VALE OF GLAMORGAN
LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW
IN RESPECT OF
CHILD "A"

EXECUTIVE SUMMARY

MARCH 2012

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1. INTRODUCTION

1.1 Child A died on 15 May 2010. He was 11 years old. His mother was tried for murder and found guilty of manslaughter on 26 May 2011.

1.2 Serious Case Reviews (SCRs) are carried out when a child has died and it is known or suspected that abuse or neglect has taken place. It was agreed that the Local Safeguarding Children Board (LSCB) would conduct a SCR in this case, as the parents' capacity to safeguard Child A had been subject to enquiry.

1.3 A panel was convened to manage the review with representation from the health service, the local authority (Children and Young People Services and Education Services), police and a voluntary sector agency, all of which had provided services to Child A and his family. The panel was chaired by a probation service representative and a legal adviser from the local authority was also a member.

1.4 An independent author was commissioned to provide an overview report, based on the detailed chronology of the case as well as individual agency management reviews completed by:

- Public Health Wales
- The South Wales Police
- Vale of Glamorgan Council, including separate reviews provided by Children and Young People Services, Child A's school and the Education Welfare Service
- The voluntary sector agency that provided a respite service to Child A and his family.

1.5 The family were contacted and the overview author met with three family members during the course of the review.

1.6 The terms of reference of the review were defined by the SCR panel as follows:-

- To establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children
- To identify clearly what those lessons are, how they can be acted upon and what is expected to change as a result; and as a consequence to improve agency working and better safeguard children
- To identify examples of good practice

1.7 The SCR panel identified the following issues for the review to clarify:

- What work was undertaken with the child and family by agencies?
- Was the work undertaken with the child and family effective?
- Were the child's wishes and feelings taken into account by the various agencies involved?
- Did robust communication take place across disciplines and agencies in a timely way? If not, what can be learned?
- Are there any factors in the chronology that would help point professionals to the serious outcome that occurred, including any indicators connected with the parenting of children with disabilities and the family's relationship with key agencies?

2. CONTEXT OF THE REVIEW

2.1 Because of the circumstances surrounding this case and its tragic outcome, there has been a significant amount of public interest, particularly in the trial of Child A's mother. It was agreed that the review should proceed although the criminal process had not concluded. However, when it became known that Child A's mother was to be charged with murder and that a trial was to take place because she had denied the charge, work to finalise the review was delayed until the final outcome of the criminal case.

3. CASE SUMMARY

3.1 Child A's parents were married in 1996. Health notes recorded that his mother subsequently informed the GP about serious incidents of domestic violence. Information was also recorded about her vulnerability to stress and depression. In the 1990s, the link between domestic abuse and risk to children was not understood fully and systems to help safeguard either children or direct victims were relatively underdeveloped.

3.2 Child A was born on 11 March 1999. On 17 June 2002, he was diagnosed with severe autism. From this point, specialist health services were provided to assist Child A and to provide support to his family. Therapy services were well received by both Child A and his mother and some excellent work was carried out to help him to develop rudimentary communication skills.

3.3 At first, he attended primary school but his subsequent statutory assessment of special educational needs led to a day placement in a special school in September 2003, when he was 4 years old. At an early stage, his high levels of need were recognised alongside the degree of pressure experienced by his

mother as his principal carer. Because Child A had an unsettled pattern of sleep, health professionals and the school noted that his mother was suffering with fatigue and needed support. It was also noted that she was a loving and committed parent and had a strong bond with him.

3.4 Children and Young People Services became involved with Child A and his family in 2003. He was acknowledged as being a child in need and the provision of respite care was discussed with his mother. Although she seemed to be accepting of such support at the time, she felt that the service was not needed once Child A had started attendance at the special school in the same year. Despite the fact that all the professionals involved in the case agreed that respite care was needed, it was unclear whether Child A's mother consistently wanted the service for her son.

3.5 During these early years, there was evidence that Child A's mother would not keep appointments with some professionals and with Children and Young People Services in particular. Social workers noted the cluttered conditions in the family home. However, no concerns were expressed by any of the agencies involved with Child A about standards of care.

3.6 Serious incidents of domestic violence occurred in 2006 and 2008, resulting in use of MARAC procedures[1]. On the second occasion, the potential risk to the children was compounded by conditions in the household which were now extremely poor. During the subsequent child protection enquiries, the parents arranged to move to temporary accommodation. As a result, the case did not proceed to an initial child protection conference. The assessment carried out by Children and Young People Services following the child protection enquiries included a sceptical view about the parents' willingness and ability to bring about the changes necessary to ensure the children's wellbeing. The plan at the time was to continue working with the parents, focussing on their capacity to safeguard and care for Child A and his older brother in the light of the domestic abuse and conditions in the family home.

3.7 During 2009, Children and Young People Services worked with both Child A and his brother as children in need and monitored the behaviour of the parents.

[1] *The Multi Agency Risk Assessment Conference is a formal conference, convened in response to all cases of domestic violence where the risk is identified as "high". The purpose is for agencies to share information with a view to identifying those at a high level of risk of serious harm and thereafter constructing jointly a management plan to provide professional support to all those at risk, including children in families as well as direct victims.

Although there were indications that both parents were taking some steps to make necessary changes, Child A's mother resisted engaging fully with social workers and both parents failed to understand the impact of the domestic violence and home conditions on the health and development of the two boys. However, during this period, Child A did begin to receive a residential respite service.

3.8 At the beginning of 2010, Children and Young People Services transferred the case to a new social worker. Child A's mother disclosed to the social worker that incidents of domestic violence were continuing and that she wished to separate from her husband. The disclosure gave rise to further child protection concerns and the need for another child protection enquiry was considered. However, it was agreed that Child A's mother should be given clear advice to co-operate with the help and support on offer from another voluntary organisation, Atal Y Fro (which offers confidential support and temporary emergency accommodation for women and their children experiencing domestic abuse).

3.9 In the event, Child A's mother chose to move into hotel accommodation with Child A whilst his brother remained in the care of his father. She did not have any further contact with Atal Y Fro. The following months were characterised by a gradual disengagement by Child A's mother with Children and Young People Services and the voluntary agency providing respite care for him.

3.10 Child A's school attendance, formerly very good, began to suffer during April 2010. The school and the speech and language therapist reported concerns about his continuing absence and further efforts were made by both education welfare and Children and Young People Services to make contact, including approaches to his father and his half-sister.

3.11 On 15 May 2010, on receipt of information, the police were called to an hotel and found Child A's body. His mother was present and said that she had strangled him and attempted to take her own life. She was arrested, charged with his murder and remanded in custody. On 26 May 2011, she was found not guilty of Child A's murder but guilty of his manslaughter.

4. ISSUES ARISING FROM THE REVIEW

Focus on Child A and his needs

4.1 Identifying and taking full account of the wishes and feelings of a child with severe communication problems was a significant challenge for those involved in meeting his needs. In addition, at times it was difficult for professionals to maintain a focus on the child's needs when the needs and problems of his carer(s) were also pressing. In this case, the evidence suggested that A's mother had a close bond with him and she was his primary carer. Under the circumstances, the work of the specialist therapists was properly carried out in partnership with his mother.

4.2 In the early stages of providing specialist services, the focus of the work was on providing additional support to a disabled child and his mother. When the focus was widened to include concerns about her ability to safeguard Child A, then the potential impact of the domestic violence and poor material conditions in the family home on his health and development did become more central to the management of the case. The specialist therapists and school staff had worked together to enable Child A to communicate about his most fundamental wishes. However, there is no indication that any attempt was made by them to assess the particular impact of the domestic abuse and home conditions on him.

4.3 Following further episodes of domestic violence and concerns about material standards in the family home, it was judged that these factors were compromising the parents' ability to safeguard their children and the parents were given firm guidance about what action they needed to take. Because the level of concern about the wellbeing of both Child A and his brother was not shared across all of the agencies involved in the later stages of work with the family, the school, specialist therapists and the voluntary sector project providing him with respite care had no reason to adapt their approach to take account of the risk of compromised parenting.

Effective work with Child A and his family

4.4 Once Child A had been diagnosed, health and education services were provided in a timely way both to assess his needs and to provide skilled therapy and support. In general, his mother co-operated with the delivery of

provision that she regarded as being vital and supportive of her in the role of the primary carer.

4.5 She did not consistently demonstrate the same approach to either the special needs health visitor or staff from Children and Young People Services. No evaluation of this difference was carried out but it was possible that she did not want staff from any agency to visit her and Child A at home. She cancelled visits to the home and missed appointments that involved home visits.

4.6 Child A's mother was unable to accept that conditions in the family home warranted the high level of concern on the part of the police and staff from Children and Young People Services. However, she was aware of the concern and about the implications of the continuing domestic violence. There was some indication that she felt that the two boys would be removed from her care. In all likelihood, this contributed to her initial ambivalence about and later resistance to engaging fully and to accepting some forms of help. This level of disengagement should have been explored and evaluated more explicitly at key points in the management of the case as it potentially reduced her capacity to safeguard the children.

4.7 The provision of respite care from an early age would normally be a core element in any package of support to a child with Child A's type and level of needs and to his family. However, this service was not put in place until he was ten years old. It is unclear whether an initial referral for the service was followed up quickly enough but a subsequent offer of respite was refused by his mother.

Communication within and between agencies

4.8 There were examples of sound communication both within and between agencies. However, on some occasions information was not shared, particularly about the full extent and seriousness of domestic violence. This contributed to difficulties in achieving an historic overview of such incidents, which led in turn to limited understanding of the severity of domestic violence that had taken place. Better communication might have enabled agencies to develop a more realistic and collective approach to the family.

4.9 The general practitioner records noted incidents of domestic violence that occurred before Child A was born. Two of these incidents involved serious violence. These records also noted his mother's history of depression. Neither

this information nor subsequent information from the MARAC meetings was communicated to other health professionals involved with Child A.

The appropriate use of procedures and processes

4.10 Opportunities were missed for developing a better and more co-ordinated approach to Child A and his family. Use of child protection procedures was considered on two occasions following episodes of domestic violence. On the first occasion, a child protection enquiry was carried out and a strategy meeting held but a decision was reached eventually that the enquiry should not culminate in an initial child protection conference. On the second occasion, a child protection enquiry was carried out in respect of Child A's sibling and Children and Young People Services decided not to use additional child protection procedures on the understanding that Child A's mother would seek assistance from Atal Y Fro. Both occasions offered opportunities to bring together all the agencies involved. The decisions not to progress use of child protection procedures did not take account of all the information potentially available and seem to have been based on a belief that Child A's mother had the capacity to safeguard her son.

4.11 On both occasions when it was decided not to convene a child protection conference, core assessments[2] were carried out. As part of a systematic approach to planning for children in need, such assessments offer the opportunity for agencies to share information methodically. It is appropriate to use this approach in ascertaining the capacity of parents to meet children's needs, including the need for protection from harm. The National Assessment Framework includes guidance for practitioners, in particular about carrying out core assessments in respect of disabled children and ensuring that such assessments are holistic, taking due account of other, specialist assessments. The assessments carried out in respect of Child A and his brother were not sufficiently multi-disciplinary nor did they focus enough on resolving professional concerns about the parents' ability to make the changes needed in their relationship to ensure that the children were safeguarded adequately.

4.12 The MARAC procedures were used in this case. However, not all the relevant information was made available by agencies to guide risk assessment. Information about the assessment and required actions was not fed back to all

[2] Initial and core assessments of a child's needs are carried out by social services in accordance with the Framework for the Assessment of Children in Need and their Families (NAW 2001).

the staff who needed to be involved. The information-sharing protocol between the police, health and social services that underpins the procedures, does not include cases involving school-aged children.

5. CONCLUSIONS

5.1 Child A's tragic death was a totally unpredictable event. There were some concerns about his parents' ability to produce the changes within the family context needed to safeguard him from the impact of domestic violence and poor material conditions in the family home. However, based on evidence about the way in which Child A and his mother presented in school, the respite care project and in using health services, most of the professionals involved regarded her as a loving and caring mother.

5.2 Child A and his family received timely services once his diagnosis had been confirmed in early childhood. All the agencies contributed to this provision. Speech and language therapy was provided throughout his life, enabling him to communicate his most basic needs. Respite care provision was not provided at an early stage and Child A's mother subsequently turned down the offer of such provision.

5.3 Child protection concerns did not influence the handling of Child A's case until the last two years of his life. Before that time, multi-agency work with the family focused on support and therapy based on his needs as a disabled child. However, serious incidents of domestic violence took place prior to Child A's birth and it is possible that they continued to occur during the whole period covered by this review. Both the extent and seriousness of this violence were underestimated to some extent by the agencies involved, largely because full information held by different agencies was not shared in a consistent way.

5.4 There were opportunities for agencies to share information that would have increased the understanding of the safeguarding concerns. MARAC meetings were held on two occasions and the use of child protection procedures considered each time. However, decisions not to proceed were based on a judgement that the family could be worked with on a Child in Need basis. This may have been appropriate but it did require a more focused use of children in need case management processes than that used in practice. Those agencies that had close and frequent contact with Child A had limited awareness about the concerns regarding safeguarding issues. As a result, his

communication and behaviour were not evaluated with those concerns in mind.

5.5 This was an exceptionally difficult, complex and challenging case for the agencies involved. One of the key features was the way in which Child A's mother used the support made available to her family. Although she co-operated with both health and education services, she increasingly resisted attempts by Children and Young People Services staff to work closely with her. Aware that the instances of domestic violence and the poor conditions in the family home were a cause of concern, she tended to cancel contact with Children and Young People Services and health service staff that involved visits to the home. Working in partnership with parents is often the key to effective safeguarding but all professionals need to act too on the basis that the welfare of the child is paramount and consider when a more directive approach is required.

5.6 It is not unusual for some parents to be ambivalent in their response to the help and support made available by agencies which have a key role in taking action to safeguard children from significant harm. However, those agencies need to be especially alert to signs that this ambivalence is becoming complete disengagement as such behaviour by a parent can indicate increased danger. Efforts were made to re-establish contact with Child A and his mother when their whereabouts were unknown to all the agencies. The history of the case indicated to the professionals involved that, once his parents had separated, concerns for his welfare were more appropriate than concerns for his safety. Those involved could not have anticipated the tragic outcome for Child A and his family.

6. RECOMMENDATIONS

All of the recommendations made in the overview report are included below and those recommendations reflected those made by individual agencies in their internal management reports. This approach follows the statutory guidance[3].

By their very nature, executive summaries are concise and include only the main points and themes that have arisen in the course of the review. The purpose of an executive summary in the context of a serious case review is to inform about the main themes that have been identified that will enable lessons to be learned and changes made by the LSCB and the agencies involved. For this reason, detailed information that gives an explanation for some of the recommendations made below is not included in either the case summary or analysis.

For the LSCB

6.1 Focus on the child

The LSCB will ask each agency to review its practice standards in respect of children with complex, special needs and their communication requirements. They should ensure that:

- staff in specialist provision who work directly with such children have an understanding of each child's typical communication methods and engage with each child on a regular basis;
- where appropriate, advice will be sought from specialists on how to communicate with these children;
- where there are concerns about a child's wellbeing or safety, then the case manager must access and record such information received directly from the child and evaluate that information on a regular basis with his/her supervisor.

6.2 Team around the family

The LSCB should encourage agencies to develop a 'team around the family'' approach on a multidisciplinary and multiagency basis for children with especially complex individual and family needs. The aim will be to ensure that

[3] Statutory guidance in respect of the content of executive summaries of Serious Case Reviews is contained in "Safeguarding Children: Working Together Under the Children Act 2004" (Welsh Assembly Government 2006)

the range of needs and the rationale for the delivery of services and interventions involved are understood in full and that all staff involved with the case communicate with each other on a regular and systematic basis.

Although Children and Young People Services have the statutory responsibility to lead and assure the quality of core assessments, the LSCB should ensure that all of its constituent agencies are aware of the significance of the core assessment of children with complex individual and family support needs and that their staff make an active contribution, as appropriate. This assessment should take account of other assessments that have taken place, e.g. of special educational need, and guide joint planning and interventions, which should be monitored and overseen by the case manager. Every case should be reviewed at six-monthly intervals as a minimum requirement.

6.3 Identifying risk when parents disengage

Children and Young People Services should take a lead in developing a protocol for the LSCB to enable staff to recognise and evaluate the risks that arise from parental disengagement and to take action necessary to manage any risks. The protocol should cover all potential signs of disengagement, including unexplained non-attendance and avoiding appointments and meetings as well as the need for a properly challenging approach by practitioners to apparent compliance by parents. Particular consideration should be given to either the avoidance or refusal of home visits by parents.

6.4 Communication

In all cases, agencies should ensure that staff not only inform colleagues in other agencies of incidents, new information or needs to be met, but also follow up if no acknowledgement is received or no action taken. If necessary, systems and processes should be modified to include this requirement and compliance monitored through staff, case or clinical supervision

6.5 Domestic violence/abuse

The LSCB should undertake a review of the current handling of cases involving school-aged children living in households where there is domestic abuse. The aim is to ensure that there is a robust pathway in place for the multi-agency management of such cases which is understood and used by all agencies and disciplines.

The LSCB should review the contribution made by all agencies and disciplines to MARACs and strategy discussions and meetings with the aim of identifying gaps that appear consistently and can be remedied.

Agencies should ensure that ALL information and intelligence about the severity and likelihood of harm is made available and that, at strategy meetings, a robust assessment is made of the need to proceed to child protection enquiries which includes information from all relevant professionals.

Following such meetings, information about any agreements and actions should be communicated to all professionals involved with the case.

6.6 Training

Training should be provided for staff within relevant agencies as a result of this review, as follows:

- to make known the findings and recommendations of this review
- improving communication with children with disabilities
- multi-agency information sharing and working together, particularly in cases where there are complex and sometimes conflicting needs, particularly in cases involving domestic abuse
- identifying and evaluating the risks that result from parental disengagement.

For Children & Young People Services

6.7 Recording Decision Making

Children and Young People Services should ensure that there are quality assurance processes to monitor the recording of decision making and the rationale on which decisions are based in all cases involving child protection concerns.

6.8 Managing cases of disabled children with complex family situations

Children & Young People Services should ensure that a single team becomes responsible for managing all aspects of a case following the decision to transfer the case for long-term work. All case managers involved should be provided with child protection training to the necessary level, with a focus on robust and consistent risk assessment.

6.9 Case handover

Children & Young People Services should ensure that case transfers are planned for appropriately and should ensure also that staff always read,

appraise and discuss background information with their supervisor when taking on a new case.

6.10 Carer assessments

Children & Young People Services should ensure that carers' assessments are offered to all carers as appropriate.

6.11 Ensuring provision is made in a timely way

Case managers should ensure that services and material assistance are provided within a given and agreed timescale and that such provision is subject to review.

For Education Services

6.12 Maintaining records at the special school

The head of the special school should ensure that all staff are aware of and compliant with the need to maintain detailed records of concerns, contacts, decisions and actions.

For Cardiff and the Vale University Health Board

6.13 Internal communication

All relevant professional staff should be reminded of the necessity to communicate significant information, particularly involving any direct or indirect risk to a child.

6.14 Clarify function of Special Needs Health Visiting (SNHV) Service

Children and Young People Services and the Cardiff and Vale University Health Board should clarify the respective role and responsibilities of Special Needs Health Visitors and social workers from child health and disability for children when working with children who have complex needs and their families.

For the Organisation providing residential respite care

6.15 Child protection procedures

The Organisation should ensure that there is no misunderstanding by staff at the named project of the purpose of the agency's child protection procedures.

6.16 Recording and record-keeping

The Organisation should ensure that all staff are aware of and able to comply with policy and that the Organisation is able to assure itself that records are kept properly.

6.17 Safeguarding children training

An assessment of safeguarding training needs should be undertaken at the project.