LOCAL SAFEGUARDING CHILDREN BOARD

Serious Case Review in relation to Clare and Ann

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A. INTRODUCTION

1. Why this case is being reviewed

1.1 In February 2015, the mother of two young children aged 4 and 18 months, killed her oldest child alongside the children's father and also seriously injured the youngest child, whilst she was experiencing an acute psychiatric disorder. The family had been known to local statutory agencies but had never met the criteria for any formal child safeguarding interventions.

1.2 Given the circumstances, the Local Safeguarding Children Board for Hammersmith and Fulham, Kensington and Chelsea, and Westminster (the LSCB) concluded that the criteria for undertaking a Serious Case Review had been met. The criteria, which are set out in *Working Together to Safeguard Children* are as follows:

> *(a) abuse or neglect of a child is known or suspected; and*
>
> *(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.* (*Working Together to Safeguard Children, (*2015:75*)*

1.3 The death of the children's father is also the subject of a Domestic Homicide Review (DHR) which has been commissioned in parallel by the Royal Borough of Kensington and Chelsea Safer and Sustainable Communities Partnership. The Safer Communities Partnership (CSP) and the LSCB agreed to commission the two Reviews together, in order to maximise learning and ensure the best use of resources. Two separate reports will however be produced, given the different methodologies being used, which is detailed further in Appendix 2.

1.4 The two children will be referred to as Clare and Ann within this report

2. Succinct summary of the case

2.1. Clare and Ann lived with their mother throughout their lives prior to the incident. Their father was understood by agencies involved at the time to live locally and to be having contact with the children. It was never entirely clear to those agencies how frequent or regular that contact was, where the father lived or what the nature of the adult relationship was. Information since provided by the father's family was that he did in fact live with Clare, Ann and their mother and was significantly involved with the children. The mother and children were well established in their locality with maternal grandmother living nearby. The Police and then Children's Social Care (CSC) became involved with the family following

low level allegations of drinking and domestic abuse. Two assessments were undertaken by CSC and for a brief period in 2014 a Child In Need[1] plan was put in place. The children were seen regularly by the Health visitor and Clare was a pupil at the local school

2.2. Prior to the events leading to the death of the children. the mother visited her GP with symptoms of anxiety and distress. A few days later she attended the mental health '*walk in centre'* at the local hospital displaying much greater anxiety and symptoms of psychosis. While the doctor was seeking advice about the next steps to take, Mother left the hospital and did not return. Approximately one week later, the Mother attended A&E with Ann, who had a number of infected wounds to her chest. Later that day police forced entry to the family home where Clare and her father were both found to be dead.

2.3. The mother was charged with the murder of both her daughter and her partner. At a court hearing in the autumn of 2015 she was found not guilty of murder on the grounds of insanity and given a Hospital Order to be detained indefinitely in a Secure Unit. Psychiatric reports prepared both by the prosecution and the defence had concluded that at the time of the killings she had been suffering from an abnormality of the mind (a psychotic mental illness).

3. Family Composition

Child 1 – Clare
Child 2 – Ann
Mother
Father
Maternal Grandmother, resident locally

3.1. No information was known to the services at the time about the father's family, although it is now known that the father had a number of family members living locally. The father was also known to the police by a number of different names.

3.2. The children have been identified as Black British. Their mother describes herself as mixed heritage of Afro-Caribbean and Irish descent. The father is Black, of Jamaican heritage. His nationality was unclear to

[1] Section 17 of the Children Act 1989 defines a child as being in need if s/he is under 18 and either

- s/he needs extra help from Children's Services to be safe and healthy or to develop properly; or
- s/he has a disability

Children's Services are required to assess these needs and draw up a plan to support the child and family.

professionals at the time but has since been confirmed as Jamaican, but he had been living in the UK for several years.

3.3. The mother identifies as Christian and attended local churches. Information provided by the father's family is that he also attended a local church on occasion. There is no information suggesting that the father or children had any physical or mental health issues. The mother is known to have some history of anxiety.

4. Time Frame for Review

4.1. The Learning Together model, in line with systems models generally, works best when reviewing in detail a period of no more than two years, in order to discover how systems are currently (or recently) operating. Scrutinising the work of agencies further back in time is unlikely to achieve useful systems learning, given the inevitable changes in personnel, local arrangements, and national guidance, regulations and legislation. The timeline for review in relation to this family begins at the point at which Ann was born and ends after Clare and her father were discovered and Ann's safety was secured.

4.2. This SCR therefore examines professional practice from all agencies with the C Family between:

July 2013 and March 2015

5. Key Dates Table

Date	Event
July 2013	**Ann (second child) born**
End July 2013	Health Visitor (HV) initiates a CAF[2] (Common Assessment Framework) assessment as Mother wants to apply for a nursery placement extension for Clare
31.07.13	Police undertake a welfare visit following an anonymous call from a neighbour Children both safe and well. Notification sent to Children's Social Care (CSC)
02.08.13	Referral from police received by Children's Social Care. Checks undertaken, HV informed
05.08.13	(HV) is notified that the extended nursery place has been approved.
09.08.13	Social Worker (SW) undertakes home visit, assessment recommended.

[2] The CAF is a shared assessment and planning framework used by all children's services in England. It is used when it is believed that a child has additional needs. The assessment identifies what those needs are and co-ordinates services who can work to meet the needs. The process is a voluntary one which requires the consent of the child's parents or guardian.

21.09.13	Father reports to the Police that he has been assaulted. No further action taken.
23.09.13	Clare starts nursery and disclosure by Clare to staff of domestic abuse at home
09.10.13	Social Work assessment completed. HV continuing to work with family. Case closed
16.01.14	Maternal grandmother calls Police while drunk, saying her daughter in an abusive relationship. Police also called by mother. Police attend. Welfare Check is undertaken and the children are seen as well/asleep. Notification made to CSC. Enquiries made by CSC. No further action
08.05.14	Mother calls police. Father would not leave the house. Police attended, father left. Recorded as non crime domestic incident. Children asleep and well. Notification made to CSC who decide to visit and undertake an assessment.
18.07.14	Child in Need assessment completed by SW.
06.08.14	Network meeting takes place (as part of the Child in Need plan) with parents, children, HV and SW. This is the first time professionals meet the father.
08.09.14	Clare starts at reception class
10.09.14	Father cautioned for possession of cannabis with intent to supply.
29.09.14	Mother attends 'Strengthening Families programme'. Only attends one session.
03.10.14	Father stopped by police for drinking alcohol. No further action taken.
10.11.14	Review network meeting held for Child in Need plan. Positive feedback, no new concerns. All agree to close the case.
25.01.15	Hospital doctor contacts police about father who had been admitted with eye injury following an assault.
05.02.15	Community nursery nurse undertakes home visit to advise mother about breast feeding.
February/March 2015	
Day 1	School meeting with mother about Clare's low attendance (91%)
Day 4	Mother attends surgery and seen by GP. Anxious, low and depressed. GP does not identify any immediate risk or current psychosis and makes a referral to the primary care mental health team, marked urgent.
Day 5	Clare not in school. Message left for mother (last day before half term)
Day 8	Primary care mental health team triages the GP referral (3 working days)

Day 9/10	Mother presents at Urgent Care Centre[3] at St Charles Hospital with symptoms of anxiety and is taken to the Mental Health Unit by one of the nurses. She becomes increasingly distressed and is expressing paranoid thoughts. She makes a number of calls to 999 and the out of hours GP service. Mother is seen initially by a nurse, later by a doctor but leaves the unit while the doctor is taking advice re next steps and cannot be found. The nurse contacts the police to undertake a Welfare check The Police initially say they will do the check, but later phone back to say they will not.
Day 11	Primary Care team make unsuccessful attempt to contact mother by phone
Day 11/Day 12	**Believed Date of deaths – not known at the time**
Day 15	Primary Care Liaison nurse attempts to undertake a home visit in response to the GP referral. No response. Clare is absent from school again and said by mother to be with father.
Day 16	Further attempts to contact mother including Second home visit attempted by Primary Care Liaison nurse and Consultant Psychiatrist. No response
Day 18 8.40pm	Mother brings Ann into St Mary's A&E with chest wounds. Staff concerned about circumstances. Duty Social work team informed.
Day 19 am (Friday)	Hospital informs CSC about Ann and concerns about Clare's whereabouts. SWs visit Mother on ward and agree to have strategy meeting on Monday re Clare.
am	School contact SW due to Clare's non-attendance since 12 Feb. CSC attempts unsuccessfully to locate Clare.
5pm	Paediatrician calls Police CAIT due to increasing concern re Clare. Police attend house and discover bodies of Clare and her father.

6. Organisational Learning and Improvement

6.1 Statutory guidance on the conduct of learning and improvement activities to safeguard and protect children, including SCRs states:

> *'Reviews are not ends in themselves. The purpose of these reviews is to identify improvements that are needed and to consolidate good practice. LSCBs and their partner organisations*

[3] Urgent Care Centre – direct access health facility providing assessment and treatment of minor illnesses and injuries provided by the CLCH NHS trust within St Charles Hospital.

should translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.' (Working Together, 2015:73)

6.2 The Local Safeguarding Children Board identified that this SCR held the potential for learning. In particular it was agreed to explore the following questions:

1. How effective is the multi-agency safeguarding children system when working with families who come in and out of services?

2. How effective is the relationship between Adult Mental Health services and Children's Social Care with regards to safeguarding children?

3. How does the multi-agency safeguarding children system identify, assess and manage the risks of harmful traditional practices?

4. What can be learnt from this parallel DHR and SCR approach about shared Strategic and Operational work between the Safeguarding Children Board and the Community Safety Partnership?

5. How do partners respond to disclosures by children?

At the outset of this Review information was provided which raised the possibility that harmful traditional practices may have featured in the assaults on Clare and her father and led to question 3 (above). It however transpired that this was not the case and therefore this is not something which has been a focus for this review.

7. Methodology

7.1 Statutory guidance in *Working Together* (2015) requires SCRs to be conducted in a way which:

- *recognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings*. (2015:74)

It also states that the following principles should be applied by LSCBs and their partner organisations to all reviews:

- *there should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;*
- *the approach taken to reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;*
- *reviews of serious cases should be led by individuals who are **independent** of the case under review and of the organisations whose actions are being reviewed;*
- *professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;*
- *families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.* (2015:73-74)

In addition, SCR reports should

"…*be written in plain English and in a way that can be easily understood by professionals and the public alike*" (2015:79)

To help all readers, a glossary (of acronyms and terminology) is provided as **Appendix 1** of this report.

7.2 In order to comply with these requirements, the LSCB has chosen to use the Learning Together systems model (Fish, Munro & Bairstow, 2009), developed within the Social Care Institute for Excellence (SCIE). A Learning Together review process is based on several key principles:

1. **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time. In particular, explore what sense they were making of the case, and the contributory factors which were influencing their practice at the time.
2. **Provide adequate explanations** – appraise and explain decisions, actions and inactions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it.
3. **Move from individual instance to the general significance** – provide a 'window on the system' that illuminates what supports and what hinders the reliability of the multi-agency CP system.
4. **Produce findings and questions for the Board to consider**. Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult issues.

5. **Analytical rigour**: use of qualitative research techniques to underpin rigour and reliability.

   Details of the model and this process are contained in **Appendix 2** of this report.

8. Reviewing expertise and independence

8.1 **Lead Reviewers:** The SCR has been led by two people independent of the case under review and of the organisations whose actions are being reviewed. Sian Griffiths and Deborah Jeremiah are both independent consultants, accredited to carry out SCIE Learning Together reviews, and with extensive experience of writing SCRs/IMRs under the previous 'Chapter 8' framework in *Working Together* as well as other Reviews. Neither had any knowledge of or involvement with this case prior to the review.

The lead reviewers have accessed quality assurance from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and reliability of the findings as rooted in the evidence.

The Review has been authored by Sian Griffiths.

8.2 **Review Team:** The Review team which worked with the lead reviewers was comprised of **12 senior managers or senior professional leads** from the multi-agency services involved with the family. Their role was to provide a source of high-level strategic information about their own agencies, as well as professional expertise in their fields. Together with the Lead Reviewers, they collected data about this case, including a review of agencies' records, and produced and agreed the content of this report.

8.3 **Case Group:** The second important group taking part in the case review were **15 front-line professionals and first-line managers** who had worked with the family in different capacities. They provided a detailed picture of what happened in the individual case; in addition to their work with the family, they brought their wider experience of working within local systems, through a range of cases. To achieve their involvement in this case, members of the Review Team held individual conversations with the Case Group professionals. Members of the Case Group also attended a full-day Workshop to respond to the analysis and emerging findings from the Review Team and Lead Reviewers.

9. Methodological comment and limitations

9.1 **Participation of professionals:** The review benefitted from a very positive and open level of participation by the professionals involved with the case. The Review team also participated well although there were some gaps due to changes in role and sickness absence. This did have an impact on the progress of the report as one of the review team members concerned was representing a key agency.

9.2 **Joint work relating to Domestic Homicide Review:** The work undertaken on behalf of the Domestic Homicide Review also provided further information that was available for use within the Serious Case Review. The two reviews were conducted as closely together as possible and reached fundamentally similar conclusions. The methodologies used by the two Reviews however are of a significantly different nature and have focussed on different elements of the case. As such there are differences in emphasis and detail, however, there is a strong shared approach to the underlying learning.

9.3 **Contact with family members:** The mother of the children and the father's sister both contributed to this review. Other family members, including the maternal grandmother had also been contacted to ascertain if they would be willing to contribute to the review, but were unwilling to do so. This inevitably leads to gaps in our understanding of the family situation and what other help they may have benefitted from.

B. FINDINGS

10. Introduction

10.1 Statutory guidance requires that SCR reports *'…provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence (*Working Together 2015:79*).*

These processes should be transparent, with findings of reviews shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone across the country has an interest in understanding both what works well and also why things can go wrong.' (Working Together 2015:72)

10.2 The Findings Section, which represent the main body of the report, begins with the contributions and then moves on to produce an **appraisal of practice**. This sets out the view of the Review Team about how timely and effective the interventions with the children were, including whether practice fell below expected standards. Where

possible, it provides explanations for this practice, or indicates where these will be discussed more fully in the detailed findings.

10.3 A bridging section (**What is it about this case that makes it act as a window on practice more widely?**) explains the ways in which features of this particular case are common to other work that professionals conduct with children and families, and therefore how this one case can provide useful organisational learning to underpin improvement ('a window on the system'[4]).

10.4 Finally, the report discusses in detail the **4 priority findings** that have emerged from the SCR. If professional practice was not more effective in protecting the children in this case, the findings examine why that was. It also outlines the evidence that indicates that these are not one-off issues, but underlying patterns – which have the potential to influence future practice in similar cases. We also consider what risks they may pose to the wider safeguarding of children.

11 Contribution of family members to the Review.

11.1. Family members are wherever possible invited to participate in a Learning Together review. Their experiences of services and the professionals involved with them are the source of important insights for the review process. In addition, they may offer a clearer, and possibly different, picture of what was 'going on for them' during the time covered by the case review.

11.2. **Contribution by the Mother:** In this case, mother was offered the opportunity to meet with the two Lead Reviewers and agreed to do so at an early stage. She was able to give a useful account of her views about services, and significantly added to our understanding of her perspective on the family's experience. What mother told us is woven into the body of the report where this is relevant to the learning. Her perspective on family life, particularly her relationship with the father are also summarised here.

11.3. The mother met with the lead reviewers while she was awaiting the criminal trial and with the agreement of her Consultant Psychiatrist. The mother spoke with considerable anger about her relationship with the father and said that he did not treat her well. She described their relationship as sometimes being violent and she believed that he was having relationships with other women. She asserted that there was a lot that services did not know about the father, and for example told us that he lied to her and she did not even know his true age or name.

11.4. Several attempts were also made to contact the maternal grandmother and a member of the father's family, initially unsuccessfully and this

[4] Vincent, C., 2004

Review was presented to the Local Safeguarding Children Board without their contributions from the father's family.

11.5. **Contribution by the Father's family:** In the summer of 2016 the father's sister did agree to contribute to the Domestic Homicide Review which had not at that point been finalised. She also agreed that her contributions could be shared with the Serious Case Review, and as a result it has now been possible to include a perspective from the father's family in the final version of the SCR. Where the information provided by the sister contributes to our understanding of the quality of services involved it is woven into the following sections. A level of detail about the father is included here however, as it contributes to our understanding of the family dynamics and how this may have impacted on the services ability to work with the family in a way that would otherwise not be possible. Services at the time were predominantly reliant on the views of the mother about what was happening in the family and were not aware of the situation as seen by the father or his family.

11.6. What is of particular significance is that the information provided by the the father's sister has demonstrated that he played a fundamentally different role with his children than was portrayed at the time. The picture provided, primarily by the mother, was that the father did not live with the family and had limited involvement with the children. However, this is far from supported by the father's sister. She instead was quite clear that the father lived as part of the family with the mother and children and had a proper parental bond with both children. The two families of the mother and the father, in fact evidently knew each other well and frequently spent time at weekends or during various family occasions. The sister described an increasingly difficult relationship developing between the parents. Both, but particularly the mother, were drinking too much. There were frequently loud arguments, sometimes resulting in the father going to stay with his sister for a couple of nights. These arguments were becoming considerably worse and included the mother threatening to kill the father.

11.7. It should be noted focus within this report is on the outcome for the children, with the implications for the father being the remit of the Domestic Homicide Review. However, it is nevertheless important to provide a more balanced picture of the father's experience. The author of this review is therefore particularly grateful for the contribution of the father's sister.

11.8. It is difficult to overstate the highly distressing nature of what happened to these two children and their father and the impact it has had on so many people, but particularly for their family members. The profound condolences of this Review go to them.

12. Appraisal of professional practice in this case: synopsis

12.1 Introduction

12.1.1. The death of Clare and serious injury to Ann, alongside the death of their father was devastating to all concerned. This was particularly so because of the level of violence involved, but also because of the sense of shock both in the community and for professionals that the mother in this case could take such extreme actions. For much of the lifetime of these two children there was limited involvement from agencies other than universal health services and the school. For a very short period, Children's Social Care was involved with the family on a voluntary basis, but this had ended several months before the events that led to this SCR.

12.1.2. This case has provided a far from unusual picture of a family who experienced occasional stresses none of which reached statutory safeguarding thresholds, but which did lead at one point to a multi-agency response to help support both children and parents on a voluntary basis with a Child in Need plan. What is however highly unusual in the context of this case is the devastating outcome for the children and their father, an outcome which could not have been anticipated from any of the information known about them at the time. This judgement will be explained in more detail in **Section 12.**

12.1.3. This appraisal of practice sets out the Review Team's views about the way in which agencies and services carried out their roles and responsibilities. It identifies why things happened as they did and therefore helps us to identify any patterns in the safeguarding system which have significance beyond this individual case.

12.2 The concerns raised about the family from neighbours and from the parents themselves between July 2013 and January 2014.

12.2.1. The review period begins with Ann's birth in July 2013. The Health Visiting service was involved with the family as a matter of routine and the only concerns at this stage were to support the mother to access an extension to the nursery place for 3 year old Clare. There had been a recent change of Health Visitor, but this had been managed well, and the new Health Visitor quickly established a good relationship with the family that was appreciated by the mother. Although the Health Visitor was new in this role, she was an experienced health professional, who herself was well supported, and demonstrated strong skills in working with families.

12.2.2. The Health Visitor was aware that the mother had spoken about domestic abuse in the past but the mother said this was not a current concern and that she was not now in a relationship with the children's

father. From the outset the Health Visitor observed good care of the children and good attachment to their Mother. She followed expected professional practice in regularly checking the mother's mood which was at times low. This was at the time not unduly concerning given the stresses of being a single parent, which is what the mother led her to believe. It is evident that the Health Visitor offered a good level of support to the mother and children throughout her involvement.

12.2.3. Shortly after Ann was born the police visited the family following a call from a neighbour complaining about loud music and stating that Mother had been drinking beer while breastfeeding. In line with required practice, the police gave advice, checked that the children were safe and well and then notified Children's Social Care of their involvement. The notification was forwarded to the MASH (Multi Agency Safeguarding Hub) whose role it is to assess referrals as they first come in and provide their assessment to the locality CSC team. The MASH undertook checks with the nursery and health visitor who advised that there were no immediate risks to the children. Nevertheless, because of the existence of some historical concerns about the mother's alcohol use and relationships, the CSC locality team decided to undertake an initial assessment. This decision was good practice and was taken in the context of a well-resourced, stable locality team with experienced managers and a focus on good practice. **The ability of CSC to provide a proactive approach to families with extra needs is explored further in Finding 1.**

12.2.4. The Social Worker was aware of the previous allegations of domestic abuse, but the mother stated that this was not a current problem and that her own mother could help facilitate the children's contact with their father who she said did not live with them. The children were seen by the Social Worker who judged them to be well cared for and attached to the mother, an assessment which was confirmed by the Health Visitor. Information provided by the mother about the children's father was vague and this was also reflected in the Health Visitor's experience. The Social Worker would ideally have liked to have more information about the father as well as contact with the maternal grandmother but the mother would not or could not give any contact details for him.

12.2.5. The decision by the Social Worker, supported by her manager, to close the case was in line with proper standards of practice. The family's vulnerabilities were recognised and explored, but in the absence of parental consent to allow further enquiries or to agree to further support from CSC and given the low level of the concerns raised, there would have been no legitimate reason for further intervention by CSC. The decision also took into account that Health Visiting services remained involved with the family and therefore would be able to play their part in monitoring any further safeguarding concerns.

12.2.6. No concerns about the family were identified during the next few months. The school designated safeguarding lead and headteacher monitored Clare's progress initially because they were aware of vulnerabilities for another pupil who was part of the wider family. However, there was no evidence for concern with Clare. The Health Visitor remained regularly in contact with the family. She also routinely saw them on their way to school as she was going to work. The children were consistently well cared for and Mother presented as physically well and positive.

12.2.7. However, unknown to any of the other professionals, in September 2013 Clare had made a disclosure at the nursery about witnessing domestic abuse in the home. The nursery staff kept their own separate log, which was not part of the school's recording systems, in which they recorded her telling them: "*my mummy doesn't like my daddy and my daddy doesn't like my mummy….daddy wants to kill my mummy. There's a knife in my house. That's why we had to go to my nanny's house to look after my mummy*". When the staff member had asked what happened when the adults fought Clare said '*daddy kills mummy….daddy kicked mummy and mummy had blood on her head…".* The nursery staff later explained that they had not told anyone at the time because it was during a settling in period in the school when '*children can say random things*'. As Clare did not refer to any further incidents, they did not feel it necessary to share the information with the safeguarding lead or the headteacher.

12.2.8. This clearly did not meet required safeguarding standards and was poor practice. The information should have been shared immediately with the school safeguarding lead and headteacher. When the information emerged in May 2014 the Headteacher took immediate action and shared the information with CSC. This will be considered further in Section 12.

12.2.9. In January 2014 the police were again called to the home, on this occasion by the mother who wanted the father to leave. The same evening the police were separately called by maternal grandmother stating that she was worried about her daughter who she believed was in an abusive relationship. The police attended the family home with the grandmother. They found that the father had left and the children were asleep in bed with no evidence for concerns. The police again followed proper procedures; notified Children's Social Care and recorded the incident as a 'non-crime domestic incident'.

12.2.10. The notification was again referred to the MASH who assessed that as the incident was limited to a verbal argument and, taking into account the previous assessment, concluded it did not meet the threshold for further assessment. The information was shared by the MASH with the Health Visitor. The Review judged that given the

information available at that time this was a defensible decision and also that it was clear evidence of routine multi-agency safeguarding processes working effectively.

12.3 <u>The third notification to CSC and the resulting decision to put in place a Child in Need Plan</u>

12.3.1. In May 2014 the mother again called the Police saying that the father and she had been drinking together but he was now refusing to leave the home. The Police attended and identified that the father was drunk, but he agreed to leave the flat. They once again checked the children who were asleep and well, they notified Children's Social Care and recorded this as a 'non-crime domestic incident'.

12.3.2. On receiving the notification, the MASH again contacted the Health Visitor. Although, as was previously the case the incident itself did not meet the threshold for statutory intervention, the MASH concluded that there were concerns about the repeated pattern of notifications and recommended that the locality team undertake an assessment. The practice manager at the locality team also recognised that this was a family where potential low level domestic disputes could be detrimental to the children's development and therefore allocated the case for assessment. The response by both the MASH and the locality team was good practice in that it took a holistic view of the information available about the children's experience rather than focussing only on the individual incident and whether that alone met their thresholds for assessment.

12.3.3. The case was allocated to a newly qualified Social Worker who the Practice Manager felt could bring the time and enthusiasm to working with a family presenting this level of concern. Information about previous allegations of domestic abuse and alcohol use were outlined in the assessment, as were the disclosures made by Clare at nursery the previous year which were uncovered by the school at this point. The assessment also identified concerns about the mother's honesty regarding her relationship with the father and some pattern of possible alcohol misuse. CSC was not in a position to initiate other background checks, for example regarding mother's mental health, as the concerns could not be said to meet the threshold for significant harm and the mother's consent would therefore be needed to make such enquiries. The recommendation was to initiate a Child in Need Plan. This assessment met expected practice standards within RBKC and again demonstrated a focus on best practice and a commitment to engaging with families at an early stage.

12.3.4. Despite some reluctance on the part of the mother to agree to involving him, the Social Worker was determined to meet the father, as Clare had talked of being frightened of him and the Mother was describing problems in managing his contact with the children. The

Child in Need plan which was agreed at the first network meeting in August was focussed on assessing the father's relationship with the children, helping to resolve the contact difficulties and accessing appropriate support for the parents. Both parents attended the Network meeting along with the Social Worker, the social work team manager and the health visitor. The father's attendance at the meeting was significant as it was the first time he had been seen by the professionals who were able to observe that the children were pleased to see him and appeared to have a good attachment with him.

12.3.5. The Social Worker continued to work with the parents both to observe the children with their father and to attempt to help them to resolve the difficulties over the arrangements for the children to spend time with him. Contact with the father and children was observed again and was positive on both occasions. The parents were able to reach agreement about how the father's involvement should proceed and there was no further evidence of disputes which might affect the children. The children were consistently seen to be well cared for, the home conditions were good and there was no evidence that the children were experiencing harm. The father said nothing to the Social Worker to contradict the mother's description of his role in the family. The Social Worker had some concerns about the Mother's depression and had advised her to speak to her GP, but she did not do so.

12.3.6. The network meeting for the Child in Need plan unanimously agreed that the case could be closed. There was evidence of improvements in the parental relationship, the children presented as happy and well cared for and the mother wanted to bring an end to CSC involvement as she found this stressful. There were still some gaps in information that the Social Worker was aware of, for example the father would not disclose his address, but nothing that could justify a more intrusive response by Children's Social Care. Judged against what was known at the time the Review team are in unanimous agreement that the decision to close the case was a reasonable one.

12.4 Mother presents at the GP surgery in February 2015 with symptoms of stress and anxiety.

12.4.1. On Day 4[5] the mother attended the GP surgery with Ann without an appointment and demanded to be seen. The positive working relationship and trust between the GP and the receptionist meant that this was well handled and the GP's appointment schedule was managed to give her the time she needed. The consultation as a result lasted 30 minutes not the usual 12 minutes allowed for a

[5] From this point onwards the days are referred to numerically, rather than by date to minimise the identification of key personal information.

planned appointment. From her previous contact with the Mother, including an appointment she had had a couple of months previously and by checking her records, the GP was aware she could be anxious, but nothing that made her stand out from a lot of patients, particularly single mothers with young children. The GP had no reason to question the mother's description of the family situation.

12.4.2. The Mother described anxiety and feeling low for several months as well as a lack of sleep due to breast feeding which meant she was struggling to cope. The GP assessed her using the correct assessment tool which confirmed her view that the Mother did need further help and support, but that there was no evidence of serious mental health problems or psychosis[6]. The mother did refer to having had thoughts about aliens, but in the context in which this was said, it was not something that gave the GP particular concern. The GP was familiar with working with patients with mental health problems and anxiety and aware that it is not uncommon for people to express what might seem odd beliefs or thoughts, but that this in itself would not indicate a serious mental health problem or reason to consider she might present a risk.

12.4.3. The GP explicitly assessed how the mother's feelings might be impacting on the children. She observed that the mother was very responsive to Ann's needs and safety while in the surgery, despite her own distress. The mother was also explicit that while she sometimes had thoughts about '*giving up*' she had no active plans to do anything and indeed would not because of the children. The GP identified no evidence of hallucinations or psychosis and also that there were social and personal factors that would explain the mother's anxiety and low mood. She prescribed anti-depressants and completed a referral to the Mental Health Primary Care Liaison Team[7] marked urgent, as from experience she believed that this was the quickest way to access support for mother.

12.4.4. The mother stated in interview that the GP had not phoned her the next day as she had promised. However, the evidence suggests that this is inaccurate. The GP did not have Mother's current mobile phone number but asked the mother to ring her as soon as she got home so that she could have the correct number. The GP did obtain the correct phone number and ensured it was recorded. The GP also gave mother information about the Urgent Care Centre[8] and the GP out of hours number (111) in case she felt she needed help out of surgery hours. Irrespective of what is subsequently known about the outcome for this

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[6] See Psychosis and Schizophrenia in Adults: prevention and management. NICE 2014.

[7] The Primary Care Liaison team (PCLT) is a GP commissioned service provided by CNWL NHS Foundation Trust. It provides time limited mental health support services in the community.

[8] Urgent Care Centres are NHS centres accessible without appointment to the public which deal with minor injuries and illnesses. The Urgent Care Centre at St Charles Hospital is a commissioned service run by Central London Community Healthcare Trust (CLCH)

family, the GP's practice was of a very good standard; her assessment was evidence based, she provided extra time and care to the mother despite the impact on her working day and sent a detailed urgent referral to the appropriate service which included reference to the mother's comment about aliens. This referral was described by the Primary Care Psychiatrist who received it is as of a very good quality and directed to the appropriate service.

12.4.5. The referral was e-mailed immediately to the Primary Care Liaison Team. The team's service standards are to respond to any referral marked urgent, as this was, by telephone triage within 5 working days. The referral was screened on Monday, after having been received on Thursday, and forwarded to the next level for a telephone triage. Attempts were made to contact the mother by phone, in line with the service standards, but this was not successful. It was agreed that the nurse would continue to try to make contact and that the Consultant Psychiatrist in the team would see her the following week. Attempts to make contact by phone and subsequently two home visits were unsuccessful and on Day 16 the nurse contacted the GP to inform her and checked that there were no further concerns, which the GP confirmed.

12.4.6. The GP was frustrated by the length of time that the Primary Care Liaison Team took to get in contact with her as the referral form stated that the patient would be contacted within 3 working days, but in fact they were working within their service standards and had gone to some trouble to try to establish contact with the mother. What neither the GP nor the Primary Care Liaison Team knew at this point was that the mother had in the meantime presented herself at an Urgent Care Centre and from there to the acute mental health hospital, St Charles, with explicit symptoms of paranoia and psychosis. **This will be explored further in Finding 2**.

12.5 The mother attends the Urgent Care Centre and is taken to the mental health unit at St Charles.

12.5.1. During the evening of Day 9, the mother attended the Urgent Care Centre provided by CLCH based at the St Charles Hospital complaining of dizziness and anxiety. She was taken by a nurse to what was known as the '*walk in centre'* at the Mental Health Unit, run by CNWL NHS Foundation Trust on the same site and at that point presented as '*guarded but calm'* and did not present as being high risk. Due to her primary work commitments, the Duty Nurse at St Charles was unable to undertake an assessment on the mother until 11pm, 2 hours after she arrived in the unit, but kept checking her during the evening and asked the security guard to keep an eye on her and inform her of any changes.

12.5.2. The Duty Nurse's initial assessment recorded the mother was experiencing paranoid thoughts and a fear that she would be harmed, but also that she would had no intention to harm herself or others. The nurse specifically asked about her children, and was reassured that they were with their grandmother, but considered this needed checking. The nurse's assessment was of a good quality given the context in which she was working and the fact that she was unable to access any of the mother's medical records as part of her assessment. However, the lack of any information about her medical history, including her recent presentation at the GP's inevitably limited that assessment. **The issue of access to health records is explored further in Finding 2.**

12.5.3. The Nurse asked the Duty Doctor to see the mother but he was unable to do so until about 2am, meaning there was a further delay. In the interim the mother made a number of phone calls to the GP Out Of Hours number and to the Police by ringing 999. The GP Out Of Hours service properly called St Charles Hospital to confirm that she was waiting for assessment. The mother was also spoken to by two police officers attending in relation to other patients. The officers sought and received assurance that the mother was receiving attention.

12.5.4. When the Doctor came to see mother she was outside the main reception in the lobby and unwilling to come in to be assessed. She was by then seen by him to be exhibiting significant paranoid thoughts and behaviour and appeared frightened of something which she would not identify. The Doctor, who was a Specialist Trainee Level 2, was concerned by her level of agitation and went to seek advice from the on call Specialist Registrar. He and the Nurse returned to reception within 15 minutes but the mother had left and could not be found. The Duty Doctor's decision to seek advice was in line with expected practice and at that point there had not been reason to believe that the mother, who had attended voluntarily, would leave the unit. Further, the security guard who had been asked to keep an eye on her was asleep. The security guard was subsequently dismissed.

12.5.5. The mother waited approximately 5 hours in reception before she could be seen by a doctor for an assessment, during which period her condition was deteriorating and gave cause for concern to the police officers who spoke to her during her wait. This lengthy delay before the medical staff were in a position to see the mother, meant that this episode did not meet standards of good practice. **The implications of reliance on a non-commissioned, 'walk in' mental health service are considered in Finding 3.**

12.5.6. Immediately after the mother left the CNWL Mental Health Unit, the Duty Nurse contacted the Police and asked them to undertake a

welfare check on the mother and children. Although the Police initially agreed to undertake the checks, they later phoned back to say that this was no longer something they could do. The Police had recently reassessed their approach to undertaking Welfare Checks, focussing more explicitly on when such checks fell clearly within their core duties, although this was not something the Nurse had been informed of. However, from the evidence of the call made by the nurse, she had identified that her concerns may well have met these criteria and as such it is questionable whether this decision met the police's own practice standards. **The issue of a shared understanding of the criteria for police welfare checks and a clear pathway for agencies when police decline to undertake a welfare check is a key feature of Finding 4.**

12.5.7. The Nurse had an address for the maternal grandmother, but no phone number and therefore was not in a position to contact her herself, she therefore left information for the morning staff. What neither the Nurse nor subsequently the morning staff considered, was that they could or should contact Children's Services. The following morning daytime staff attempted unsuccessfully to speak to the GP to inform her of the mother's presentation. There was no formal requirement for them to do so, but best practice would have been to ensure that the GP was provided with the information. The lack of clarity about **follow up for voluntary presentations will be considered further in Finding 3**. The staff also made a referral for the mother to the Assessment and Brief Treatment Service, the secondary mental health service provided by CNWL for those needing more urgent assessment.[9] However due to a problem with how the referral was logged onto the patient information system, her details did not appear and no action was taken. The implications of **managing information within complex systems will be covered further in Finding 2.**

12.6. Clare's absence from school in February 2015

12.6.1. The day after the mother had presented herself to the mental health service at St Charles (Day 10), the school recorded that Clare was absent without explanation. This was the last day before half term. When school returned Clare still was not present and each day attempts were made to speak to the mother. On one occasion when the school receptionist spoke to mother she said that Clare was with her father, but that she did not know his number. She appeared irritated rather than worried and hung up the phone. By Day 18, her fifth consecutive day of absence, the Head Teacher was informed.

[9] Mental health services are provided by Central and North West London Trust and commissioned by Central London and West London CCG. The Primary Care Mental Health Services are provided by CNWL include Access to Psychological Therapies (IAPT) and the Primary Care Liaison Nurses Team. Secondary Care mental health Services include the Assessment and Brief TreatmentTeam.

He decided that a referral should be made to CSC the following day if she was not in school again.

12.6.2. The school had no reason for concern about Clare and had seen her with her mother the week before half term. Their persistence in following up Clare's absence, particularly as she was not of statutory school age and therefore not legally required to be in school, was good practice as was the Head Teacher's decision to refer to CSC on Day 19. Whilst it is now known that the mother had presented with serious mental health problems and that Clare had already been killed at this point, there would have been no reason for the school to take action any quicker given what was known to them at the time.

12.7 <u>Mother takes Ann to hospital with infected wounds to her chest.</u>

12.7.1. The response of all the agencies when Ann was taken into hospital by her mother in the evening Day 18 was of a good, often excellent standard. Her medical needs were responded to immediately and to good clinical standards. From the outset staff identified concerns about: mother's explanation as to how the injuries had been received; the delay in seeking treatment and the mother and child's unusual presentation. The on call Registrar contacted the Duty Social Work Team during the night and was given information that the family was known, but there were no serious concerns. The following day the Consultant Paediatrician who was responsible throughout the day for Ann's care immediately identified the need for background checks and as a result information about mother's presentation at the GP and the Mental Health 'Walk In' centre came to light. The locality social work team was informed first thing in the morning and the social worker who had previously been allocated came with a colleague to make further enquiries and attempt to locate Clare. A Strategy meeting was arranged for the next working day and was in line with required standards when there are concerns about an injury to a child. Arrangements were also made for a psychiatric assessment of the mother later that day.

12.7.2. The mother had told the professionals that Clare was with her father and had been since Day 4, but attempts to locate them by CSC and the police during the day were unsuccessful. By 5pm the Consultant Paediatrician had become increasingly concerned about Clare's whereabouts given the vagueness of the mother's explanations and contacted the police Child Abuse Investigation Unit direct, who agreed to treat Clare as a missing person. The police attended the family address in the early evening and on breaking into the flat found Clare and the father dead. Immediate arrangements were made to

secure Ann's safety and initiate the required Rapid Response procedure[10].

12.7.3. All the professionals concerned in the immediate hours and days following Ann's admission to hospital worked effectively, communicated well with each other and responded quickly to concerns. The Review team concluded that this represented a 'text book' response. In particular the Consultant Paediatrician identified the strong team working in paediatrics as being a significant factor in how effectively they were able to respond.

13. What is it about this case that makes it act as a window on practice more widely?

13.1. A fundamental principle of undertaking a systems review is to identify what it is about the particular case that provides us with wider learning about the effectiveness of the safeguarding system as a whole. Findings for the Board are identified arising out of the appraisal of practice those areas of learning that provide the most significant learning for wider practice are then prioritised.

13.2. At the outset of this Review it was expected that there would be learning about some particular features of multi-agency safeguarding in the Borough, including, but not exclusively the following:

- **The effectiveness of safeguarding with families who come in and out of services.**
- **The effectiveness of the relationship between adult mental health services and Children's Social Care.**
- **Strategic and operational working between the safeguarding children Board and the Community Safety partnership.**

As was anticipated, this case has identified learning regarding these three factors and therefore contributed to the Findings which follow in the next section.

13.3 The Review was provided with information at the outset which raised the possibility that features of this case could indicate the presence of **harmful traditional practices** and it was identified that this might lead to further learning in this area.

During the course of the Review however, it became apparent that this was not in fact the case, and therefore it is not something that has been explored further within this review.

[10] Rapid Response: Working Together 2015 requires all areas to have in place a Multi-agency protocol for responding to unexpected deaths in childhood.

13.4 **The response to a disclosure by one of the children**. At the outset a further area for potential learning related to the response of professionals to disclosures from children. A significant error was made by nursery staff in not disclosing that Clare had made comments about conflict and possible domestic abuse in the home. They had not done so because Clare did not subsequently make any further similar comments. However, this fell short of the requirements for education staff as outlined in the Statutory Guidance.[11]

The Review team considered whether there was information to suggest an underlying pattern or weakness in wider systems, which might contribute to our understanding of this error. However, no other information came to light during the course of this review that provided evidence that this was anything other than a misjudgement on behalf of particular individuals. As has been noted, the Headteacher in the school responded immediately on identifying this mistake by putting in place extra support and training for those concerned and ensuring the requirements for sharing information were understood. The Education member of the Review team described this incident as highly unusual, particularly in this school, in which she stated: "*practice is robust and the head has established an effective partnership with the local Social Work team"*. This judgement was also supported by Children's Social Care.

Examples of professionals either failing to properly record key information or take full account of what children are saying is a recurring feature of Serious Case Reviews at a national level. However, this Review has not identified any evidence that in this case the decisions taken represented more than an isolated incident and **as such no related finding has been made.**

13.5 In appraising the experience of this family the Review gave careful consideration to a specific issue which was of great significance in the family's story but nevertheless did not lead to a wider finding for the Board in relation to safeguarding systems. This was regarding the **ability of professionals to identify risk arising out of the mother's mental ill health.**

Two psychiatric assessments in relation to the mother were undertaken for the criminal proceedings. Both independently concluded that the mother was suffering from an abnormality of mind, paranoid psychosis, at the time she killed Clare and Clare's father. A central question for this Review has therefore been whether the professionals involved gave proper consideration to the mother's mental health needs and whether or not they could have identified that she was developing a serious disorder of this nature. The catastrophic and highly distressing outcome for this family has presented a

[11] DfE: Keeping Children Safe in Education, 2014 & 2015

particular challenge to the Review. All reviews are required to take into account the risks of hindsight bias when making judgements regarding standards of practice. In this Review it has also been especially important to be aware of the risk of 'outcome bias'. That is: knowing the outcome of a case, particularly when that outcome is so devastating, can affect our judgement of the practice at the time as well as our judgements about what should be done differently in the future.

The mother presented as experiencing some degree of anxiety and low mood during the time period under consideration. As has been outlined in Section 11, proper assessments were made and routinely reviewed by the Health Visitor and the GP who correctly referred her for a further psychological assessment. Prior to her presentation at St Charles Hospital, no evidence of serious mental disorder was apparent. At St Charles Hospital the Duty Nurse and Duty Doctor recognised the developing level of her psychological distress, that this had paranoid features and that the mother might pose a risk to anyone she felt threatened by, but were unable to conduct a full assessment. It is the clear conclusion of this Review that the health professionals concerned made reasonable judgements about the nature of her mental health given the information that was available to them at the time. The mother during her contribution to this review described an increasing level of anxiety during the final few months prior to the events in February, but was only conscious of feeling more unwell for about a week beforehand. She told this Review that she had not felt able to be truly honest with professionals about the thoughts and feelings she was experiencing. There is no evidence to suggest that the potential for the mother to become psychotic was missed.

Guidance from the National Institute for Health and Care Excellence, NICE[12] summarises the approach to recognition and treatment of Psychosis and Schizophrenia in adults. It identifies that the initial symptoms which may occur prior to a first psychotic episode can last for anything from a few days to 18 months. These can include '*positive symptoms'* such as hallucinations and delusions, and '*negative symptoms*' such as emotional and social withdrawal. These symptoms will be unique to each individual and, for some, the first acute episode of psychosis may take place without any obvious symptoms. What is apparent is that identification of the early onset of psychosis is far from straightforward and ultimately requires a full psychiatric assessment. '*The prepsychotic phase is often prolonged and characterised by subtle and confusing symptoms'*.[13]

Research in relation to whether there is a correlation between psychosis and increased risks of dangerousness has identified there

[12] NICE (2014:4)
[13] McGorry, P et al (2005)

are some statistical links[14]. However, it is crucial to note that even at the point at which the possibility of a psychotic episode is identified, this does not in itself mean that a particular individual presents a serious and immediate risk or that accurately assessing the level of that risk can be guaranteed. It is well recognised that in risk assessment the '*past is the best guide to the future*' and that '*…it is almost impossible for a patient to be rated as presenting a high risk of violence without a history of actual or threatened violence*'[15]. Research regarding filicide and maternal ill health also presents a complex picture and identifies that "*few studies have been able adequately to assess the relationship between filicide and mental health*"[16]. The authors further identified that '*understanding the risk factors for filicide….is far from complete'* .

The reality in this case is that the degree of the risk posed by the mother could not have been anticipated by those who had contact with her at the time. Nor does the case raise a general issue about the identification of psychosis and any risk to children more widely. This is a conclusion that has been explored in depth during this Review, supported by psychiatric opinion and is unanimously shared by the Review Team. A clear decision was therefore taken that it would be inappropriate to produce a finding regarding early identification of acute mental health related risks in such circumstances. However, access to a full Mental Health assessment and the implications of delay are considered further in **Finding 3.**

13.6 As a result the **4 findings** for the Safeguarding Children Board and partner agencies as follows:

[14] Maden, T (in Kemshall and Wilson, 2011) & Walsh et al (2002)
[15] Maden, T (p107)
[16] Flynn, S et al (2013)

Finding	**Typology** (see methodology, Appendix 2)
1. The commitment to developing and providing a proactive service at the point of referral in children's social work within RBKC optimises early intervention and assessment.	**Management Systems**
2. The inability of health professionals in RBKC to access records in a timely way can undermine their capacity to effectively assess patients and any risk they might present	**Tools**
3 There is a risk in RBKC that the focus given to safeguarding children is not fully integrated into systems for responding to parents who present in crisis with serious mental health problems.	**Management systems**
4. There is a lack of shared understanding across the partner agencies in RBKC about the purpose and processes for undertaking urgent checks on children whose carers present with significant concerns.	**Multi agency working in response to incidents and crises**

14. FINDINGS IN DETAIL

14.1 Proactive service at point of referral to Children's Social Care

Finding 1: The commitment to providing a proactive service at the point of referral in children's social work within RBKC optimises early intervention and assessment.

14.1.1 The ability of the safeguarding system to respond effectively and proportionately when there are low level repeating concerns about children, is recognised as a pressure point and is frequently a feature of Serious Case Reviews. Children's Social Care have established thresholds that need to be met for them to become involved, with those thresholds being higher if there is no parental consent. Such thresholds are intended to ensure that the involvement of a statutory body in families' lives is proportionate to the degree of concern about children. Identifying which children need help, in the context of the numbers of referrals that are made creates significant challenges for the safeguarding system.

14.1.2 How did the issue feature in this particular case?

Referrals to CSC raising low level concerns about the care of Clare and Ann were raised on three occasions during the 18 month period subject to this review. Individually none of these referrals identified concerns that would meet Children's Social Care's established thresholds for significant harm, which could have triggered a statutory intervention, such as a Child Protection Plan or Care proceedings. Despite the comparatively low level of concern the first of these referrals in July 2013 led to an initial contact and assessment and the third, in May 2014 also resulted in the decision to undertake a full assessment.

Both the MASH team and the practice manager on receiving the third referral reached the conclusion that despite the superficially low level concerns which led to the referral a more comprehensive assessment was justified. This was one of a series of referrals and in the Practice Manager's words "*there was the risk of ongoing exposure for the children to bickering parents".* At both points in the entry into the system it was recognised that such a pattern of behaviour required serious consideration irrespective of the seriousness of individual events.

The Practice Manager did not feel under any resource or target constraints in making this decision and presented as confident in the level of autonomy and responsibility for decision making that he had been given by the authority. The Social Worker was given adequate time and supervisory support to assess the family. The eventual closure of the case was based on a practice decision and the family's wishes, not as a result of other work pressures

being prioritised or other organisational constraints. That much of the picture the social worker, indeed all professionals, had been given of the family dynamics, now appears to have been fundamentally misleading, this should not be seen to detract from the good practice that took place here. Whilst it is now known there was a much more worrying situation in the home, this was consciously concealed from social workers and others by both parents. The social work staff had no legitimate basis for challenging what they were told, despite evidently having reservations about it, or taking other action at this point.

14.1.3 How do we know it has wider significance and is not peculiar to this case?

The practice approach in this case was described by all the social work professionals as being typical of the way in which their team worked and part of a sustained approach to best practice not only within their team, but across the borough. Both the social workers and their managers described a very stable team, with low staff turnover, access to good reflective supervision and peer support and a commitment to achieving best practice. Staff talked knowledgeably about the significance of issues such as domestic abuse and family conflict on children's development and the importance of intervening early in families where there were problems.

14.1.3. How prevalent is this and how widespread is the pattern – local, boroughwide, national?

Positive evidence has been provided to this review that the social work practice described in this case is representative more widely of work within the authority. The most recent OFSTED inspection[17] described RBKC as having an '*established culture of continuous improvement (which) means that the local authority and its partners, supported by a strong political commitment, are progressive in their desire and effort to build quality services.*' In October 2014 the authority launched 'Focus on Practice' to develop professional expertise amongst social workers and other related professionals in order to improve outcomes for children. The purpose of the programme includes more effective intervention with families in order to reduce re-referrals to services over the next 2-3 years. 'Focus on Practice' is outcome focussed and underpinned by an extensive programme of skills development, including coaching and the development of practice focussed career development. Initial auditing has identified very consistent levels of good qualitative work by social work teams and related professionals and evidence of significant change with 65% of families[18].

The picture of practice nationally is more variable. RBKC's ability to work in a consistent and intensive way is a reflection of a cultural approach that has been taken consciously at a senior level, but also benefits from the authority

[17] OFSTED 2012
[18] RBKC Practice Week Report May 2015

being in a position to resource a significant development programme, helped by funding from the government. Social work caseloads in RBKC are at a lower level than is the case in many authorities, contributing to the capacity to work intensively with families below the 'significant harm' threshold.

14.1.4 What are the implications for the reliability of the multi-agency child protection system?

The 'revolving door' syndrome, whereby families come in and out of service on a number of occasions before being identified as needing more intensive support or assessment, is a recognised feature of referrals to Children's Social Care. A recent report to ADCS identified that 23% of all referrals to CSC are 're-referrals' (second or subsequent referrals on a closed case within 12 months of the previous referral).[19] This is of concern because it highlights that for many of these families their needs are not being recognised and opportunities for early intervention therefore may be missed. It is also important in managing limited resources to avoidi the increased likelihood of expensive long term interventions with families in the future.

The provision of a consistent response to referrals into CSC which identifies emerging patterns of concerns and needs at an earlier stage can therefore be expected to contribute to improving longer term outcomes for children, as well as a more efficient use of resources.

Finding 1: The commitment to providing a proactive service at the point of referral in children's social work within RBKC optimises early intervention and assessment.

Demand for child protection and safeguarding services is high, and resourcing increasingly restricted. In this context, judgements have to be made about priorities when designing and reviewing the way that services are provided. A child protection system has to balance responding to situations of immediate risk of harm to children, and interventions targeted at preventing harm from escalating in the future to such crisis levels. When child protection systems have been set up to prioritise the former, this makes it difficult to respond effectively to the latter.

This finding shows how system redesign focussing specifically on the quality of practice, together with increased investment, can enable a more balanced approach.

Questions for the Board to Consider.

- *Does the Board recognise the picture of social work with children as identified in this review?*

[19] ADCS, (Nov 2014:65)

- *How can high quality social work practice which is focussed on achieving good outcomes for children be maintained in the long term in the context of potentially changing budgets and pressures on the system?*
- *Is the Board satisfied that there are good processes for assessing the impact on children's lives of the Focus on Practice approach?*
- *Is there any information emerging from partner agencies regarding 'unintended consequences' as a result of the development of Focus on Practice?*

14.2 Health professionals' access to medical records

Finding 2: The inability of health professionals in RBKC to access records in a timely way can undermine their capacity to effectively assess patients and any risk they might present.

Parental mental health and what impact, if any, it may have on the care of children is assessed at a number of different points throughout the contact that health services and other professionals have with the individual. This takes place at a variety of levels, starting from non-health professionals who draw on their general practice knowledge in order to identify unresolved concerns through to specialist psychiatric assessments undertaken under the remit of mental health legislation. The quality of assessment is likely to be significantly reduced where historical information is not available to the assessor**.** Effective record keeping systems which can be accessed quickly when required are therefore a crucial tool in achieving quality assessments.

14.2.1 **How did the issue feature in this particular case?**

During the course of this review it became apparent that there were historical and current mental health records relating to the mother which for a variety of reasons was either unknown to key professionals or where those records were inaccessible in a timely way. It is not the contention of this Review that access to these records would in itself have resulted in a change in outcome, however, it meant that professionals were not able to undertake assessments with the full information that should have been available to them. This issue was highlighted in 2 different ways:

i Health records held by Imperial College Healthcare Trust identified that the mother had a history of depression and panic attacks dating back to 1992. She had also attended A&E in 2007 following an overdose, as a result of which she was seen by the Psychiatric liaison nurse and referred to her GP for follow up in the community. It is further recorded that she was seen by the CNWL Adult Psychology department in 2008 for anxiety and panic attacks. However this information was not known to the Health Visitor, and as it was

stored within previous paper records, was not readily accessible to the GP who would have needed to specifically request old records.

ii. When the mother attended at the Urgent Care Centre[20] and from there the '*walk in'* centre at the mental health unit in St Charles Hospital, there was no means for staff to access any other health records for her, either from within their own Trust or the GP Records, and as a result they were completely reliant on her own self reporting. CNWL, which is commissioned to provide mental health services in the borough, does not currently have one shared recording system. Staff in the Primary Care Liaison Team use a different electronic recording system (IAPTUS) to CNWL staff in the secondary mental health services who use a system called JADE. The duty nurse and doctor at St Charles, who are also CNWL staff, did not have access to the IAPTUS system, which would have alerted them to the fact that the mother had recently been referred to Primary Care Liaison by her GP. The JADE system alerted the duty nurse and duty doctor at St Charles that there was an old paper file, but this is not available on site and the doctor's experience was that it could take up to a week to order it.

14.2.2 How do we know it has wider significance and is not peculiar to this case?

The difficulties experienced in this case over accessing records and recording systems that are unable to communicate with each other are a widely recognised problem within health services.

14.2.3. How prevalent is this and how widespread is the pattern – local, boroughwide, national?

This is a pattern that features widely within health services both at a national level and specifically in relation to CNWL NHS trust which uses JADE, a system not widely adopted within the NHS.

14.2.4 What are the implications for the reliability of the multi-agency child protection system?

The implications for the child protection system are potentially highly significant.

In this family's case the nature of the historical information regarding the mother meant that although it may well have heightened awareness, it would have been unlikely to have significantly changed the clinical care provided by the primary mental health practitioners. However, in general terms the absence of such information limits the capacity of health practitioners to contribute to multi-agency assessments of children, which in some situations could be of crucial significance. We know that most parents with mental

[20] Urgent Care Centre – direct access health facility providing assessment and treatment of minor illnesses and injuries provided by the CLCH NHS trust within St Charles Hospital.

health problems do not present a risk of harm or neglect to their children. However the risk increases when '*parental mental illness coexists with other problems such as substance misuse, domestic violence or childhood abuse"*[21]. Absence of key information regarding historical mental ill health therefore is likely to undermine both good assessment and the quality of any interventions to support a family and protect children.

For very similar reasons a significant risk exists in assessing the quality of parenting capacity when systems prevent good information sharing between health specialisms. It is particularly of concern if services providing a crisis response are unable to access all the information as this increases risks both to staff, but also to the assessment of parents and therefore identification of any child protection issues.

Finding 2: The inability of health professionals in RBKC to access records in a timely way can undermine their capacity to effectively assess patients and any risk they might present
Good assessments of adults with mental health problems, and any implications for their capacity as parents or risks to their children, are reliant on access to historical material. Where this exists but is not available due to the way record retrieval systems are set up, managed, or accessed, this creates a significant vulnerability. **Questions for the Board to consider:** • *Is there an achievable means of enabling primary health practitioners to have access to historical records that could contribute to their assessment of patients with dependent children?* • *Does the Board consider that there are particular circumstances when it would be considered to be best practice for primary health practitioners to access historical records of patients with dependent children?* • *Given the difficulties with the current electronic recording systems Is the Board satisfied that arrangements for information sharing across the relevant health trusts both now and in the future are robust enough to support good child protection practice?* • *Will the new arrangements for providing Crisis mental health services include a robust information sharing system?*

[21] Cleaver et al (2011:31)

Safeguarding Children and provision of mental health services.

Finding 3: There is a risk in RBKC that the focus given to safeguarding children is not fully integrated into systems for responding to parents who present in crisis with serious mental health problems.

A small but regular number of adults attend mental health services in crisis. Some of those adults will be parents or carers of children and the response they receive when seeking services can have significant implications for their children. The experience of this family has shone a light on a serious vulnerability in the way that adult mental health crisis services had been provided in the borough for a substantial period of time prior to these events. As a result and in parallel with this SCR taking place, the mental health crisis response service has been reorganised in relation to the particular identified point of vulnerability: the reliance on a '*walk in centre'* for assessing self-referring patients. The implications more generally for adults with mental health problems is not the remit of this review. However, what is clearly within the remit is whether, across the range of services provided, there is a robust focus on the needs of children whose parents have mental health concerns.

14.3.1 **How did the issue feature in this particular case?**

The most powerful example arises out of the mother's presentation at the urgent care centre when she was taken to the '*walk-in centre'* at St Charles Hospital. The individual health professionals who became involved with her showed proper professional care and concern about her mental health needs. However, as has been outlined earlier in this report, the context in which they were working made it extremely difficult for them to undertake a proper assessment of her needs within a reasonable timescale, or of the needs of any dependant children.

It has now been clearly acknowledged by CNWL that responding to individuals attending without referral was not a part of staff's role and it is very evident that they were already fully occupied dealing with their core tasks on the wards and within the S136[22] suite. The reception arrangements were not designed to support or safely contain unknown individuals self-presenting; there was no means for staff to undertake proper records checks and no service standards to deal with patients presenting in this way.

It is recognised by the Trust that self-referrals frequently require; '*experienced assessment and substantial staff time'*. Instead staff were left to manage individuals who presented at the '*walk in centre'* in any gaps between their core job tasks, and by adapting their professional response to the situation that presented rather than by having a clear understanding of what the Trust expected of them in this setting. On this occasion the considerable delay

[22] S136 Mental Health Act : provision for a police officer to take someone to a place of safety if they appear to be suffering from a mental health disorder and it is the person or the public's interest to do so.

coincided with a significant decline in the mother's mental well-being and created further problems for the medical staff when they attempted to assess her. From the description provided to this Review the impact for the mother as a patient in her own right was highly significant, but it also had serious implications for Clare and Ann, which were not fully understood at the time. No information had been provided to the medical staff about the children's father being part of the family. It is now known that the father had considerable concerns about the mother's mental health, but this had not been shared with any professionals. It is evident that both the duty nurse and doctor made enquiries about her children and were assured that they were being cared for by their grandmother. However, what did not take place was a referral to the Children's Services.

The doctor had the option of seeking clinical advice about the mother's mental health needs from the on call registrar, which he properly accessed. What was not apparently available to the professionals dealing with this worrying and escalating situation, was an adequate safeguard, whether in the form of a well understood process, or access to advice and support, which would have supported them to focus more critically on the potential risks to the children. What is apparent is that a referral should have been made to the CSC Emergency Duty Team during the night, or to Children's Services the following day. The other option, once the decision of the police not to undertake a welfare check had been made, would have been for the duty nurse or doctor to have maintained the urgency around their concern by referring that night to CNWL on-call for it to be escalated by senior staff with the Police.

In the context of what was taking place at the time including the mother's apparent assurances and view of her children as a protective factor, it may not be seen as entirely surprising that adult mental health professionals, with limited experience of children's safeguarding, did not focus in a more critical way on the level of risk to the children and the options for escalating these concerns. It is also possible that the decision of the police not to undertake a welfare check as requested also impacted on decision making and this will be considered further in the subsequent finding. Nevertheless the lack of a such a referral was not good practice in relation to safeguarding children.

The following morning the day staff attempted, unsuccessfully to contact the GP to inform her of the mother's presentation at St Charles and made a referral to the ABT team for an urgent appointment. No specific protocols existed regarding actions to be taken after a 'walk-in' patient was seen and again it was reliant on the staff concerned to take whatever steps they felt necessary. Again, in the absence of clear protocols or other triggers, this did not include a referral to children's services or escalation regarding the police decision.

14.3.2 How do we know it has wider significance and is not peculiar to this case?

That there was no proper management, resourcing or service standards in relation to the 'walk-in' clinic at St Charles has now been recognised by CNWL in internal documents provided for this Review as well as in the subsequent redesign of the service. It appears that no assessment had been undertaken as to the safeguarding implications (for adults or children) of allowing a service to continue to operate in this way. This raises a question for both CNWL and the commissioners as to how well safeguarding children is considered in service design, management or review.

In July 2015 a decision was made by CNWL to close the 'walk-in' centre at St Charles in recognition that this was not a commissioned service and in the way it was used represented a significant risk to both service users and staff. Instead any self-referrals would be directed to A&E. What is not clear to this review is what, if any, implications this has for safeguarding children and whether or not the Psychiatric Liaison service based in A&E has any greater familiarity with , or capacity for managing safeguarding children issues when a parent seeks psychiatric help.

14.3.3. How prevalent is this and how widespread is the pattern – local, boroughwide, national?

It is difficult to assess how prevalent or widespread this issue is as there is no national or local data collection in relation to the numbers of adults, who are also parents or carers, receiving specialist mental health services.[23] In the absence of that baseline information it is therefore difficult to assess the extent of any gaps in safeguarding children practice in adult mental health services.

At a local level, it is known that over a five month period between October 2014 and March 2015 an average of 20 people a month attended the walk in centre. It is not known what proportion of those individuals had caring responsibilities for children or whether in any of these cases referrals were made to Children's Services. It has however long been recognised at a national level that the role of adult services in contributing to the safeguarding of children has required strengthening[24] and the requirement for the two services to work together is clearly laid out in Working Together 2015:

> *'When staff are providing services to adults they should ask whether there are children in the family and consider whether the children need help or protection from harm. Children may be at greater risk of harm or be in need of additional help in families where the adults have*

[23] OFSTED (2013:4)
[24] See for example: DfE 2011 Research Briefing, Safeguarding Children Across Services: Messages from research on identifying and responding to child maltreatment.

mental health problems, misuse substances or alcohol, are in a violent relationship, have complex needs or have learning difficulties'. (p58)

In particular OFSTED identified[25] that '*mental health services did not consistently consider the impact of the adult mental health difficulties on children'*

14.3.4 What are the implications for the reliability of the multi-agency child protection system?

If an understanding of child safeguarding is not an integrated component of Adult mental health services' policy, systems and practice, some children who are at risk of abuse or neglect will not be recognised as such.

In the case of this family, there was an over-reliance on the capacity of individual professionals to manage risk in the absence of organisational support. It is an expectation that all health and social care professionals have a responsibility to contribute to safeguarding children. However to achieve this effectively in complex clinical settings professionals require a strong level of support from their employing bodies.

> *Staff need advice and support on how to change their practice and how to make change. Most staff seem to be aware of the issues, but state they need more effective leadership and guidance to help them overcome the barriers.*[26]

Finding 3: There is a risk in RBKC that the focus given to safeguarding children is not fully integrated into systems for responding to parents who present in crisis with serious mental health problems.
Managing the health and social requirements of adults who present with mental health concerns necessitates a clear focus on their rights and needs and a sophisticated understanding of what, if any, risks may exist to themselves or others. The significance of patients' roles as carers needs to be understood as a high priority. A proper focus on child protection should be fully embedded within this complex service including strong safeguards to support staff who work directly with patients. **Questions for the Board to consider** • *Does the Board accept the judgement within this finding?* • *What information would the Board need to establish the degree of risk that may exist?* • *Has the Board responded to the recommendations in the OFSTED*

[25] OFSTED 2013
[26] SCIE May 2012

report 'What about the children?' including undertaking an evaluation or audit of child safeguarding practice within adult mental health services.

- *Are routes into mental health services for parents properly understood across services?*
- *How well are pathways for raising concerns about children's care properly understood and implemented within mental health services?*
- *Is the level of safeguarding training required for adult mental health professionals an adequate basis to support good safeguarding practice?*
- *Is there adequate awareness of the need to assess adults who have significant contact with children other than as parents?*

Shared understanding of the purpose and process for 'Welfare checks'

Finding 4 : There is a lack of shared understanding across the partner agencies in RBKC about the purpose and processes for undertaking urgent checks on children whose carers present with significant concerns.

A wide range of professionals have historically looked to the police to respond on their behalf when they are significantly concerned about an individual's welfare or safety. This may be because the individual is thought to be missing, or in some way at risk and the professional concerned believes that a face to face check on their welfare is necessary. Statutory agencies have for many years been reliant on the police to undertake what are known as '*welfare checks'* to identify whether an individual adult or child is 'safe and well'. However, recent changes in the Metropolitan Police Policy to welfare checks has led to a significant reduction in the number of such checks and a lack of clarity as to how agencies who have concerns should respond.

14.4.1 **How did the issue feature in this particular case?**

When the mother presented at St Charles Hospital, nursing and medical staff identified that she could present a risk of harm to others. Staff were also aware that they had limited information about her children who were understood to be staying with their grandmother, but they had no means themselves to check this.

After the mother left the hospital in the early hours of the morning, the duty doctor agreed with the nurse that she should contact the police to raise their concerns. The nurse did so and was explicit in identifying their concerns for the mother's welfare, their fears that she could attack someone if she felt threatened and she stated that the mother needed to be brought back to hospital. She provided the mother's address and phone number but specifically stated that the mother had not been willing to give her own

mother's phone number so that they could make checks on the children. The Review has been given access to the recording of this call which confirmed that she was clear and explicit during the call. The call handler's response was a clear commitment to getting *'someone looking around the houses, as soon as'.* Twenty minutes later the police called the nurse and she relates that they told her they 'no longer do welfare checks on mental health patients'.

In the absence of response police check on the mother or children, the nurse referred the information about the mother's presentation to the daytime staff to make a referral to the Assessment and Brief Intervention team during office hours.

The nurse's expectation that a check would be undertaken was based on previous experience, reinforced by the response of the call handler that evening. In fact the police had, in December 2014, issued an operational instruction tightening their approach to undertaking welfare checks, but this information does not appear to have been disseminated to front line practitioners or to all the relevant agencies. The combination of factors leading up to this point appears to have contributed to a sense that there was little else that could be done during the night and a loss of the sense of urgency about the degree of risk that might exist. Unknown to the nurse the referral to ABT, which was made as she had requested the following morning, was logged incorrectly on receipt and therefore not identified within the ABT as a referral.

14.3.2 How do we know it has wider significance and is not peculiar to this case?

During 2014 the Metropolitan Police undertook a review of the way that 'welfare checks' were being responded to. That review identified that these checks were significantly increasing and creating a demand on police resources that could not be justified. What is therefore apparent is that there is believed by partners to be a need for such checks, although the Police have produced evidence that in the majority of these cases the need is not one that justifies their involvement.

The Police had discussed the development of their new approach with mental health partners and Adult Social Care in a wide range of meetings across London both prior to and after the implementation of the new policy. However the information was not formally communicated with the LSCB by the Police or by those partners in Adult Social Care who had been briefed by the police. As a result the new Police Policy briefing regarding Welfare Checks was not known to the LSCB until April 2015. No evidence has been presented to this Review as to whether the safeguarding children implications of this policy were assessed by partner agencies or whether new guidance and advice was put in place for staff by the relevant agencies.

Given the established nature of referring to the Police for welfare checks and the lack of clarity amongst partners as to the change and any implications it might lead to, it is reasonable to assume that this is not a case specific concern, but has wider implication.

14.3.3. How prevalent is this and how widespread is the pattern – local, boroughwide, national?

The Metropolitan Police's briefing on welfare checks (initially created March 2014, updated March 2015) identified that in one month across London they received over 12,700 requests for welfare or 'safe and well' checks. Dip sampling suggested that only 4% of these actually justified police attendance. What is evident from these figures is that there is a widespread and high demand for such checks across London. No figures for the Borough have been provided, but there is no reason known to this review to suggest that the Borough's experience would be fundamentally different to this.

The Police's analysis identifies a considerable mismatch between the requests for checks and their policing responsibilities. They have identified that there is no general responsibility for the safety or welfare of the public, only as part of their core duties to:

- Prevent and detect crime.
- Keep the Queen's peace
- Protect life and property

The Police have therefore asserted that they will only carry out such checks if there is an emergency and when there is a real and immediate concern about serious risk[27]

What is not known is the numbers of welfare checks where there may be a legitimate challenge by the referrer to a police decision not to take action.

14.3.4 What are the implications for the reliability of the multi-agency child protection system?

The level of welfare checks requested, even taking into account that a number of these may by any reasonable judgement be inappropriate, identifies that there is felt to be a need by a variety of agencies for some means of reassurance about the welfare or safety of individuals. The Metropolitan Police's decision to review their role is of itself a reasonable one. However it raises questions both about the way in which it has been managed and communicated and the way in which key services have, or have not, responded.

[27] Further details are laid out in the Metropolitan Police External Briefing Note – welfare Checks.

Whilst it is reasonable to draw the conclusion that a proportion of the referrals in fact did not require any urgent response, it is equally reasonable to conclude that whether or not the Police was the right agency to take action, there was adequate reason for the referrer to have believed that an urgent response of some description was necessary. If good systems are in place to identify an alternative response or to escalate a challenge to the police then there is minimal cause for concern. However, this remains an unknown and as such represents a vulnerability for the child protection system.

Finding 4: There is a lack of shared understanding across the partner agencies in RBKC about the purpose and processes for undertaking urgent checks on children whose carers present with significant concerns.

Where routes and rationales for undertaking legitimate urgent checks in relation to children are unclear amongst the multi-agency partnership, this leaves open the potential for inaction in situations of genuine concern.

Questions for the Board to consider:

- *Does the Board agree that there is a lack of a clear understanding of processes when a need for an urgent welfare check on an individual is raised by an agency?*
- *Is there a need for further work between partners and the Police to establish best practice protocols in relation to welfare checks and children's safeguarding?*
- *Is there need for individual agencies to review their own processes when identifying immediate concerns about an individual's welfare?*
- *Are there lessons about communication between the Safeguarding Adult Board and the Children Safeguarding Board when partners inform the Boards of policy changes?*
- *Are there lessons for the Board about the way it ensures that partners recognise the implications of policy changes by individual agencies?*

15. Conclusion

The circumstances leading to this Review were of a highly distressing and extreme nature. There has been significant learning identified and a recognition that there were some limited opportunities to intervene with the mother that were not recognised. However, what has also been highlighted is a significant level of high quality professional practice across a range of practitioners. From the health visitor to the social worker; the safeguarding and teaching staff in school ; from the GP to the clinicians at St Charles; the medical staff at Imperial college who treated Ann and the police who responded and found Clare and her father: what stands out is a level of

empathy and persistence in working with a family whose needs were not easily identified and for most of their involvement, risks that were extremely difficult to predict.

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Appendix 1: Acronyms and Terminology

DA	Domestic Abuse
DHR	Domestic Homicide Review
GP	General Practitioner
HV	Health Visitor
LSCB	Local Safeguarding Children's Board
MA	Multi-Agency
MASH	Multi-Agency Safeguarding Hub
RBKC	Royal Borough of Kensington and Chelsea
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SW	Social Worker
WT	*Working Together to Safeguard Children*, 2015 National statutory guidance for multi-agency safeguarding children

Appendix 2: Methodology and process

1. This SCR has used the SCIE Learning Together model for case reviews. This is a 'systems' approach which provides a theory and method for understanding why good and poor practice occur, in order to identify effective supports and solutions that go beyond a single case. Initially used as a method for conducting accident investigations in other high risk areas of work, such as aviation, it was taken up in Health agencies, and from 2006, was developed for use in case reviews of multi-agency safeguarding and CP work (Munro, 2005; Fish et al, 2009). National guidance since the 2013 revision of *Working Together to Safeguard Children* (2013) now requires all SCRs to adopt a systems methodology.

2. The model is distinctive in its approach to understanding professional practice in context; it does this by identifying the factors in the system that influence the nature and quality of work with families. Solutions then focus on redesigning the system to minimise adverse contributory factors, and to make it easier for professionals to practice safely and effectively.

3. Learning Together is a multi-agency model, which enables the safeguarding work of all agencies to be reviewed and analysed in a partnership context. Thus, many of the findings relate to multi-agency working. However, some systems findings can and do emerge which relate to an individual agency. Where this is the case, the finding makes that explicit.

4. The basic principles – the 'methodological heart' of the Learning Together model – are in line with the systems principles for SCRs now required by guidance in *Working Together* (2015):
    a. **Avoid hindsight bias** – understand what it was like for workers and managers who were working with the family at the time (the 'view from the tunnel'). What was influencing and guiding their work?
    b. **Provide adequate explanations** – appraise and explain decisions, actions, in-actions in professional handling of the case. See performance as the result of interactions between the context and what the individual brings to it
    c. **Move from individual instance to the general significance** – provide a 'window on the system' that illuminates what bolsters and what hinders the reliability of the multi-agency CP system.
    d. **Produce findings and questions for the Board to consider**. Pre-set recommendations may be suitable for problems for which the solutions are known, but are less helpful for puzzles that present more difficult conundrums.

e. **Analytical rigour**: use of qualitative research techniques to underpin rigour and reliability.

5. Typology of underlying patterns.To identify the findings, the Review Team has used the SCIE typology of underlying patterns of interaction in the way that local child protection are functioning. Do they support good quality work or make it less likely that individual professionals and their agencies can work together effectively?

   They are presented in six broad categories of underlying issues:

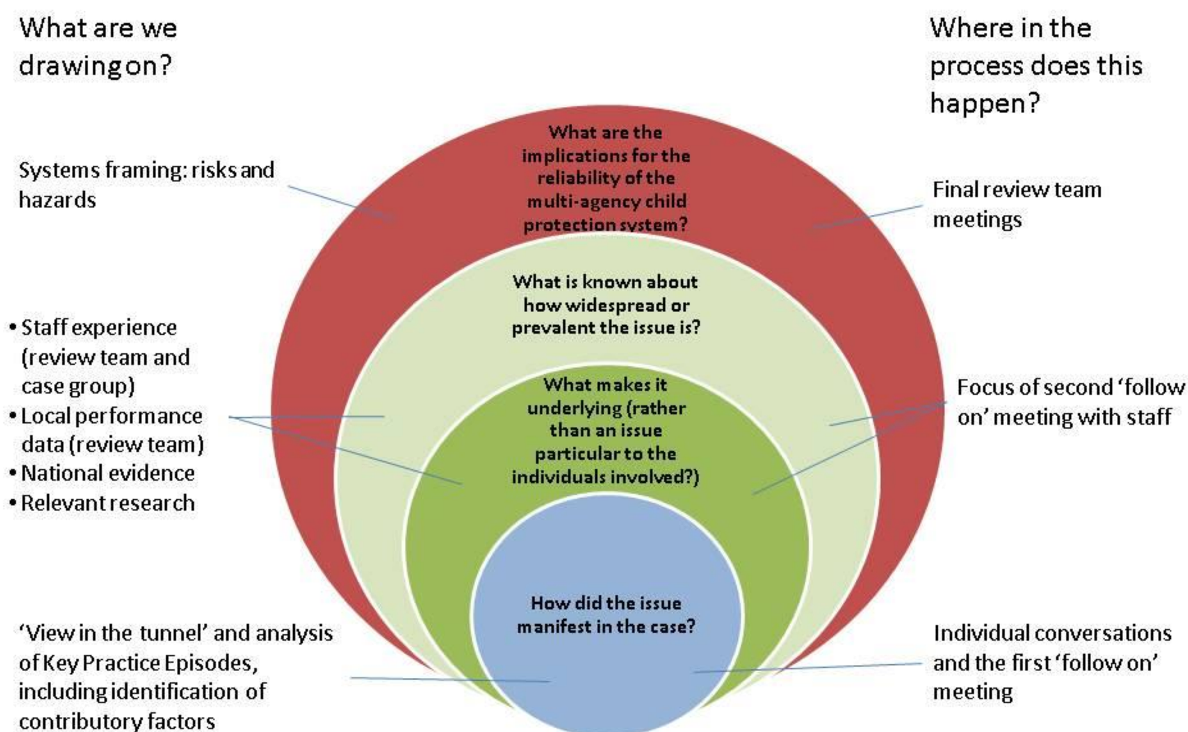
   1. Multi-agency working in response to incidents and crises
   2. Multi-agency working in longer term work
   3. Human reasoning: cognitive and emotional biases
   4. Family – Professional interaction
   5. Tools
   6. Management systems

   Each finding is assigned its appropriate category, although some could potentially fit under more than one category.

6. Anatomy of a finding

   For each finding, the report is structured to present a clear account of:
   - How did the issue feature in the particular case?
   - How do we know it is not peculiar to this case (not a quirk of the particular individuals involved this time and in the particular constellation of the case)?
   - What information is there about how widespread a problem this is perceived to be locally, or data about its prevalence nationally?
   - What are the implications for the reliability of the multi-agency child protection system?

These ‘layers’ of each finding are illustrated in the Anatomy of a Learning Together Finding (below).



7. Review Team and Case Group

7.1 Review Team

The Review Team comprises senior managers from the agencies involved in the case, who have had no direct part in the conduct of the case. Led by two independent Lead Reviewers, they act as a panel working together throughout the review, gathering and analysing data, and reaching conclusions about general patterns and findings. They are also a source of data about the services they represent: their strategic policies, procedures, standards, and the organisational context relating to particular issues or circumstances such as resource constraints, changes in structure, and so on.

The Review Team members also have responsibility for supporting and enabling members of their agency to take part in the case review.

Sian Griffiths, SCIE independent Lead Reviewer
Deborah Jeremiah, SCIE independent Lead Reviewer
Allison Hamer, Metropolitan Police
Liz Royle, Central London Community Healthcare NHS Trust
Sarah Green, Imperial College Healthcare NHS Trust
Hilary Shaw, Tri Borough Safeguarding and Child Protection , Schools and Education Catherine Knights, Central and North West London NHS

Foundation Trust
Catherine Hoy, RBKC Children's Social Care
Lavinia Armotrading, North West London CCG
Lily Tripathi, Catalyst Housing
Neera Dholakia, Named GP for Safeguarding Children in West London CCG
Rob Shaw, Housing Options

7.2 Case Group

The Case Group are the professionals who were directly involved with the family. The Learning Together model offers a high level of inclusion and collaboration with these workers/managers, who are asked to describe their 'view from the tunnel' – about their work with the family at the time and what was affecting this.

In this case review, the Review Team carried out individual conversations with 14 of the Case Group professionals. Case Group members were invited to an Introduction Meeting (to explain the Learning Together model and the SCR process) and later to an all-day Workshop.

8. Structure of the review process

A Learning Together case review reflects the fact that this is an iterative process of information-gathering, analysis, checking and re-checking, to ensure that the accumulating evidence and interpretation of data are correct and reasonable.

The Review Team form the 'engine' of the process, working in collaboration with Case Group members who are involved singly in conversations, and in Case Group meetings. They also receive copies of the draft report to comment on.

For this SCR, the following meetings were held:

- Joint scoping meeting with wider group also representing the Domestic Homicide Review
- 3 Review Team Meetings
- 2 joint Review Team and DHR team meetings
- Case Group: Introductory Meeting and Full Day Workshop

9. Scope and terms of reference

9.1 Taking a systems approach encourages reviewers to begin with an open enquiry rather than a pre-determined set of questions from terms of reference, such as in a traditional SCR. This enables the data to lead to the key issues to be explored.

In this SCR, we noted and explored the questions (Para 6.2) which the SCB had posed as of particular interest.

9.2 The time frame for the SCR was decided as follows:

July 2013 and March 2015

This was chosen beginning with the birth of Ann and ending shortly after the point until Clare and her father were discovered to have been killed.

10. Sources of data

10.1 Data from practitioners

- Conversations, as described above, with members of the Case Group; these were recorded and discussed by the whole Review Team.
- Contextual information was also provided by a Mental Health Social Worker working in community services
- A Workshop Day in which members of the Case Group responded to the analysis of the case and gave feedback about accuracy and fair representation of their views. In relation to the emerging findings, the Case Group were asked to comment on whether these were underlying and widespread/prevalent. In other words, could we draw conclusions about whether, and in what way, this case provides a 'window on the system'?

10.2 Key Practice Episodes and Contributory Factors

The data from the conversations with the Case Group translates into their 'view from the tunnel' and thence into a selection of Key Practice Episodes (KPEs) which enable us as reviewers to capture the optimum learning from the case. These KPEs are significant points or periods in relation to how the case was handled or how it developed. Case Group members are also an invaluable source of information about the why questions – an exploration of the Contributory Factors which were affecting their practice and decisions at the time.

10.3 Participation

The Learning Together model relies on professionals contributing very actively to the review and the resultant learning, as it is their unique experiences which help us understand what happened and why.

We know that participation in an SCR can raise anxieties and sometimes distress about what has happened to children, and may prompt self-questioning about 'could I have done something differently?'. In this context, the Lead Reviewers and the Review Team are especially

grateful for the willingness of the professionals to reflect on their own work, and to engage openly and thoughtfully in this SCR.

10.4 Data from documentation

The Lead Reviewers and members of the Review Team were given access to the following documentation:

- Various policies and practice documents (draft and finalised) from Children's Social Care, the Metropolitan Police and CNWL.
- Transcripts of recordings of calls made by the mother to the Police 999 call centre.
- Transcripts of conversations recorded by the Father in the family home
- Copies of CCTV stills produced for the Criminal Trial in relation to mother's attendance at St Charles hospital, in a public place and at Imperial hospital
- Medico-Legal Psychiatric Report prepared for mother's criminal trial
- Copy of request for Support Family Services form in relation to obtaining a nursery place.
- Post Mortem Report

10.5 Data from family, friends and community

As is established practice in SCRs, the Learning Together model aims to include the views and perspectives of family members as a valuable element in understanding the case and the work of agencies.

The mother agreed to meet with the Lead Reviewers who visited her in the Secure Mental Health Unit. The mother spoke in some detail about her experience prior to the events directly relating to the deaths of Clare and the father.