed as high risk.

5.39 The Domestic Abuse Investigation Unit reviewed the case and requested an enhanced risk assessment which was not immediately carried out as an alarm was being fitted to the home and confidentiality issues prevented the assessment completion. Mother told officers that Birth Father 2 had previously threatened to kill himself and to kill her if he found her with another man.

5.40 Birth Father 2 requested appointments in July 2010 with the social worker in an attempt to gain contact with his children. He described Mother as a "rubbish" mother and that they had separated 7 weeks previously. This differs greatly from the date given by Mother for separation as 7 months previously. He stated he would kill himself if he could not see his children. He was told to seek legal advice. On the second visit, Birth Father 2 spoke disparagingly about the U.K. and about British women. The social worker recorded that Birth Father 2 was using strategies to avoid formal assessment.

5.41 As no further domestic violence incidents were reported to the police, a local police officer arranged for the alarm at Mother's home to be removed in September 2010 but did not contact children's social care who believed the alarm to be still in place in a meeting the following month.

5.42 In October 2010 Subject Child 1 had surgery to correct his kidney problem but Subject Child 2 failed to attend health appointments in respect of a possible squint during the early part of 2011.

5.43 Mother applied for a housing move in January 2011, citing harassment and domestic violence. She wished to move to a different area of the city where there were more links with the Muslim faith and easier access to Mosques. She was said to have recently converted to Islam (although her own father advised that she had converted prior to her marriage to Birth Father 1). The housing move was supported by a letter from the social worker but this was not forwarded by housing to the local housing office so no assessment was undertaken of the domestic violence.

5.44 In January 2011, Mother told the social worker that she had not seen Birth Father 2 since the previous summer. The maternal grandfather indicated he had been advised of ongoing contact but he believed this was under coercion from Birth Father 2. No agency was aware of ongoing contact at that point.

5.45 Mother and the children were regular attendees at local pre-school provision throughout the lives of the children. Mother also accessed local parenting services at the Children's Centre and Community Centre. The children were said to be well supported by her and they were both making good progress. Some of the services were not aware of her history with the half-sibling and some were not aware of the domestic violence problems in the relationship with Birth Father 2, believing them to be "historic". At a Stay and Play Session in January 2011, Mother was described as "happy and relaxed". Children's social care services were considering closing the case as Mother was in attendance at the Freedom Programme and the children were making good progress.

5.46 Birth Father 2 experienced some difficulty early in 2011 in carrying out his unpaid work requirements and breach action was threatened by the Probation Trust. This was the last agency contact with him prior to his body being found. The Freedom Programme had notified of their difficulty in contacting Mother when her body and those of the two subject children were found.

5.47 Police enquiries following the deaths suggest there is evidence that Mother and Birth Father 2 had reunited some months prior to their deaths and without the knowledge of any of the agencies. It is possible that this was a covert relationship as the parents were aware that the children may be removed if they were seen to reunite. It is not known whether Mother reunited willingly or under coercion.

6. Good practice identified

6.1 There was good practice noted when a police officer made a return visit to the family to check on Subject Child 1, recognising links to earlier child abuse.

6.2 There was prompt response by police in 2010 when it was alleged that Birth Father 2 was intending to remove the children to his home country. "Markers" were placed on relevant addresses and an alarm was fitted. Children's social care services were advised.

6.3 Good liaison was noted between police and children's social care during the period of non-cooperation by Mother. Police undertook "safe and well" checks on the children and encouraged Mother to cooperate.

6.4 From 2006, the health visitor was tenacious in attempting to access practice therapy support for Mother, recognising her vulnerability. Visiting was very regular, especially in light of a large caseload.

6.5 The G.P. actively ensured the family would attend hospital follow-up after the injury to the half-sibling's arm.

6.6 Midwifery services were well coordinated when Mother presented as a pregnant teenager.

6.7 There was sensitive response by the school to the needs of the half-sibling following the deaths of Mother and the subject children.

6.8 The Probation Trust provided continuity for Mother in allocating an offender manager who had worked with her previously, when case transfer was required.

6.9 The SCR panel members responded quickly to address any emerging issues. Early action was taken to address deficits identified. The SCR Panel also ensured good consultation with police and Coroner to ensure family involvement could be sought in the SCR process.

6.10 There was also good practice in the LSCB manager attending another local authority to see Mother's historic case files. This provided background information not always available in SCRs.

6.11 The SCR panel enabled good dialogue with the Individual Management Review authors, involving them effectively in the process and enabling early learning to be identified. They also provided effective scrutiny and challenge and sought advice from an experienced practitioner involved in domestic violence services, to aid learning.

7. Key themes and learning arising from this case

7.1 Nine themes have been identified for learning from this case, as follows:

7.2 Lack of consideration of the early history of the parents and potential effect on their functioning and risk to children.

7.2.1 Both Mother and Birth Father 2 told professionals about their previous life experiences which they believed were impacting on their lives. Mother had been in care since the age of 13 following unsubstantiated allegations of abuse, and initially had significant problems including solvent abuse. Birth Father 2 told his G.P. Practice on three occasions of his concerns at his anger management. No agency took full account or assessed the potential impact of these histories which, taken together, suggest serious vulnerability in the family and potential impact on parenting capacity. Agencies did not share effectively all the available information. Mother's failure to bond effectively with her oldest child was not formally assessed and there was no pre-birth assessment of Subject Child 1 even though Mother was categorised by her conviction as a person posing a risk to children. Little was known about Birth Father 2. The **learning** is that agencies should include an historical perspective in their assessments which could lead to better identification of risk and support needs for children. This point was well made in the second SCR in respect of Baby Peter in Haringey in 2010.

7.3 Lack of attention to cultural issues

7.3.1 Problems arose during Mother's marriage to Birth Father 1 linked to cultural difficulties and issues arising from his asylum status. These problems were repeated in the subsequent relationship with Birth Father 2 but were never formally considered. Mother acknowledged that language difficulties sometimes led to misinterpretations in their relationship but the couple were not offered any assistance on cross-cultural issues and there was no consideration of the effect of these difficulties on their parenting or account taken of potentially different child-rearing values and expectations. No assessment was made of the reported stress of Birth Father 2 although incidents of post traumatic stress are known to be high for asylum seeking individuals.

7.3.2 These two small children were of dual heritage but lived in a predominantly White British area. No account appears to have been taken by any agency of their cultural needs. Only the school, police and the U.K. Border Agency formally recorded ethnicity, language and religion although the expectation across all agencies was that these would be in records. In hindsight, some agencies concluded they could have done more to address cultural issues. The **learning** is that agencies need to be able to ensure that appropriate recording and attention is given to cultural issues in order to provide appropriate services and also to understand potential impact on children and their families.

7.4 Domestic violence/domestic homicide/filicide

7.4.1 Over 8000 incidents of domestic violence are reported in Leicester each year. There is a comprehensive inter-agency strategy in place supported by robust procedures to identify those most at risk. In this case, procedures were generally well followed, although there were three occasions when it may have been beneficial for the police to have alerted children's social care services at an early stage of family difficulties and of ongoing contact between Birth Father 2 and the children, as reported by Mother to them. In addition, there was a missed opportunity to refer to the Independent Domestic Violence Adviser when police assessed risk as "high" in 2010 and earlier opportunities for any agency to have referred to the Domestic Violence Integrated Response Project. In general, most incidents attended by the police were not classed as crimes and no medical attention was required on any occasion when police were called. The spacing of the events also potentially led to the view that the risk did not meet the criteria for referral for a Multi Agency Risk Assessment Conference (MARAC), set up to consider support needs for high risk victims.

7.4.2 Two domestic violence incidents occurred when Mother was pregnant and this is highly correlated with increased risk, but not considered by any of the agencies. In addition, all agencies were reassured by the understanding that the parents had separated, not taking account of known research which suggests separation may indicate increased risk. A similar concern arose from another local SCR in respect of Case W where agencies wrongly assumed that separation reduced risk and accepted assurances that separation had occurred when in fact the relationship continued.

7.4.3 Some research on child homicide suggests that there is a strong link with suicide attempts by the perpetrator where this is a biological father. Sometimes categorised as filicide-suicide or familicide, the research suggests that alerts to future intentions are not easy to identify or predict and differ from other domestic violence situations - although are strongly correlated with these and with mental health issues and substance misuse. All of these elements were present in this family. Manchester University undertook a literature review of filicide in 2009 and concluded that it was difficult to *"identify an effective intervention and it is unrealistic to presume all filicides are preventable".* It is suggested in the literature that threats of suicide made by perpetrators may also include an ideation of including other family members in this and that it may be of benefit to enquire about children when a parent talks of suicide. This research is not well known or disseminated given the relative rarity of such catastrophic events. It is very difficult to ascribe motivation to these events but it is suggested in the literature that many familicides have an "altruistic" motive from the perspective of the perpetrator. The **learning** from consideration of domestic violence and familicide would

suggest the need to revisit the priorities of the local Domestic Violence Strategy (2009 – 2014) to consider whether MARAC capacity could be increased, as planned, alongside increase in accredited programmes. Birth Father 2 was never offered any intervention in relation to his anger management or domestic violence. In addition the learning supports plans for further multi-agency training, including a focus on the correlation between domestic violence, drug and alcohol usage and opportunity to disseminate learning across agencies from complex cases. These plans are already in place in the strategy but may benefit from review as to whether they can be expedited. There is already work underway to review the arrangements for provision of domestic violence services in Leicestershire and it is recommended that the review takes full account of learning from this SCR.

7.5 Lack of involvement of men in the family

7.5.1 A familiar theme in national Serious Case Reviews is the lack of information and assessment about men involved in families and this is replicated in this SCR. The Family Rights Group has carried out research on working with "risky fathers" and concluded that they are rarely offered assessments or programmes of work to address domestic violence. It is concluded that assessment is essential to determine whether these fathers are a risk or a protective factor for their children. In this situation, there was no formal assessment of Birth Father 2 and the knowledge of his self-reported concerns was not shared across agencies. He was not provided with any opportunity to change and when he finally met with the social worker to try and get contact with his children, he was advised to seek legal advice. No agency had recorded whether this man actually held parental responsibility for his children and what their relationship with him was. It is understood that he was present at their births and was seen to be warm and caring towards the children by professionals and family. Brandon et al (2009) comments on "rigid thinking" sometimes present where men are assumed to be "all good" or "all bad" without formal assessment. The **learning point** is that fathers should always be considered as part of any parenting assessment and that this should include the perspective of the children.

7.6 Communication/information sharing

7.6.1 This is again a familiar theme in national and local SCRs. While there were examples of effective communication sharing in this case, there were also some deficits. Internal communication problems in two agencies, housing and U.K. Border Agency were identified and rectified.

7.6.2 It was noted that some agencies had reliance on self reporting of difficulties. The midwifery service was not able to access previous birth records so relied on Mother to identify problems which she chose not to do. Pre-school

services, even when commissioned by children's social care often had incomplete information on record and this was even more apparent in universal services which relied on self-reporting.

7.6.3 Even more difficult to achieve are the required changes in inter-agency communication. There was evidence of a lack of formal communication by children's social care and the health visitor with the midwifery service and between the G.P. and health visitor and the G.P. and social worker. The G.P. records held information about missed health appointments by the children and the parents and significant history presented by Birth Father 2. These records and information were not shared. It is possible that sharing of the information would have led to continuation of the child protection plans for the subject children in May 2010 and potentially a more robust response. The **learning** is that it is essential that systems are effective in supporting multi-agency communication and information-sharing to identify the "big picture" of the complete circumstances for children.

7.7 Rule of optimism/disguised compliance

7.7.1 It is easy with hindsight and the benefit of all relevant information to state that the two subject children should not have had their child protection plans ended in May 2010 and that a Child Protection Conference should have been called when concerns escalated in June 2010. Instead, agencies were reassured by partial information gathered which showed that Mother was accessing local services at the Children's Centre and the Community Centre and she attended almost all ante-natal appointments. The children were seen to be making good developmental progress and Mother was believed to be strong enough to withstand the increasing contacts made by Birth Father 2. However, this did not take account of her reported depression and loneliness, all the missed health appointments, the seeking out of services by Mother which she then failed to access and the selective and varied information she shared with various agencies. Mother was seen to be a likeable, vulnerable young woman and agencies were keen to support her. Her account of events was often accepted without question or challenge and it appeared that professionals wanted to believe she was making good progress. There was optimism in the two rehabilitations of the half-sibling to her care without assessment of attachment, one immediately following the difficult birth of Subject Child 1. There was optimism in the lack of a pre-birth conference prior to the birth of Subject Child 1. The difficulties were assumed to relate solely to the relationship with the older child, with no account taken of Mother's history and a new relationship and new baby. Records also show that there were behavioural difficulties with Subject Child 1 which mirrored those experienced with the older half-sibling. These were not formally seen as needing intervention. There was no "respectful uncertainty" about her denial of contact with Birth Father 2 and she in fact advised some other

agencies that she was taking the children to see him. Ongoing contact has been confirmed by the maternal grandfather although he believes Mother was coerced into this. Another suggestion is that they reunited some months before their deaths, but concealed this from agencies for fear of losing the children. The **learning point** is that all agencies must maintain "respectful uncertainty" in working with parents and should seek evidence to support statements, challenging where necessary.

7.8 **Variable and incomplete focus on the children**

7.8.1 There was some very good recording about the two subject children by some professionals but no direct work was undertaken with the children to understand, for example, the impact of domestic violence incidents or their parent's separation. The social worker allocated at the time of their deaths was the only professional to attempt any direct work. Both parents presented as "needy" and it is apparent that even when work was focused on improving parenting capacity, the recording often focused on the adult rather than the child. Capacity problems in children's social care led to one period where visits to the children were not as frequent as the plan required and management oversight was not effective in rectifying this. The plan for the offender manager was to undertake home visits and this would have provided a good focus on the children, but only one home visit occurred in the two year period. Police reports did not always provide clarity as to whether the children were present at incidents, although there was good practice on one occasion when a police officer returned to check on the child, recognising past history may indicate increased risk.

7.8.2 Health visitors visited frequently and there was good recording of the children's progress in developmental terms. The G.P.s provided good individual care but there was little formal evidence of their consideration of the children in the treatment of their parents. No reports were provided to Child Protection Conferences for example. The **learning point** is that when work has to focus on change required with the parents, the child's perspective must be considered and maintained and there must be assessment of the impact of the work on their day to day experiences.

7.9 **Recording**

7.9.1 There are no major deficits in recording in relation to agency expectations, although potential for some improvement was identified. Lack of presentation of reports to Child Protection Conferences has already been noted. Internal problems in accessing records was noted in midwifery services and the offender manager raised some concerns about the family in the supervision record which was not then transferred to the risk assessment

and was then lost to subsequent professionals. G.P. files did not all hold "markers" to identify when there were child protection concerns in the family. The U.K. Border Agency and Housing services both identified problems of information stored in one part of the service but not shared across to another team. Both have put systems in place already to address this. Some reports identify good narrative recording, but less effective analytical recording. The **learning point** is that effective recording is essential both in narrative and analysis to understand the situation from the children's perspective and to share appropriate information with others to better safeguard and promote the welfare of the children.

7.10 **Management Oversight**

7.10.1 This is strongly linked to many of the preceding themes. Where deficits occur in practice, it is effective management oversight and supervision that will enable appropriate professional support and challenge. Most agencies identify effective management oversight but highlight a few occasions where this could be improved. These will be considered within each agency. The problems with effective management oversight in children's social care are identified for one period of involvement, but not others. A number of agencies identified increasing volume of work and in these circumstances, management oversight is crucial. The **learning point** is that management oversight is essential to ensure there is both adequate support for staff involved in highly complex work and appropriate challenge to their assessment and analysis, along with sufficient quality assurance systems in place.

8. Conclusions

8.1 It is the opinion of the Serious Case Review Panel and of this author that the tragic deaths of these two children and their parents could not have been predicted.

8.2 These two small children were well known to local agencies and appeared to be well loved by both their parents and were meeting developmental milestones. There was nothing that would have indicated such a catastrophic event and the research into familicide points to the difficulty in predicting such events and intervening effectively.

8.3 However, as indicated earlier there are many learning points in the way that agencies interacted with and supported these children and their parents. It is unfortunate that there are no new messages in this Serious Case Review and the learning reflects themes that are common in both local and national serious case reviews. This emphasises the importance of ensuring learning is effectively embedded in practice.

8.4 It is less certain whether the tragedy could have been prevented by different responses. The only known certain preventative factor would have been if the U.K. Border Agency had succeeded in their attempts to remove Birth Father 2 to the third country when it was recognised he had claimed asylum there. This opportunity was lost and while it is possible that fuller information sharing would have led agencies to a more complete "whole picture" and more identification of risk, greater assessment of both parents and more focus on the children, it is by no means certain that this would have prevented such a tragedy. Without knowing the motivation for such a catastrophic event, it is impossible to reach such a conclusion. This should not, however, get in the way of agencies responding to the learning identified to improve outcomes for vulnerable children and their families.

9. Recommendations

9.1 The agencies providing reports for this Serious Case Review have all completed action plans outlining their recommendations. These will be monitored by the Serious Case Review sub group of the Leicester Safeguarding Children Board to ensure they are completed. The sub group will seek evidence to assure themselves that actions have been embedded in practice.

9.2 In addition, the Health Overview Author has made recommendations which address the learning identified for the health agencies involved. These are also included on the Action Plan and will be similarly monitored.

9.3 This overview author and the Serious Case Review Panel endorse the recommendations made by agencies but this author also makes a further 8 recommendations in light of the themes identified and where the agency recommendations do not fully cover these. These recommendations arise from the learning points identified earlier.

9.4 In relation to ethnicity and diversity, it is recommended that:

Agencies with a duty to cooperate must report to the LSCB their arrangements for recording of nationality, ethnicity, first language and religion and how this is monitored.

9.5 In relation to information-sharing, it is recommended that:

NHS Leicester City must report to the LSCB the arrangement for monitoring the response of General Practitioners to requests for provision of reports to Child Protection Conferences and how this is monitored and reflected in commissioning arrangements.

9.6 In relation to anger management, it is recommended that:

Where a parent or carer with children presents with anger management issues that could impact on the wellbeing of their children, General Practitioners must liaise with the health visitor or school nurse.

(This is a repeat of a recommendation made in a national SCR and reported by Ofsted 2010) It is included because of its relevance to this case.

9.7 In relation to maintenance of focus on the child/ren, it is recommended that:

Agencies with a duty to co-operate must review their quality assurance systems to ensure that they adequately reflect the required focus on the child/ren in work with parents/families and are able to evidence impact on the child/ren. Results of this review must be reported to the LSCB.

9.7 In relation to domestic violence it is recommended that:

- **The LSCB must liaise with Leicester City Council to ensure that the recommendations arising from this SCR inform the development of a single commissioning strategy for domestic violence services and the development of a new and integrated model for the delivery of domestic violence services within Leicester City.**
- **The LSCB must liaise with the Leicester Domestic Violence Strategy Group to ensure there is wide dissemination of learning from this SCR, in particular the learning arising from research into familicide and the links to domestic violence, mental health, drug and alcohol use and the increased risk in pregnancy and at the point of separation in a relationship, or subsequent to this.**
- **Training for agencies in respect of domestic violence must ensure it addresses cultural issues and the stresses that may arise in cross-cultural relationships.**

9.8 In relation to information sharing systems, it is recommended that:

University Hospitals, Leicester (UHL) will consult regionally and nationally to share concerns about the system constraints on information sharing between hospital and community midwives, in order to seek potential solutions. Consultation will include contact with the Regional Local Supervisory Authority (LSA) officers for midwives in England.

9.9 In relation to Child Protection Conferences and the full sharing of information across all relevant agencies, it is recommended that:

- **The Independent Chair of a child protection conference must review the invitation list and ensure it is sufficient to provide the full range of information required to safeguard the child/ren and promote their welfare. This must include General Practitioners.**

- **In relation to assessment of parents, the Independent Chair must be satisfied that assessment includes all relevant history of both parents, analysis of the potential impact on parenting capacity and what supports are required for the child/ren.**

- **Prior to agreeing the cessation of Child Protection Plans, the Independent Chair must check that all elements of the Child Protection Plan have been completed unless there are strong reasons for discontinuing them.**

9.9 In relation to threats to kill self or others, it is recommended that:

A review of the Leicester Interagency safeguarding procedures must take place to ensure that there are clear references in the procedures at key points about how to respond to any parent of carer of children threatening to kill themselves or others.

10. Arrangements for progressing recommendations and dissemination of learning

10.1 The Serious Case Review Sub Group of the Leicester Safeguarding Children Board (LSCB) will monitor the Action Plan arising from this Serious Case Review at its monthly meetings. The SCR Sub Group will recommend to the Board publication either of the full overview report or the Executive Summary. Consideration will be given to protection of confidentiality for surviving family members. Action Plans will be published in full.

10.2 Key messages will be shared at a full Board meeting with the expectation that safeguarding leads will then disseminate learning within their own agencies. Briefing packs will be made available to support them in this task.

10.3 Learning will be included in the LSCB's monthly Research Digest. Report outcomes will be featured on the LSCB website and will also feature in a joint conference event planned for February 2012.

10.4 The Procedures and Development sub group of the LSCB will consider whether any amendments/additions are required to LSCB procedures in light of learning from this case.