

Cambridgeshire Local Safeguarding Children
Board

Serious Case Review

Executive Summary

Child C (D.O.D 2007)

Child E (D.O.D.2007)

This report is the Executive Summary of the Overview Report containing the findings of the Serious Case Review¹ conducted by the Cambridgeshire Local Safeguarding Children Board (CLSCB). The report has been redacted and some details, including a recommendation, withheld to protect the confidentiality of the children.

1. Introduction

The circumstances that led to this review being undertaken

1. Child C, and her sibling Child E, were found dead at home in 2007. The children died of stab wounds. Their mother was arrested that day. She pleaded not guilty to murder but guilty to manslaughter on the grounds of diminished responsibility. Two years later, the mother was convicted of the murders of both children.

2. The Purpose of a Serious Case Review

2.1 The Serious Case Review (SCR) of Child C and Child E was established under paragraphs 8.2, 8.3 and 8.6 of Working Together to Safeguard Children 2006 in order to identify any lessons to be learned about the ways the agencies involved worked together to safeguard and protect the welfare of both children. It was intended to identify clearly what those lessons were, how they would be acted on and what changes those actions were intended to achieve.

2.2 The purpose of all Serious Case Reviews under 'Working Together to Safeguard Children 2006' is to:

- establish whether there are lessons to be learned from the case about the way in which professionals and organisations work together to safeguard and promote the welfare of children
- identify clearly what those lessons are, how they will be acted on and what is expected to change as a result; and

¹ Working Together to Safeguard Children (2006), HM Government
Re-Written Executive Summary August 2010
Final report.
Helen Chrystal

- as a consequence, improve interagency working and better safeguard and promote the welfare of children

2.3 This Executive Summary describes the key facts and findings from the SCR. Nine agencies contributed to the SCR, each providing an Independent Management Review (IMR) on the basis of case records and interviews with staff from their agency who had been involved with the family. The agencies who contributed to the SCR are listed below:

Terms of reference for the review

2.4 The review focussed on professional involvement with Child C and Child E, their mother and their father from the point at which the family moved to Cambridgeshire in 1999 to the point at which the two children died. Information from the area in which the children lived prior to moving to Cambridgeshire was requested and summarised. Individual Management Review authors were requested to be alert to any earlier or later background information that they thought the panel should be made aware of.

Contributors to the Review

2.5 Individual Management Review Reports were received from:

Cambridgeshire and Peterborough NHS Foundation Trust

Cambridgeshire Community Services: School Nursing Service

Cambridgeshire Constabulary

Cambridgeshire Children and Young People's Services, Education

Cambridgeshire Children and Young People's Services, Social Care

Cambridgeshire University Hospitals NHS Foundation Trust

Cambridgeshire Youth Offending Service

NHS Cambridgeshire: General Practitioner Services

NSPCC (ChildLine)

Family Involvement

2.6 The mother did not respond to a request from the Chair of the Safeguarding Board to contribute to the Serious Case Review

2.7 The Father wished to contribute so that the learning might safeguard other children in the future. He met with the Overview Report Author after the conclusion of the criminal trial.

Process of the Serious Case Review Panel

2.8 The Serious Case Review Panel were advised by the Cambridgeshire Constabulary to wait for the outcome of the criminal trial before finalising the Overview Report and publishing the Executive Summary, however recommendations that came out of the review were implemented immediately

3. Lessons Learnt

3.1 It is not the role of the Serious Case Review Panel to inquire into how a child died or who is culpable, that is a matter for Coroners and criminal courts to determine, as appropriate.

3.2 However the Serious Case Review Panel has carefully considered whether any of the information known to the agencies and practitioners involved with Child C and Child E might have enabled anyone to predict their deaths and what lessons could be learnt.

3.3 The Panel considered some of the research literature available on filicide (the deliberate act of a parent killing their own child). The consistent message from research is that we know very little about parents who kill their children or why.

3.4 A search for national statistics did not provide a picture of how common it is for a mother, or indeed a biological parent, to kill their children.

3.5 The factors that led the mother to kill Child C and Child E are not clear, even after the criminal trial.

3.6 The mother chose not to give evidence and her legal team gave no reason, motivation or catalyst for her actions.

3.7 The Serious Case Review has identified the mother as a parent who sometimes physically and emotionally abused her children. It appeared that she was sometimes unable to put their needs ahead of her own. However there were no factors that could have led any of the professionals to predict that she was one of those very few mothers who would kill her children.

3.8 The Judge summing up at the end of the criminal trial stated *“I wish to say some things in conclusion. This is not one of those murder cases, in my view, where professionals or anyone else overlooked some obvious indication that the children were at risk. Hindsight is a wonderful thing, but there was no evidence called in this trial to show anyone should have seen this terrible crime coming.”*

3.9 Without any evidence that the mother posed such a serious and violent physical risk to the children the Serious Case Review Panel did not consider that even the removal of the children from the mother’s care could necessarily have prevented the children’s deaths.

3.10 Although the Serious Case Review Panel concluded that the children’s deaths could not have been predicted or prevented, the detailed reports provided by the individual agencies identified a number of lessons that could be learned.

3.11 The Individual Management Reviews detail many hours of professionals’ time, spent over several years, working with the children and family and attempting to support them with a number of difficulties.

3.12 There are examples of good practice and the work done by the agencies had some positive outcomes for the children.

3.13 It is clear that although there was some good practice overall the considerable involvement and interventions of the agencies and professionals over several years did not impact as effectively on improving the children’s

outcomes as they might have expected, because often the mother would sabotage the work carried out.

3.14 The Panel did identify a number of lessons to be learned from the review of the agencies' involvement with the children and their family.

3.15 These included the importance of:

- keeping the needs of the child as the focus when dealing with difficult parent(s) or carer(s) who avoid engagement with practitioners or refuse or are unable to act in the child's best interests;
- focusing on the impact of parental behaviour on children rather than the motivation or causes of the behaviour
- recognising that persistent emotional abuse can be as seriously damaging to a developing child as any other form of abuse;
- a detailed multi agency assessment being undertaken whenever there is reason to suspect a child may be suffering significant harm, including emotional harm;
- listening to children and taking their views, wishes and feelings into account in all decisions about meeting their needs and safeguarding them;
- involving both of a child's parents in multi agency assessments and taking their views into account
- ensuring that the known history of referrals and incidents within a family are considered as a whole, rather than as separate incidents, when deciding how to respond;
- ensuring that assumptions and pre judgements about families do not lead to observations being ignored or misinterpreted and that information from family, friends and neighbours is carefully considered, whatever their motivation is thought to be;

- ensuring that there is good co-ordination between the services that work together to meet the needs of children so that as a child's needs change, either reducing and needing less intervention or becoming more complex and requiring more intensive intervention the services can respond effectively.
- ensuring that when the Family Court directs a local authority to undertake a report the report provided is comprehensive, addresses all the issues required and is of an acceptable quality
- taking robust action to prevent children missing education without clear and valid reasons;

4. Conclusions

4.1 The loss of these two young lives is a tragedy for everyone who loved and cared for them.

4.2 The Serious Case Review Panel was unable to identify any factors that could have raised reasonable suspicion that the children would be seriously assaulted or killed. Nor could the Panel identify any reasonable action that could have been taken to prevent their deaths.

5. Recommendations

Multi agency practice recommendations:

These recommendations have been transferred into a Cambridgeshire Local Safeguarding Children Board action plan which sets out who will do what, by when and with what intended outcome.

The progress of the action plan will be monitored by the Cambridgeshire Local Safeguarding Children Board