GWYNEDD AND ANGLESEY LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW ON CHILD G AND CHILD H

EXECUTIVE SUMMARY

25th OCTOBER 2011

FOREWORD

This report is published by the Gwynedd and Anglesey Local Safeguarding Children Board. This is a multi-agency group that has responsibility to oversee how services and professionals cooperate and work together to safeguard children and to make sure that the inter-agency arrangements in place within the two counties bring about positive outcomes for children.

The Local Safeguarding Children Board in Gwynedd and Anglesey operates under Government Regulations that came into force in 2005. These Regulations require all Local Safeguarding Children Boards to set up a serious case review when abuse or neglect of a child is known or suspected and a child dies or sustains a potentially life-threatening injury or serious and permanent impairment of health or development.

This review was set up following the death of two young children at the hands of their mother, who also took her own life. The main objectives of the review were to:

- establish whether there were lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard children;
- identify clearly what those lessons were, how they would be acted upon, and what was expected to change as a result; and as a consequence:

    - identify issues in inter-agency working in order to better safeguard children; and
    - identify examples of good practice.

The review was conducted under the guidelines set out in the Welsh Assembly Government document *Safeguarding Children – Working Together under the Children Act 2004.*

KEY TO FAMILY MEMBERS

Adult 1	Mother of Child 1, Child 2, Child 3, Child G and Child H
Adult 2	Adult 1's ex-husband, father of Child 2 and Child 3 and step-father of Child 1
Adult 3	Mother's ex-partner and father of Child H
Child 1	Adult 1's eldest child (female) and Adult 2's step-child
Child 2	Adult 1's second child (male) and Adult 2's eldest child
Child 3	Adult 1's third child (male) and Adult 2's second child
Child G	Adult 1's fourth child (father unconfirmed)
Child H	Adult 1's fifth child (fathered by Adult 3)

BRIEF OUTLINE OF THE CASE

1. This serious case review looked into the case of a 5 year old child (Child G) and his 2 year old half-brother (Child H), both of whom died at the hands of their mother, who also took her own life. The case review covered the period from January 2005, when Adult 1 had her first ante-natal appointment when pregnant with Child G, until the death of Child G and Child H in December 2010, i.e. a period of almost 6 years.

2. As an adult, Adult 1 first came to the attention of Social Services as a result of concern about her children following her separation from her husband, who was the father of her second and third children. Although her husband was not the father of her first child, he brought the child up as if she were his own.

3. After the separation from her husband, Adult 1 formed a relationship with the person who became the father of Child G. Soon after the birth of Child G, she began a relationship with Adult 3, who was to become the father of Child H.

4. In the 6-year period covered by the case review, the family had contact with several agencies. Most of the contacts arose as a result of concerns about the impact of custody and contact disputes between Adult 1 and Adult 2 (in relation to Child1, Child 2 and Child 3), as well as between Adult 1 and Adult 3 (in relation to Child H). These custody and contact disputes were a key feature of the case, with Adult 1 involved in two separate sets of private law proceedings at the same time, one involving her three older children and the other in relation to Child H.

5. Although some of the concerns raised about the children in the period covered by the review were to do with their safety and welfare, none of those concerns were viewed as serious enough to justify taking any child protection action beyond carrying out initial investigations into some of the reported incidents. On those occasions when Adult 1 was offered help, none of the offers made were taken up.

6. The bodies of the children and their mother were discovered on the day that Adult 3 called at the home of Adult 1 to collect Child H for his first overnight stay with him.

HOW THE CASE REVIEW WAS CARRIED OUT

7. Following the death of the two children and their mother, the Local Safeguarding Children Board met and agreed that a serious case review should be carried out to examine the involvement of agencies with the children and their family, starting from the first antenatal contact with the child's mother when she was pregnant with Child G and ending when the children died.

8. The serious case review panel was made up of representatives from Public Health Wales; the Betsi Cadwaladr University Health Board; Anglesey Social Services; Anglesey Education Service; Gwynedd Social Services; Gwynedd Education Service; North Wales Police; Anglesey County Council Legal Department; CAFCASS Cymru and Barnardos Cymru. The panel was chaired by the Assistant Director, Barnardos Cymru.

9. Each agency that had been involved with the children and their family was required to produce a chronology of their involvement, together with a report identifying key aspects of that involvement. The chronologies and reports were then used as a basis for an overview report that was compiled by an independent author appointed by the Local Safeguarding Children Board. The full report, which contains 10 recommendations and an action plan, will be sent to the Welsh Government.

SUMMARY OF AGENCIES' INVOLVEMENT WITH THE FAMILY IN THE PERIOD COVERED BY THE REVIEW

Health Involvement

10. From the point at which Adult 1's pregnancy with Child G was confirmed until the death of Child G and Child H, most of the contact that health professionals had with the family took the form of routine appointments for universal health care. Throughout that whole period, there was little that came to the attention of health professionals to indicate that there were concerns about Child G or Child H and nothing to suggest that they were at any risk of harm from their mother.

11. There were occasions in this period when health professionals were aware of concerns about Adult 1 and her children, but these were more often about her older children rather than about Child G and Child H. Although, as early as November 2007, the health visitor was aware of the stress that Adult 1 was under as a result of custody/contact disputes with Adult 2, there was nothing to suggest that this was any more than a normal and common reaction to a difficult situation.

12. In summary, despite being aware of the tension within the family resulting from the ongoing custody and contact issues in relation to Child H and Adult 1's three older children, there is nothing to suggest that health professionals should have done more than they did in this case. Furthermore, none of the health staff who had contact with the family could have anticipated that there would be such a tragic outcome for Adult 1 and her two youngest children.

Social Services Involvement

13. Most of the involvement that Social Services had with the family took place between November 2005 and December 2010. In this period, their contact was mostly in relation to concerns about Child 1 and Child 3. For the most part, these concerns were seen as connected with the custody and contact disputes between Adult 1 and Adult 2 and the concerns related to the care the children were receiving in their mother's home as well as in the home of their father and his new wife.

14. In relation to Child G and Child H, Social Services received a total of 6 separate referrals between December 2008 and August 2010, i.e. a period of 20 months. On three of these occasions, they decided to take no action and in relation to only one of the three referrals did they make enquiries with other agencies before making their decision. These three referrals were about an attempted attack on Child H by a dog in the home of Adult 1; a pinprick on Child H allegedly caused when Adult 3 consented to a blood sample being taken from Child H; and allegations that Child G and Child H were neglected by their mother. On the basis of the information available to Social Services at the time, their decision to take no further action in relation to these referrals was a reasonable response to incidents that were not serious enough to justify intervention.

15. The remaining three referrals were made in the space of a three-day period in August 2010 and they took the form of allegations about the standard of care provided by Adult 1 to her children. Social Services responded to these allegations by carrying out an initial assessment as opposed to a child protection investigation. This was an appropriate response and, when the assessment revealed that the allegations made were unsubstantiated, they took no further action.

16. In summary, it is fair to record that Social Services responded to the referrals they received in an appropriate way. The most serious matters were investigated and there

were never sufficient concerns to justify taking any child protection measures. In relation to Child G and Child H, observations by Social Services, together with information from the police, indicated that both children were well and happy, with no evidence of mistreatment or neglect by their mother and certainly no evidence to suggest that they were at any risk of physical harm from their mother.

Police Involvement

17. In the period following the birth of Child G up to the time of the deaths of Child G, Child H and their mother, the police had sporadic contact with the family. Most of this was in connection with concerns about Child 1 or Child 3.

18. The only occasion on which the police response can be criticised was in February 2007, when they were informed by Adult 3 that Adult 1 had gone missing from home and had left a suicide note in which she stated her intention to kill herself and Child G. Although the police responded quickly to this report and subsequently found Child G and his mother safe and well at the home of Adult 1's mother in the Midlands, the matter ended there and there is no record of the police informing Social Services about it. Given the circumstances, this matter should have been reported to Social Services, who would then have carried out background checks to help determine whether there was any significant risk of harm to the child.

19. Although there is no certainty about what response would have followed if the matter concerning Child G had been reported to other agencies, a full child protection investigation should have been carried out. Had that happened, even if it did not lead to a child protection case conference being convened, other agencies would have been given the information, which might have created a greater concern among partner agencies about subsequent reports in relation to Adult 1's care of her children. However, given Adult 1's apparent reluctance to accept help from Social Services, there is little to suggest that intervention in February 2007 would have had any direct impact on the eventual outcome for Child G and Child H almost 4 years later.

20. In summary, on all of the occasions that the police were asked for assistance, they responded quickly and appropriately and, on all but one occasion, they shared relevant information with partner agencies. The one exception was in relation to the February 2007 incident.

Education Department involvement

21. The Education Department were involved with Child G, as well as with Child 1, Child 2 and Child 3. They had no involvement with Chid H, who was not of school age.

22. Most of the issues that were of concern to the Education Department in their dealings with Adult 1 and her children were matters concerning Child 1.

23. It wasn't until September 2009 that Child G started school and, in the following 15 months, there was only one matter of concern noted in relation to him, which concerned his awareness of the conflict between his mother and his (step)father (Adult 3). However, there is nothing in the record to indicate that there were any child protection concerns in relation to Child G.

24. From the school perspective, there was nothing to indicate that Child G might be at risk of harm from his mother, who is reported as visiting the school quite often and being happy, friendly and courteous whilst there. Only three weeks before the deaths of her children and herself, while Adult 1 was helping with preparations for the school Christmas concert, school staff noted that she had a natural and happy relationship with Child G. This positive view was reinforced on the day of the Christmas concert, which took place less than two weeks before the deaths.

25. In summary, the Education staff involved with the family responded to the concerns that they had in an appropriate way and there is nothing to suggest

that they could have done anything to predict or prevent the deaths of Child G and Child H.

CAFCASS Cymru involvement

26. CAFCASS Cymru's involvement with this family was solely in respect of private law applications made by the parents of the children, mostly in respect of residence and contact matters.

27. The first involvement that CAFCASS Cymru had with the family was in 2001, at which point Adult 1 was in the process of obtaining a divorce from Adult 2. CAFCASS Cymru had no further involvement with the family until June 2008, when they were requested to prepare a report for the court on residence arrangements for Child 1, Child 2 and Child 3. While these matters were still unresolved, Child H was born and CAFCASS Cymru became involved in the preparation of reports on contact and residence issues in relation to him.

28. In the course of preparing reports for the court on custody and contact arrangements for Child H, the Family Court Advisor (FCA) dealing with that part of the family received representations from Adult 1 and Adult 3 about concerns they had about each other. These concerns included allegations that each had harmed Child H in some way. Adult 3's allegations included his fear that Child H would be harmed in future. The FCA took the view that only one of the incidents reported to her needed to be referred to Social Services.

29. In a report to the court in November 2010, the FCA reported that, despite the concerns raised by Adult 1 and Adult 3 about each other, there was a "tacit level of agreement" between them that Child H should spend time with each of them. The matter was resolved with the agreement of both parents at a court hearing on 13th December 2010, when staying contact was agreed for Child H with his father (Adult 3).

30. In his statement to the police, and in interview as part of the case review, Adult 3 stated that he believed that Adult 1 posed a risk to Child G and Child H and he said that he had told others (notably CAFCASS Cymru) about his fears. He still feels strongly that his concerns were not taken seriously. He also believes that, had CAFCASS Cymru worked more closely with Social Services and recognised

that they were dealing with a family in crisis, Adult 1 may have received the support she needed, which would have prevented the deaths of the children. However, whilst more could have been done to ensure that all agencies had a fuller picture of the family, there is nothing to suggest that this would have led to a different outcome.

31. One matter about which Adult 3 and the FCA had very different views was in relation to Adult 3's belief that the FCA did not take seriously his concern about the incident in February 2007, when Adult 1 allegedly left a suicide note declaring her intention to kill herself and Child G. Adult 3 believed that this indicated that Adult 1 was a potential threat to her children, a view shared by Adult 2. Despite this, there is nothing in the records to suggest that either Adult 2 or Adult 3 believed that Adult 1 should not have care of her children. Nor was there any indication that Adult 1 intended to take her own life and those of her two youngest children.

32. The records available certainly indicate that, towards the end of 2010, Adult 1 was under considerable stress because of the contentious issues in relation to custody and contact involving Child H and Child 3, together with difficulties she had been having with Child 1. As a person who reportedly liked being in control, there were several things over which she appeared to have very little control at that time. On top of that, she was reported to have some financial difficulties. However, none of this created worries that she would end the lives of her two youngest children and herself. What it possibly should have done was lead to a discussion within CAFCASS Cymru and with other agencies about how best to offer support to the family to help alleviate the levels of stress they were obviously experiencing. This did not happen.

33. In summary, CAFCASS Cymru were involved with the family almost continuously from June 2008 until December 2010. In that time, the FCAs dealing with the family were aware of virtually all of the incidents that were referred to either Social Services or the police. Like those two agencies, the

FCAs concluded that only one of the concerns may have reached the child protection threshold and, for that reason, they did not refer any of the others to Social Services. Whilst that was a fair judgement on the basis of the information they had, it would have been advisable for them to discuss their concerns with their managers in order to gain support for their decisions or, alternatively, pursue a different approach.

Good Practice Points

34. Throughout this case, there were examples of good practice from all agencies, as follows:

i. in compiling their reports for the court, the FCAs:
   a. did all that they could to ascertain the wishes and feelings of the children involved;
   b. made appropriate enquiries of other agencies;
   c. attempted to mediate and gain agreements before court hearings;

ii. when the two FCAs dealing with the family became aware of each other's involvement, they discussed the cases and shared their previous court reports;

iii. the health visitor sought appropriate advice when Adult 3 requested verbal information about Child H's health;

iv. overall, there was good communication between Social Services and the police when responding to referrals from or about the family;

v. the ambulance staff who attended the family home on the day of the deaths made a clear record of the reasons why the SUDI Policy was being overridden.

Lessons Learned

35. There are several lessons to be learned from this case, as follows:

    i. the importance of being aware of the safeguarding concerns that can arise in complex private law cases, particularly when children are repeatedly drawn into parental disputes;

    ii. the importance of sharing safeguarding concerns with partner agencies so that decisions about assessment and/or intervention can be based on a full picture of family circumstances and needs;

    iii. the need to consider how best to provide help and support to families where there are many concerns that do not reach the child protection threshold;

    iv. the need to review the practice of copying CID 16s to health colleagues, together with the need to establish a process within health for acting on the information received.

CONCLUSIONS

36. This tragic case has identified only one procedural gap, which was the failure by the police to notify partner agencies when Adult 1 and Child G were reported missing in February 2007. Although it is difficult to know whether knowledge about this event would have made any difference to the subsequent actions of partner agencies in this case, it is unlikely to have changed the outcome, giving that the unreported event happened almost four years prior to the deaths of Child G, Child H and their mother.

37. What is striking about this case is the complexity of the family relationships and the absence of any substantial child protection concerns that might have led to help being provided to Adult 1. Although concerns were raised about Child G and Child H, all by other family members, investigations and assessments carried out

found those concerns to be unsubstantiated. In fact, it was other children in the family, notably Child 1 and Child 3, about whom most of the concerns were raised in the period covered by the case review.

38. Even if Social Services had been aware of all the information that CAFCASS Cymru had about the family, it is unlikely that they would have done any more than offer services to Adult 1. On the three occasions that they did offer help, Adult 1 stated that she did not need it. Since none of the concerns reached the child protection threshold, it is difficult to know what more could have been done at the time.

39. In the absence of sufficient grounds for convening a child protection case conference, one option that was open to Social Services, as it was to other agencies, was to convene a child in need meeting. This would have provided an opportunity for partner agencies to share their concerns about the family and consider whether offering help might alleviate the continuing tensions in the relationships between Adult 1 and Adult 2/Adult 3. However, the potential benefits of a child in need meeting would have relied on agreement from Adult 1 that such a meeting would be helpful and there is nothing to suggest that she would have taken that view. In the circumstances, it is not surprising that none of the agencies involved with the family considered a child in need meeting as an option.

40. From the perspective of Adult 3, and to a lesser extent of Adult 2, this was a mistake because Adult 3 certainly believed that Adult 1 posed a threat to her children and Adult 3's view was, and is, that a child protection case conference should have been convened. However, there were not sufficient grounds at the time to initiate the child protection procedures in this case.

41. Whilst Adult 3's view that those agencies involved with the family failed to respond appropriately to the risks that he and others identified, it is difficult to know what could have been done to prevent the deaths of the children and their mother. Arguably, the only way of protecting Child G and Child H would

have been to remove them from the care of their mother and there were never any grounds to do so.

SECTION E: RECOMMENDATIONS

42. The following recommendations all relate to some aspect of inter-agency work.

Health

i. BCUHB, Social Services and North Wales Police should establish a consistent approach to the sharing of CID16s across North Wales. In the interim, the BCUHB will strengthen governance arrangements by implementing guidelines for staff who receive copies of CID16s which identifies their responsibilities on receiving these forms until such time a consistent North Wales approach is agreed.

Social Services

ii. Social Services should establish a clear protocol or working arrangement with CAFCASS Cymru that facilitates discussions about complex or ongoing contact arrangements between families known to Social Services.

iii. Social Services and Health should establish a system that allows Health to make secure electronic referrals to Social Services.

Education

iv. The Education Department should ensure that school staff receive awareness training about the impact of custody-related matters on children and their families. This should include the importance of sharing relevant information with partner agencies.

Social Services and Education

v. Social Services and the Education Department should establish a clear working protocol between children's teams and TAC[1] regarding sharing of information,

[1] The TAC is to be known as Team around Family (TAF) as a result of changes resulting from Families First implementation.

working arrangements and prevention work in cases that do not meet the child protection threshold.

North Wales Police

vi. North Wales Police should consider the introduction of refresher training or additional education on child protection for all frontline staff to ensure that they are aware of their responsibilities to share relevant information with partner agencies.

vii. The Head of Strategic Public Protection within North Wales Police should review the current Missing Person Procedures to ensure that all relevant Missing Persons results in a CID 16 Child Protection or Vulnerable Adult Referral being created and shared with partner agencies.

The Children and Young People's Partnership

viii. The Children and Young People's Partnership should ensure that, when the new implementation model for the TAC/TAF in Gwynedd is introduced, it should include protocols to ensure that relevant information is shared with other agencies to ensure that vulnerable families receive appropriate support.

CAFCASS CYMRU

ix. CAFCASS Cymru should ensure that, when FCAs are involved in the preparation of reports concerning families known to other agencies, managers help them to identify and discuss any safeguarding issues within those families.

x. In relation to access to records held by Social Services, CAFCASS Cymru should:

a. seek to resolve the situation with Gwynedd County Council over access to their case records;

b. consider raising the matter with the Heads of Children's Services across Wales with a view to establishing a national agreement;
c. raise with the Welsh Assembly Government the possibility of amending legislation to give FCAs similar rights of access in private law as they have in public law.
