

SANDWELL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

**(Under Chapter 8 of Working Together to Safeguard Children 2006)
In respect of the death of a child known as DS**

EXECUTIVE SUMMARY

**Report by: Nicki Pettitt, Independent Author
Presented to Sandwell Safeguarding Children Board on 30 March 2010**

SERIOUS CASE REVIEW EXECUTIVE SUMMARY

1 INTRODUCTION

- 1.1 A child, known throughout this report as DS, died in August 2009. She was 9 years old. She was sexually abused and murdered by her Mother's boyfriend.
- 1.2 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards to undertake Serious Case Reviews (SCR) in accordance with the government guidance contained in Chapter 8 of Working Together to Safeguard Children.
- 1.3 The purpose of a Serious Case Review is to:
 - Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
 - Identify clearly what those lessons are, how they will be acted upon, and what is expected as a result.
 - As a consequence, improve inter agency working and better safeguard and promote the welfare of children.
- 1.4 In the production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality. Sandwell Safeguarding Children Board (SSCB) has balanced the need to maintain the privacy of the child and family, with the need for agencies to learn lessons in relation to practice identified by the case. It has authorised the publication of sufficient information to enable this to take place.
- 1.5 The SCR Panel were initially unable to have direct involvement of the family in this review due to an on-going Police investigation. A letter was sent to inform them of the Review process. Once the investigation was completed, a meeting was arranged with DS's Mother. However she decided that she did not wish to meet with the Overview Report author at this time. It has been agreed that she can request a meeting at a later stage and the SSCB remains committed to providing her with information when she feels ready.
- 1.6 The Board is committed to the recommendations of this review, and intends to implement them immediately and robustly to improve safeguarding practice.

2 THE REVIEW PROCESS

- 2.1 On 24 September 2009, after 2 information sharing sessions, the Chair of the SSCB accepted the recommendation of the Sandwell Serious Case Review Sub-Group that a Serious Case Review be held, and they communicated this decision to Ofsted (the regulatory authority); and the Government Office for the West Midlands on 25 September 2009.
- 2.2 The composition of the Serious Case Review Panel established by the Board ensured that those involved were experienced child care professionals who had no prior involvement with the family or any line management responsibility for the staff who had worked with them.

- 2.3 The independence of the Panel and review process was established by the appointment of Hilary Thompson as Independent Chairperson and Nicki Pettitt as an independent author to write the Overview Report.
- 2.4 On 14 October 2009, a meeting of the Serious Case Review panel was held which took the following actions:
- agreed the 'terms of reference' that would provide the structure for the review,
 - agreed the scope of the review (period to be addressed by agencies etc),
 - agreed which other LSCB's should be contacted for information about DS and her family.
- 2.5 Following the meeting, all partner agencies of Sandwell Safeguarding Children Board, and the LSCB's in Thurrock, Peterborough, Salford, Wolverhampton, and Walsall, were requested to undertake Individual Management Reviews. They were asked to provide reports detailing their involvement with DS and her family, and to ensure they addressed the terms of reference. A briefing was provided for the authors of these reviews on 10 November 2009.
- 2.6 The designation and agency of the Serious Case Review Panel members were:
- Consultant Paediatrician and Designated Doctor for Child Protection, Sandwell & West Birmingham Hospitals NHS Trust.
 - Detective Chief Inspector, West Midlands Police.
 - Children's Services Manager, NSPCC.
 - Divisional Manager for Looked After Children, Sandwell MBC.
 - Lead for Inclusive Learning, Sandwell MBC.
 - Lead Nurse, Child Death Review, Sandwell PCT.
 - Child Death Co-ordinator, Sandwell MBC.
 - Director of the Sandwell Mental Health Trust.
 - Senior Joint Commissioning Manager. Sandwell Children's Trust.
- 2.7 The issues addressed in the terms of reference were:
- 1 Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?
 - 2 Were the wishes and feelings of DS and other children listened to and taken account in assessments and actions taken?
 - 3 Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
 - 4 What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family?
 - 5 Do assessments and decisions appear to have been reached in an informed and professional way
 - 6 Did actions accord with assessments and decisions made?
 - 7 Were appropriate services offered / provided, or relevant enquiries made, in the light of assessments?
 - 8 Was information recorded?
 - 9 Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?

- 10 Were more senior managers or other organisations and professionals involved at points where they should have been?
- 11 Was the work in this case consistent with each organisation's and the LSCBs policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- 12 Were appropriate arrangements in place to act upon risks to the children in circumstances of domestic abuse?
- 13 Were assessments, information regarding interventions and recording transferred in a timely way to other areas so that receiving areas could act appropriately?
- 14 Were there examples of good practice and specifically was good practice interrupted by the family's moves of location?

3. CASE SUMMARY

3.1 In August 2009 DS was sexually abused and then murdered by her Mother's boyfriend. He then committed suicide.

3.2 In light of this, it was the decision of the Chair of the SSCB that the criteria for holding a Serious Case Review as set out in Chapter 8 of Working Together To Safeguard Children (DCSF 2006) were met, i.e. "a child dies (including death by suicide) and abuse or neglect are known or suspected to be a factor in the death".

3.3 In this case there were some additional concerning features. They were:

- The mother of DS had been in care as a child, she had a history of domestic abuse in her adult relationships, and she moved a number of times with her children. These factors had not been appropriately considered by agencies involved with her children as a significant factor which may impact on their on-going care and protection.
- There had been some concern expressed in the past about A2, in relation to child safeguarding issues, which had not been adequately investigated.

3.4 There were no safeguarding concerns about DS or other children in the family at the time of her death. There had been no involvement with Children's Social Care while the family lived in Sandwell, which was from September 2007. DS had some health issues, but otherwise she presented as a happy and settled 9 year old. It was not established that A2 lived with the family, and most agencies were not aware he was in a relationship with DS's Mother. The SCR concluded that the death of DS was neither predictable nor preventable. However the process of the SCR has highlighted lessons that can be learned by all the agencies involved.

3.5 The family concerned are from a White British background and the Serious Case Review Panel is satisfied that there were no racial, linguistic or religious issues that impact upon this review. However, there were some cultural/lifestyle issues which may have had an impact on any assessments made and on any services which could have been provided to the family.

3.6 As the family had moved a number of times the other LSCB's, as referenced above, were also asked to provide information for the review. This added to the complexity of the process. The scope of the review, which covered the lifetime of DS and her siblings, involved the consideration of professional and agency practice both now and in the past.

4 KEY ISSUES

- 4.1 Each agency that completed an Individual Management Review to support this Serious Case Review has identified a number of weaknesses about their practice in the past, and has shown that they have already been addressed by both local and national changes. The agencies more recently involved with the family have identified some ongoing issues in practice that are in the process of being addressed via a series of internal recommendations.
- 4.2 Those recommendations relating to other LSCB's have been agreed by them and they have taken responsibility for implementing them.
- 4.3 The recommendations relating to Sandwell will be robustly monitored by SSCB to ensure that they are actioned within the agreed timescales and have the desired impact upon local services for safeguarding children.
- 4.4 In addition to these recommendations, the Serious Case Review has identified a number of key issues that need to be addressed by the Safeguarding Children Board as a whole or where the Board needs to maintain a close watching brief because of the importance of the issue.

These recommendations are; -

Recommendation 1:

SSCB will audit consistent and routine use of Common Transfer Files between schools, in line with Pupil Information Regulations 2005, and will recommend that DCSF promote and support this nationally.

Recommendation 2:

All LSCBs contributing to this SCR to review their policy regarding those children, who leave their area, but continue to be Children in Need.

Recommendation 3:

SSCB audits the compliance of the Rapid Response Process in line with Chapter 7 with particular reference to the surviving sibling(s) and children in the family.

Recommendation 4:

SSCB to formally notify those LSCB's who have contributed to this SCR of their responsibility to monitor that their IMR recommendations have been implemented.

I have no professional or personal connections with Sandwell Safeguarding Children Board or its partner agencies.

Nicki Pettitt
Independent Author