Briefing on Serious Case Reviews

The Anderson Family (Published by Suffolk LSCB January 2014**)**

Background

Three children and their mother died in April 2013. The children were aged 3 years, 2 years and 13 months at the time of their deaths and mother was 7 months pregnant. Evidence suggests mother killed the children prior to committing suicide by jumping from a multi-story car park. The family were known to a variety of child care agencies from the time of mother's first pregnancy up until the deaths of all three children. There were two periods of time when Child Protection Plans were in place for one or more of the children. Plans identified concerns in respect of possible physical and emotional neglect, and were in place at the time of all the children's deaths.

There were legal initiatives to obtain Care Proceedings in respect of the first child, these were withdrawn, but later legal strategy meetings were held to continue to consider if the children met the criteria to seek care or supervision orders. Although legal interventions via the Public Law Outline were considered again, the plan for these drifted and no Care Proceedings were initiated.

The parents were not married and the father's presence in the home was not constant and it is unclear what periods of the children's lives he was involved in. Parents, particularly mother, were highly resistant to professional involvement.

Issues identified include: adversarial relationship between parents and professionals from outset, parental non-attendance at health appointments and child protection meetings, lack of stimulation and infrequent opportunities for children to interact with others leading to social, language and emotional development delays and professional uncertainty over mother's mental and emotional health.

Key Learning Points:

Engaging with hard to reach families

- Some parents and carers are hostile, deceptive, avoidant and uncooperative. Working with hard to reach and avoidant families is challenging. Innovative multi-agency interventions and new initiatives are required to engage parents in a more constructive working alliance. The predominant feature of this case was the challenge of how to engage the mother particularly who avoided professional interventions. This meant there was minimal contact with her and the children, and therefore the CP plans achieved little. It is noted that parental attendance at Child Protection Conferences and Core Groups was almost non-existent. The early application for care proceedings for the first born child also set a tone of an adversarial relationship.

Focus on the child – Exploring Emotional Neglect

- Professionals need to focus on the experience of the child and identify what the impact of any emotional neglect might be. In this case it was the physical neglect which was given most attention even when there was evidence of emotional neglect. Whilst emotional neglect was suspected it proved especially difficult for professionals to evidence, although a more concerted collation of these areas of concern could have potentially realised greater evidence.

Ensuring high quality supervision

- Practitioners need effective supervision and support to enable them to retain a child focus and assess their behaviours and development within families where the parents have high levels of need.

Ensuring management oversight and action.

- Robust management oversight of the progress of the case is essential and should be shown to have a direct role and impact on the professional interventions. In this instance whilst there was a system of senior management oversight in place, it did not sufficiently impact on the case.

- All professionals have the responsibility to challenge inappropriate or ineffectual practice. Escalate concerns to senior mangers when necessary.

- When cases are not progressing in terms of the protection of children, and the multi-agency process has become entrenched, there needs to be a separate process to objectively review why the case has become problematic.

- Drift of the Public Law Outline process must be avoided by strong management oversight

Effectiveness of Child Protection Conferences

- The role of the CP Chair is a pivotal one in challenging the management of a case which is not achieving CP plans. In this case lack of objective input to the Child Protection conferences impacted on the ability of the CP processes to create a more challenging and questioning environment in which to monitor and improve the care of the children.

- CP Plans should not continue unaddressed throughout a number of child protection conferences. Up to date plans could reduce the likelihood that children will continue to be subject to significant harm whilst still within the child protection process. In this case the CP plans continued largely unchanged for a period of 18 months without some form of review and formal revision.

- For Child Protection Conferences to only include those professionals directly working with the family will deprive the CPC of objective input by managers and specialists to help progress the case and reduce safeguarding risks to the children.

- Important decision and agreement reached between CPC Chairs and managers outside of the CP process must be recorded. Any actions agreed to ensure that a

case is properly progressed can then be effectively reviewed and monitored and helps prevent management drift.

Effective partnership working and understanding of legal services

- Drift of the Public Law Outline process must be avoided by strong management oversight as above, but also via a Drift of the Public Law Outline process must be avoided by strong management oversight. For this to be achieved there must be a shared understanding and clarity about the separate roles, responsibilities and accountability for decision making.

- A shared understanding by non CYPS agencies of legal processes instigated for children will enable them to contribute and challenge the process as part of partnership working.

Parental Mental Health

- Possible adult mental health issues must remain on the agenda for multi-agency discussions in consideration of any changing family circumstances. How any such assessment is carried out with people who are avoidant is very challenging and will require a skilled and thoughtful approach. Whilst the mother's behaviours and attitudes to her children and to professionals raised concerns, the process of the CP plans was unable to secure any psychological or mental health assessment.

Background information about parents' childhoods

- Background information of a parent's own childhood is essential to understanding their own parenting capacity. This information needs to be collected and shared among professionals to ensure accuracy of any parenting assessment.