



WORCESTERSHIRE SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW RELATING TO CHILDREN BW AND CW

BW Date of birth: 2004

BW Date of death: 2010

CW Date of birth: 2003

Ethnic Origin: White British

Agreed by Worcestershire Safeguarding Children Board July 2011.

EXECUTIVE SUMMARY:

1. INTRODUCTION

This is a summary of a Serious Case Review undertaken by Worcestershire Safeguarding Children Board (WSCB) following the death in 2010 of BW and the serious injury to CW. The decision to proceed with a Review was taken in 2010 by the Independent Chair of Worcestershire Safeguarding Children Board, Hilary Thompson.

The Executive Summary provides information about:

- Reasons for the Serious Case Review
- The Serious Case Review Process
- The Family Background
- The Case Summary of Agency Involvement
- Brief Analysis
- The Conclusions of the Independent Overview Report
- The Lessons to be Learnt
- The Recommendations
- The Action Plan for the WSCB

The findings of the Review have been reported to the Office for Standards in Education, Children's Services and Skills (OFSTED) as is required. The Review was granted an extension to the prescribed timescale of six months because of the impact of the criminal investigation and trial, which were concluded in March 2011.

Once the trial had ended the parents were able to contribute to the Review process in May and June 2011.

Information in this report has been anonymised to protect the privacy of family members including references to the gender of children and the subject children are referred to as BW and CW.

2. REASONS FOR THE SERIOUS CASE REVIEW

On a school day morning in 2010 the mother of BW and CW telephoned the police saying that the father of the children had threatened to "throw himself and the children in the river". Mother attempted to pull the children, who were described as terrified, out of the car but father had driven off with them. Within a

few minutes there was a call from a member of the public reporting that a car with children in it had driven into the river and was sinking fast.

The father and CW escaped from the car and were rescued from the river with the assistance of the local police. BW remained submerged for two hours.

Both CW and BW were taken to the local hospital and CW made a good recovery and was released home three days later.

BW died three days later despite resuscitation and intensive care treatment.

Father was taken by ambulance to the local Accident and Emergency department and was treated for hypothermia and near drowning. He responded well to the treatment and was discharged into police custody later the same day.

Father was convicted of murder and attempted murder in March 2011 and sentenced to life imprisonment to serve a minimum of 15 years with 10 years to run concurrently for the attempted murder.

3. THE SERIOUS CASE REVIEW PROCESS

Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards to undertake Serious Case Reviews in accordance with the government guidance contained in Working Together to Safeguard Children. As the tragic event occurred in early 2010 the Worcestershire Safeguarding Children Board acted in accordance with the Working Together to Safeguard Children chapter 8 as revised in December 2009 in making their decision.

The decision taken by the Serious Case Review Subgroup and the Independent Chair to proceed with a Serious Case Review was based on the following paragraphs:

8.10

When a child dies and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parents, carer or close relative with a mental illness, known to misuse substances or to perpetuate domestic abuse.

8.11

LSCBs should consider whether to conduct a SCR whenever a child has been seriously harmed in the following situations:

- A child sustains a potentially life threatening injury or serious and permanent impairments or physical and/or mental health and development through abuse or neglect.

The purpose of the Serious Case Review process is set out in Working Together to Safeguard Children March 2010 as follows:

To

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;
- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

Serious Case Reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate.

This Serious Case Review has proceeded in accordance with the above guidance.

The Terms of Reference of the Review were drawn up by the Serious Case Review Subgroup of the WSCB and stipulated the following:

Aim:

To review the circumstances leading to the tragic incident in 2010 and agencies involvement with the family in order to ascertain whether there are any lessons to be learnt, locally and nationally, for:

- Individual agencies
- Inter agency working

Process:

A Serious Case Review Panel, with an independent chair, will be established to oversee the process. An independent author of the Overview Report will be appointed. Membership of the Panel will include representatives from the agencies, who will be independent of the management of the case:

- Police
- Children's Services
- Adult Mental Health Services
- NHS (PCT)
- Cafcass
- Domestic Abuse Forum
- Inter Agency Training officer

All agencies which had had contact with the family members were required to conduct an Individual Management Review (IMR) including a full Chronology of contacts. All nil returns were noted. An Integrated Chronology was produced to aid the Review process and inform the Overview Report.

Timeframe:

The Review should cover the period from 2007, when it was believed that the difficulties over contact arrangements began, to the date of the incident in 2010.

Older half siblings were also considered within the Review process as one was living in the household throughout and one was there on and off. Children's Social Care provided services to the older half sibling at times when there was a need for services and accommodation by the Local Authority or with other family members due to concerns about anti social behaviour. The Review concluded that this information should form a part of the process as the circumstances had impacted on the family as a whole.

Issues to be considered by the Individual Management Reviews (IMRs), the Health Overview Report and the Overview Report were set out in addition to those stipulated in the Worcestershire Safeguarding Children Board Interagency procedures for Serious Case Reviews .The issues covered inter and intra agency working and some were specific to the agencies involved :

- *Were staff sensitive to the needs and protection of the children in their work?*
- *Were the needs and safety of the children prioritised?*
- *How were the children's wishes and feelings ascertained, and taken account of, when making decisions about the provision of services? Was this information recorded?*

- *Was consideration given to the family's racial, cultural and religious background in the work undertaken by the agency?*
- *What were the key points for assessments and decision making in the case in relation to the children and family? Were these assessments reached in an informed and robust way?*
- *Was there sufficient management oversight and accountability for decision making? Is this recorded?*
- *Were staff knowledgeable about potential indicators of abuse and neglect?*
- *Does the agency have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare, which are compliant with WSCB's Inter Agency Child Protection Procedures for Safeguarding Children?*
- *Were the procedures well known to the staff involved with BW and CW and their parents?*
- *Were the procedures followed by all staff? If not, why not?*

The Individual Management Reviews and the Health Overview Report were also expected to

- *Be explicit about the family's racial, cultural and religious background and give consideration to this in the evaluation of work undertaken by their agency.*
- *Be evidenced based and where appropriate make reference to research.*
- *Consider practice at individual and organisational levels and analyse this openly and critically against national statutory requirements, professional standards and current local procedural guidance.*

The Overview Report was required to focus on learning lessons and the following issues:

- *Was information shared in a timely and appropriate way between agencies?*

- *Were WSCB's Inter-Agency Child Protection Procedures for Safeguarding Children followed?*
- *Was the assessment of risk to the children following the allegation in November 2009 robust and comprehensive?*
- *Was appropriate consideration given to the family's racial, cultural and religious background in the work undertaken by agencies?*
- *Was the response of agencies' adequate?*
- *Initial information indicates that the level of stress in father's life was increasing during January/February 2010. Was there any way that this could have been identified and acted upon to prevent the incident occurring?*
- *The findings and recommendations should be evidenced based and grounded in research and national and regional findings from SCRs.*

The Serious Case Review Panel was chaired by an Independent Chair, Nicki Pettitt and met on five occasions from May 2010 to March 2011. The Overview Report was presented to the Worcestershire Safeguarding Children Board in August 2010 and the revised report following the conclusion of the criminal process and the involvement of the parents in the process was reviewed in July 2011.

Action Plans were drawn up by each agency providing an IMR as well as an integrated Action Plan for the WSCB as required. Actions identified at any stage in the Review process have been implemented within set timescales and are monitored by the Serious Case Review subgroup regularly. The WSCB Action Plan has been attached to this Executive Summary.

4. THE FAMILY BACKGROUND

The parents were first recorded as being in a relationship in a joint household in 2002 when they were both in their early thirties. Both of them had previous partners and children, who have remained in contact with them both, either living with them or visiting.

All members of the families are white British and Christian. Mother's family originates from the Worcestershire area and there were nine siblings. The

relatives live in the local area. Father's parents are divorced and live outside the local area and abroad.

Father worked as a welder by trade with his own small business and he had also worked as a market trader at times. Mother did not work regularly at any time. At the time of the event resulting in the death of BW the children lived with their mother in privately rented accommodation and father was staying in rented rooms and occasionally with his first family.

Both CW and BW were described by their school as two well behaved children who were observed to be settled at school. They had both grown in confidence and learning at school and had groups of friends. They were observed to be happy to be collected by either parent after school and on the day before the event were seen with their father in the local shopping area interacting quite happily. Both parents attended Parent's Evenings and specific events but were not otherwise proactively involved in school life.

Both children were described as healthy, rarely having time off and always well presented, smart and clean.

There are no reports of any concerns about the daily practical care being provided to BW or CW or their sibling by any agency or person other than father reporting concerns about mother's care of the children after they had separated. Mother also raised concerns with the social worker in December 2009 about father's care and supervision of the children during contact.

The picture that emerges of the relationship between the parents over the period from 2007 is one where the family experienced a gradual increase in arguments, aggressive behaviour and violence between the parents, although there is never any referral to any agency of physical violence to the children by the adults or any reported physical injuries to mother. The relationship between the parents was characterised by break ups and reconciliations until late autumn 2009, when the separation became final.

5. CASE SUMMARY OF AGENCY INVOLVEMENT

The Integrated Chronology, which was compiled from the records in the agencies, provided an overview of the involvement of the different agencies with the children and their parents.

It became apparent that the two parents made regular visits to the same GP practice over the period covered by this review. They did not go together at the same time and did not always see the same GP but their GP practice medical records demonstrated the ongoing treatment of both parents for depressed

moods, anxiety and sleep difficulties explained by both as due to 'relationship problems primarily'.

In the case of father serious problems with an increased misuse of alcohol were also noted in the records.

The GP practice did not consider the impact on the parent's abilities to meet their children's needs in relation to the mental health problems the parents were experiencing and the parallel alcohol misuse by father as advocated in the government initiative 'Think Child, Think Parent, Think Family' and to work collaboratively with Health colleagues as well as other agencies. (Reaching Out: Think Family review Social Exclusion Taskforce 2007, Reaching out: Think Family. London: Cabinet Office).

The electronic flagging system in place in the GP surgery was not made use of in relation to the notifications from the police of Domestic Abuse incidents sent to the PCT Health Safeguarding Team.

The GP practice did not consult with other Health professionals including any consultation with the Health Visitor, the School Nurse, and the Nurse Consultant for Safeguarding (Designated Nurse) or with Children's Services about the welfare of BW and CW.

Health was the agency that had most of the information and knowledge about the parents.

The Police also had significant and direct involvement with the family and responded to Domestic Incident call outs to the family either in connection with the parents' conflict about contact or in relation to the older half sibling and anti social behaviour issues.

The numbers of local police contacts were not unusually frequent but they were enough to lead to notifications being made to the Domestic Abuse Unit and the Public Protection Unit as well as Children's Services and the PCT Health Safeguarding team on most occasion.

Children's Services were notified by the police on each occasion but did not have direct contact with the family about BW and CW until December 2009. Prior to that date the response had been to record police reports and send standard letters to mother with the information that 'Children's Services have been informed about the Domestic call out but will not be taking any further action'. The letters offered assistance 'if mother would like to make contact'. The records demonstrate that five letters were sent out to mother in respect of BW and CW.

Children's Services had contact with the parents for significant periods of time about the older half sibling. There had therefore been different services within

Children's Services involved in responding to the household in respect of the different children without the link being made within Children's Services of the fact that there were concerns about the parents' relationship and the impact this was having on BW and CW.

Between October 2008 and September 2009 Cafcass became involved to provide a report to the Court in connection with the application by mother for contact and residence. The contacts with Cafcass were taking place as the Police, the GP and Children's Services were dealing with contacts with the family as well but the agencies did not collaborate and pool their information.

The picture emerges of CW, BW and the half sibling, who also lived in the household permanently, as children whose needs were not assessed at different points in time when their welfare should have been promoted as 'vulnerable children in need of services and of safeguarding'. There is more information in detail in all the records about the parents than the children.

In spite of the police being called the children were not spoken to specifically, whether the call out was in relation to the parental conflict or the behaviour of the older half sibling, whose behaviour also impacted on them.

In reality the children were not seen and spoken to on their own by anyone from the statutory agencies until they were seen by Cafcass in February 2009. At that point the conflict surrounding the parents' relationship breakdown and the contact between the children and father had been going on for a year.

At the time of the tragic event and BW's death another year had passed where the mental health problems of both parents had continued as before. Father's drinking was still increasing and the conflict around the contact had not ceased. Father was consulting a solicitor again as mother was trying to restrict the contact arrangements originally agreed with the Court in the period just prior to Christmas 2009.

Although the threats to kill the children and himself had been expressed in November 2009 and reported by mother to the Police, who consulted with Children's Services, the children were not seen until the 17th December 2009 and they were not seen and spoken to on their own at that time. They were not seen again before the event although a meeting had been arranged by Children's Services to observe them with father during contact. The Initial Assessment, which had been allocated by a Team Manager for follow up, was still not concluded by the time of the death. It should have taken a maximum of seven working days from the referral date as set out in Working Together to Safeguard Children at that time, but 53 working days had passed at the time of the event.

The Initial Assessment should have routinely involved information checks with other agencies such as Health agencies and schools.

At no time did Children's Services, the Police or Cafcass consult with or seek information from Health professionals. They were therefore not aware of the history of treatment for depression and anxiety of both parents and the alcohol misuse by father.

The school, which the children attended, was aware of the parents' separation as they had been contacted by Cafcass in February 2009. They were not aware of the conflict around the contact until November /December 2009 when there was a report of a burn to BW's hand and the Head Teacher contacted father. The burn was reported as an accident when taking a pizza out of the oven. At the same time mother approached the Head Teacher about contact arrangements for collecting the children from school.

According to records in Children's Services there was a contact with the school prior to the homevisit by the social worker in December but there were no records in the school of the telephone conversation about the children and there was no mention recorded of the original referral reason, which was the threat by father to kill the children and himself. The outcome was that the school, where the children spent a significant amount of time, were not actively participating in a multi agency assessment as should have been the case.

6. BRIEF ANALYSIS

There were a number of missed opportunities for the agencies to share information and work together to assess the needs of the children and promote their welfare through consultation, referral and Initial Assessments:

- 2008: Father reported suicidal thoughts on a number of visits to the GP which should have led to his parenting capacity being considered and consultation and information sharing internally in Health.
- 2008: A Domestic Abuse incident call out to the uniformed police when father refused to hand the children back after contact. The children were noted as present ;they should have been spoken to by the police and a referral to Children's Services for an Initial Assessment should have been considered
- 2008:Cafcass should have clarified the information received from Children's Services in order to assess mother's parenting capacity
- 2009: Domestic Abuse incident –'children present'; this should have been followed up with an Initial Assessment particularly as the contact was subject to reports before the Family Court.
- 2009; telephone call from father to the Children's Services Access Centre. In view of the concerns being raised and the past records an Initial Assessment should have been considered to ensure that the children were spoken to.

- 2009; father raised a number of concerns with Cafcass about mothers care of the children, and the older half sibling, in person and in writing .Cafcass should have made a referral to Childrens Services to undertake an Initial Assessment.
- 2009; mother reports that father has made a ‘threat to kill the children and himself’ on two occasions. An Initial Assessment should have been started with checks with other agencies including Health and the school. A Strategy Discussion should have taken place. Children’s Services and the Police Child Abuse Investigation Unit should have undertaken a Section 47 Enquiry to establish the likelihood of the risk to the children. The children should have been seen and spoken to.
- The Initial Assessment that was being carried out failed to check and share information with Health professionals and school. The time frame for the Initial Assessment had been missed.

In their decision making and actions the agencies involved focussed on their immediate remit and provided services to the adults without considering them in their roles as parents and their abilities to meet their children’s needs. This is often referred to as “silo practice “(Brandon et al 2009) which fails to address the needs of the children as the agencies do not focus on the children or work together collaboratively.

The original referral reason in November 2009 of ‘the threat to kill the children and himself’ by father was lost and as mother expressed it ‘no one took any notice’.

An exploration of the research studies around the world into parents killing their children and in particular filicide combined with suicide reveals that there are some common themes that emerge from the studies. If those themes can be understood the awareness of professionals in responding to situations where a statement is made such as father’s threat to kill the children and himself should improve.

The research literature has not agreed a definition of filicide –suicide but it is usually a biological parent killing a child or children and then attempting to kill themselves sometimes for altruistic motives and sometimes for revenge.

The themes which emerge are that

- fathers are more likely to kill an older child and then commit suicide
- a history of domestic abuse including controlling behaviour
- times of separation after relationship breakdown are high risk
- contact arrangement disputes are high risk
- the presence of mental health problems, particularly depression, is high risk
- the presence of alcohol misuse is a high risk

In the Study: 'Twenty nine child homicides' by Hilary Saunders (2004) the following findings are of particular relevance:

- Several of the homicides occurred during overnight stays.
- Mental health issues (including depression and suicide threats or attempts) are mentioned with regard to 9 of the 13 fathers who killed their children.
- In several cases where statutory agencies knew that the mother was experiencing domestic violence, the children were not viewed as being at risk of 'significant harm', even when she was facing potentially lethal violence.
- In five cases it is clear that the father killed the children in order to take revenge on his ex-partner for leaving him.
- Some professionals clearly did not have any understanding of the power and control dynamics of domestic violence, and did not recognise the increased risks following separation or the mother's starting a new relationship.
- In several cases professionals did not talk to the children and this meant that, in effect, there was no assessment of their needs. Sometimes this was because the perpetrator prevented any meaningful contact with the child.

The circumstances of CW's and BW's parents and their drawn out separation where father was unwilling to accept that the relationship had ended demonstrate the themes that are present in the research; a history with both parents of depression; a history of sporadic domestic abuse call outs over a long period of time, which intensify when the relationship ends and alcohol misuse by father in particular.

The interaction of the different issues was not recognised by the agencies as the inter agency collaboration was limited and in particular the Health agencies were not involved as they should have been.

Whether the GP had recognised that the circumstances of the parents required an assessment of the children's needs and any likelihood of significant harm for them ;or whether the Children's Services had initiated an Initial Assessment at some point as previously outlined and undertaken checks with Health the information would have been shared.

It is clear that the information should have been sought and shared after the referral in relation to the 'threat to kill'. If a Section 47 Enquiry had been actioned the children would have been seen and spoken to on their own .The accumulated background history of referrals would have been reassessed and the risk would

have been properly evaluated. There would have been an opportunity to assess the children's circumstances fully. If the enquiries had led to an Initial Child Protection Conference it is very likely that an assessment of father's state of mind would have been undertaken by a specialist mental health service provision.

7. THE CONCLUSIONS OF THE OVERVIEW REPORT

The Review of the tragic death of BW and the 'near death' of CW was asked to consider a range of questions in the Terms of Reference about the services provided to BW and CW and their family. The Individual Management Reviews, the Health Overview Report and the Independent Overview Report have examined the information and assessed it with reference to national legislation and guidance and to the local Worcestershire Safeguarding Children Board Interagency Procedures.

The Review has identified that there were five crucial points where information should have been shared and, if it had been, it would have led to the agencies getting a full picture of the circumstances of father, in particular his mental ill health and alcohol misuse as well as the domestic abuse.

The key points all relate to the issues surrounding the contact arrangements to the children for father.

- The first point is the failure to access all the information as Cafcass first becomes involved after the application to the Court. The HM Court Service should have forwarded the correct forms with the information provided by mother.
- Secondly the fact that Children's Service sent out five letters to mother in response to reported domestic abuse incidents and father made allegations about mother's care of the children culminating in a call in January 2009 without taking action to assess the needs of the children, who were not being seen or spoken to. The accumulation of concerns should have been responded to by Children's Services.
- Thirdly the incident in August 2009 which took place shortly before the final Court hearing where the police and Children's Service should have considered the children's safety and should have alerted Cafcass.
- Fourthly Cafcass should have checked that father's concerns about mother's care of the children were responded to by contacting Children's Services.

- Finally the Initial Assessment undertaken in response to the referral in November 2009 of the 'threat to kill the children and himself' by father should have undertaken checks with Health agencies and school.
- A very brief Initial Assessment should have been followed on the same day as the original referral in November 2009 by a Strategy Discussion and Section 47 Enquiry.

The WSCB inter agency procedures were not followed as the Initial Assessment failed to undertake the required agency checks and share information with Health agencies and school.

The fact that a Strategy Discussion should have taken place and did not is due to the professional judgement and the interaction between the police and Children's Services at the point that they were liaising about the referral.

The assessment of risk to the children in November 2009 by the police was not robust enough as it dealt with the risk in an episodic way rather than take a longer view of the elements of risk. The level of risk assessed was wrong.

The risk assessment lacked significant information to be comprehensive as it had failed to consult with partner agencies in Health and schools.

It is difficult to judge how far the agencies, which were involved with the family, had assessed the family's racial, cultural, economic and religious background and taken it into account when providing their services because of the sparse information available. The main information from the IMRs about the family came from the Cafcass IMR where the interviews with the family had involved looking at family trees and other background.

The response of the agencies did not adequately consider the needs of the children, who were caught up in the conflict between the parents over the relationship breakup and the contact arrangements.

The impact on BW and CW of their parents' behaviour and the behaviour of the older half sibling was not explored with the children on a number of occasions when it should have been.

The children's wishes and views were not heard by agencies. On the one occasion when the half sibling living permanently in the household provided information, it was not followed up.

If the agencies had shared information at the points identified above and had undertaken an assessment of father's state of mind and the risk he posed to the

children, it is likely that the event leading to the death of BW and the near death of CW could have been prevented.

As the Review Panel and the Author did not have the opportunity to access a specialist assessment of father's state of mind, it is possible that the event would have happened whatever intervention had been made at the time, if father was determined and committed to this course of action.

8. THE LESSONS TO BE LEARNT

Where parents are going through relationship break ups the children's needs and the children's own feelings about the situation can often be forgotten. The important issue, when allegations are being made by both parties about each other and the care being provided to the children, is to ensure that the needs of the children are not overlooked. The information provided by both parents after the criminal trial in this case reinforces the message that the children's interests must always be considered by agencies as the parents are still preoccupied with the issues of the conflict about contact and the behaviour of the adults.

A threat to kill children by a parent must always be taken seriously and must be responded to by an urgent assessment of the circumstances by all agencies.

Whenever any professional, such as a GP or police officer, is working with an adult they must see the adult as a parent also and consider the needs of the children and the impact on any child of the parent's or carer's circumstances. Understanding the background history and context of the adult should enable the professionals to assess the needs of the child more effectively and to share information appropriately.

Cafcass system for checking information with other agencies, unless otherwise stated in a court order, is with the police, Children's Social Care Services and schools. If the children are not yet of school age checks are undertaken with Health. The experience of this Review is that consideration should be given to checking older children and their parents with their GP practice in relation to on going mental health treatment and substance misuse in cases of disputed contact.

The subject of this Review which is called filicide –suicide does not fit into any particular established category of Safeguarding headings and is not referred to specifically in Working Together 2010 other than very briefly in paragraph 9.30 in 'Mental Illness of parent or carer' in chapter 9 – Lessons from research. It is not an event that occurs often but when it does, it is a devastating event not only for those children who die or are injured but also for the surviving child, CW, in this case.

Training programmes need to be able to pick up the many factors identified in the research and assist staff in all agencies to be able to understand the dangers that are involved when someone makes a threat to kill so that there is no risk that the response is to minimise and dismiss the threat.

9 THE RECOMMENDATIONS

A range of recommendations have been made by the agencies contributing to this review and have been endorsed by the Worcestershire Safeguarding Children Board (WSCB). The recommendations have been incorporated in the Action Plan for the WSCB. The recommendations in the IMRs were judged by the Serious Case Review Panel to have addressed the Lessons Learnt and Conclusions comprehensively .

The WSCB has agreed to the conclusions and recommendations of the Overview Report and has drawn up an Action Plan to implement the recommended changes, which includes clear timescales for monitoring and review. The Action Plan is attached to this Executive Summary.

The additional recommendations by the Independent Overview Author, the Serious Case Review Panel and the Worcestershire Safeguarding Children Board are set out below:

Recommendations by the Independent Overview Report Author

1.
The WSCB Safeguarding Children Interagency Procedures for Domestic Abuse and Children of Parents who Misuse Alcohol must be reviewed and updated to reflect the lessons from this Serious Case Review.
2.
A chapter for Children of Parents with Mental Health Needs must be added to the Inter Agency procedures as soon as possible to ensure that the procedures reflect the lessons from this Review and support all staff working with parents and carers with mental health needs to carry out their duties in relation to children and young people.
3.
Inter Agency and internal single agency training should be reviewed to ensure that the training contents reflect the lessons from this Review.
4.
The system for passing police incident notifications by the Police to Children's Services (and within Children's Services) and to the Health Safeguarding team

(and within Health) and internally to the PPU and CAIU and to the MARAC should be the subject of a multi agency audit exercise six monthly to ensure that the information sharing system is working effectively. An audit report should be presented to the WSCB to monitor the system and to put in place Action Plans as necessary.

5.

Cafcass should review the need to undertake checks of parents with Health agencies in relation to alcohol misuse and mental health problems in all cases of disputed contact.

Recommendations by the Serious Case Review Panel

1.

The WSCB Toolkit and Processes for Serious Case Reviews must be reviewed to reflect the changes in Working Together to Safeguard Children March 2010 for example the Leaflet to Parents needs updating.

2.

The WSCB should consider the merits of discussion with neighbouring LSCBs with a view to standardising the templates for Action Plans, Chronologies and IMRs as a number of member agencies attend more than one LSCB.

Recommendations by the Worcestershire Safeguarding Children Board

1. The Worcestershire Safeguarding Children Board must engage with local General Practitioner representatives to ensure participation by GPs in WSCB activities such as involvement in Board committees and training to promote GP awareness and compliance with the Inter Agency Procedures and Working Together to Safeguard Children 2010 in the interests of children in Worcestershire.

2. The WSCB must review, relaunch and disseminate the Children Trust Board Information Sharing Protocol to promote effective collaboration and information sharing practice across agencies to safeguard children.

(The full Overview Report includes a list of sources which has been attached to the Executive Summary to assist in Learning Lessons.)

Birgitta Lundberg

Independent Overview Author

June 2011.

To be added:

Sources and Action Plan.